

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
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NAME OF PROVIDER OR SUPPLIER  NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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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
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K 0000  Bldg. 01	<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: 08/18/15</p> <p>Facility Number: 010758 Provider Number: 155662 AIM Number: 200229550</p> <p>At this Life Safety Code survey, Nursing Care at Hartsfield Village 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. The original one story building except a therapy gym on the first floor and a six bed addition in rooms B209 to B214 on the second floor was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility is a two story building with a one story section and a partial basement. The one story section is Type II (000) construction and the two story building is of Type II (111) construction. Because</p>	K 0000	<p>Thank you for considering this Plan of Correction Please do not hesitate to contact me should you have questions or require additional information Sincerely, Susan Finn - Administrator</p>	
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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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K 0018 SS=D Bldg. 01	<p>the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of Type II (000) construction. The building is fully sprinklered with supervised smoke detectors on all levels including in corridors, in resident rooms, and in areas open to the corridor. The facility has the capacity for 112 and had a census of 105 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>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 82 resident</p>	K 0018	Nursing Care at Hartsfield Village 503 Otis Bowen Drive	09/17/2015

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	<p>room corridor doors closed and latched into the door frame. This deficient practice could affect 2 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/18/15 at 11:39 a.m., the Maintenance Director acknowledged the corridor door to resident room A105 failed to latch when tested.</p> <p>3.1-19(b)</p>		<p>Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K018</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are substantial doors; doors are provided with a means suitable for keeping the door closed. The facility failed to ensure 1 of 82 resident room corridor doors closed and latched into the door frame.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The resident room corridor door was repaired on 8/19/15. The door closes and latches properly into the</p>	

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			<p>door frame.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> The two residents residing in this room could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b> All resident room corridor doors were checked to ensure they close and latch into the door frame.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/week for 4 weeks to ensure that all resident room corridor doors remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b></p>	

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 7 residents and staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 09/18/15 at 3:01 p.m. then again at 3:20 p.m., second</p>	K 0025	<p>Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> September 17, 2015</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of</b></p>	09/17/2015

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	<p>floor phone room had multiplug gaps around conduit passing through the ceiling. Then again second floor D Wing by elevator smoke barrier wall penetration above the ceiling tile, a quarter inch gap around sprinkler pipe. Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p><b>the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. K025</b> Smoke barriers are constructed to provide at least a one half hour fire resistance rating. The facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one hour fire resistance rating. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> The second floor phone room had gaps around conduit passing through the ceiling. These penetrations were properly sealed on 8/26/15. The second floor D Wing near the elevator had a smoke barrier wall penetration above the ceiling tile which was a quarter inch gap around the sprinkler pipe. This penetration was properly sealed on 8/26/15. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents on the second floor could potentially be affected. <b>To ensure that proper practices continue:</b> The Maintenance Director will continue to monitor for smoke barrier wall penetrations through daily rounds and routine maintenance</p>	

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect at least 16 residents, staff, and visitors.</p> <p>Findings include:  Based on observation with the</p>	K 0044	<p>of the facility. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for further corrective action will be discussed and implemented as needed. Completion Date: September 17, 2015</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p>	09/17/2015	

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	<p>Maintenance Director on 08/18/15 at 11:51 a.m. the fire doors near resident room A105 failed to latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged both sets of doors were fire doors and would not latch into the frame.</p> <p>3.1-19(b)</p>		<p><b>K044</b></p> <p>Horizontal exits, if used, are in accordance with regulations requiring fire doors to be self-closing or automatic closing. The facility failed to ensure 1 of 8 fire door sets were arranged to automatically close and latch. The fire doors near resident room A105 failed to latch.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>The fire doors near resident room A105 were repaