

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155338	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/14/2013
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/14/13</p> <p>Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services - Prestwick was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Building 0101, the original building, was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101, built prior to March 1, 2003, was determined to be of</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 64 of 79 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 79 resident sleeping rooms. The facility has a capacity of 140 and had a census of 109 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 79 resident room corridor doors would close and latch into the door frame. This deficient practice could affect 36 of 109 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the corridor door to resident Room 310 would not latch into the door frame because the latching bolt was stuck inside the door. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to resident Room 310 would not latch into the door frame.</p>	K010018	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.</p> <p>K 018</p> <p>It is the practice of Manorcare Prestwick to have resident room corridor doors close and latch properly.</p> <p><b>What corrective actions will be</b></p>	03/16/2013			

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	3.1-19(b)		<p><b>taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>The door handle and latch for the affected door was replaced.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>The Director of Maintenance inspected all resident corridor doors and no other problems were identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance or Designee will incorporate the inspection of resident room corridor doors into the monthly preventative maintenance schedule.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance / Designee will inspect 23 doors a month ensuring that all resident room corridor doors are inspected at least quarterly. The Director of Maintenance or Designee will report</p>		

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			to the inspection findings to the Quality Assurance Committee monthly and the committee will make recommendations about the continuation of the inspection schedule based on findings.	

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K010052 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to maintain 5 of 69 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 94 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the following smoke detector locations were each located less than three feet from an air return vent:</p> <p>a. the smoke detector on the ceiling in the corridor by the north nurses station was located sixteen inches from an air return vent.</p> <p>b. the smoke detector on the ceiling in the</p>	K010052	<p>K 052</p> <p>It is the practice of Manorcare Prestwick to maintain smoke detectors with proper spacing from air return vents.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>Identified smoke detectors were moved providing sufficient space between detector and air return vents.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>The Director of Maintenance inspected all the smoke detectors to identify any others that were too close. There were none identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the</b></p>	03/16/2013			

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	<p>corridor by the south nurses station was located one foot from an air return vent.</p> <p>c. the smoke detector on the ceiling in the corridor outside Room 312 was located one foot from an air return vent.</p> <p>d. the smoke detector on the ceiling in the corridor outside Room 110 was located one foot from an air return vent.</p> <p>e. the smoke detector on the ceiling in the corridor outside Room 711 was located one foot from an air return vent.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detector locations were each installed less than three feet from an air return vent.</p> <p>3.1-19(b)</p>		<p><b>deficient practice does not reoccur?</b></p> <p>The Director of Maintenance/Designee will inspect any new smoke detectors or air return vents that are installed to validate the placement is compliant with the code.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance or Designee will inspect smoke detectors once a quarter and report findings to the Quality Assurance Committee. The committee will make recommendations for continues monitoring based on the information provide.</p>		

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:35 a.m. to 10:40 a.m. on 02/14/13, documentation of annual fire hydrant testing within the last twelve months was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the facility has one fire hydrant located near the parking lot by the</p>	K010062	<p>K 062 It is the practice of Manorcare Prestwick to ensure the fire hydrant is inspected annually and after each operation. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The fire hydrant was inspected and found to be in good working order. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b> Residents that reside in this facility would be at risk. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The Director of Maintenance / Designee will incorporate inspection of the fire hydrant into his annual inspection plan <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> The fire hydrant inspection is now set up on a tickler file with a reminder a month prior to the due date. The inspection will be flagged as open</p>	03/16/2013			

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	<p>emergency generator. Based on interview at the time of observation, the Maintenance Director stated the aforementioned fire hydrant was owned by the facility and acknowledged documentation of annual fire hydrant testing within the last twelve months was not available for review.</p> <p>3.1-19(b)</p>		<p>until it is completed. The Director of Maintenance or Designee will report the due date to the Quality Assurance Committee the month prior to it being due and will also report completion to the committee.</p>		

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 2 outside areas where smoking was permitted. This deficient practice could five staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the staff smoking area located</p>	K010066	<p>K066</p> <p>It is the practice of Manorcare Prestwick to provide approved noncombustible containers in areas where people smoke.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>An approved noncombustible container, Smokers Oasis, was purchased and placed in the area affected.</p>	03/16/2013			

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	<p>ten feet outside of the building near the parking lot next to the emergency generator had in excess of 200 extinguished cigarette butts deposited on the ground. A noncombustible ash tray and a metal container with a self closing cover device into which ashtrays can be emptied were not provided in this area by the emergency generator where staff smoking was permitted. Based on interview at the time of observation, the Maintenance Director acknowledged cigarette butts were disposed of on the ground by staff and a noncombustible ash tray and metal container with a self closing cover device into which ashtrays can be emptied were not provided at the aforementioned outside smoking area.</p> <p>3.1-19(b)</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>The Director of Maintenance inspected the grounds outside of the facility for other areas that would need a noncombustible container. No other areas were identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance will incorporate a weekly inspection of the area to validate smokers are utilizing the container.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance will track and trend the inspections and report analysis to the Quality Assurance Committee at the monthly meeting. The committee will make recommendations based on the information presented for a schedule of continued monitoring.</p>		

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical wall fixtures in the oxygen storage and transfilling room were located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet (60 inches) above the floor to avoid physical damage. This deficient practice could affect 36 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on</p>	K010076	<p>It is the practice of Manorcare Prestwick to maintain electrical outlets at least 5 feet above the floor in rooms where oxygen is stored / transferred.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>The electrical outlets have been moved to a minimum height of 5 feet off the floor.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>The Director of Maintenance inspected rooms where oxygen is stored or transferred to determine if there were other areas affected. None were noted.</p>	03/16/2013	

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	<p>02/14/13, one electrical outlet and one light switch were each located on the wall 42 inches above the floor in the oxygen storage and transfilling room. Eleven liquid oxygen storage tanks were observed stored in the room. Based on interview at the time of observation, the Maintenance Director acknowledged each of the aforementioned electrical wall fixtures were located on the wall less than five feet above the floor of the oxygen storage and transfilling room.</p> <p>3.1-19(b)</p>		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>If the oxygen storage room is moved, the Director of Maintenance or Designee will inspect the room prior to the move to validate the outlets are in compliance with the regulation.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance or Designee will inspect the oxygen storage rooms monthly to ensure the outlets continue to be in compliance and report findings to the Quality Assurance Committee for additional recommendations.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 64 of 79 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 79 resident sleeping rooms. The facility has a capacity of 140 and had a census of 109 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155338		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED  02/14/2013	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK				STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123			
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K020062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:35 a.m. to 10:40 a.m. on 02/14/13, documentation of annual fire hydrant testing within the last twelve months was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the facility has one fire hydrant located near the parking lot by the</p>	K020062	<p>K 062 It is the practice of Manorcare Prestwick to ensure the fire hydrant is inspected annually and after each operation. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The fire hydrant was inspected and found to be in good working order. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b> Residents that reside in this facility would be at risk. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The Director of Maintenance / Designee will incorporate inspection of the fire hydrant into his annual inspection plan <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> The fire hydrant inspection is now set up on a tickler file with a reminder a month prior to the due date. The inspection will be flagged as open</p>	03/16/2013			

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	<p>emergency generator. Based on interview at the time of observation, the Maintenance Director stated the aforementioned fire hydrant was owned by the facility and acknowledged documentation of annual fire hydrant testing within the last twelve months was not available for review.</p> <p>3.1-19(b)</p>		<p>until it is completed. The Director of Maintenance or Designee will report the due date to the Quality Assurance Committee the month prior to it being due and will also report completion to the committee.</p>		

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K020066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 2 outside areas where smoking was permitted. This deficient practice could five staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:30 p.m. on 02/14/13, the staff smoking area located</p>	K020066	<p>K066</p> <p>It is the practice of Manorcare Prestwick to provide approved noncombustible containers in areas where people smoke.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>An approved noncombustible container, Smokers Oasis, was purchased and placed in the area affected.</p>	03/16/2013			

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	<p>ten feet outside of the building near the parking lot next to the emergency generator had in excess of 200 extinguished cigarette butts deposited on the ground. A noncombustible ash tray and a metal container with a self closing cover device into which ashtrays can be emptied were not provided in this area by the emergency generator where staff smoking was permitted. Based on interview at the time of observation, the Maintenance Director acknowledged cigarette butts were disposed of on the ground by staff and a noncombustible ash tray and metal container with a self closing cover device into which ashtrays can be emptied were not provided at the aforementioned outside smoking area.</p> <p>3.1-19(b)</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>The Director of Maintenance inspected the grounds outside of the facility for other areas that would need a noncombustible container. No other areas were identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance will incorporate a weekly inspection of the area to validate smokers are utilizing the container.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b></p> <p>The Director of Maintenance will track and trend the inspections and report analysis to the Quality Assurance Committee at the monthly meeting. The committee will make recommendations based on the information presented for a schedule of continued monitoring.</p>		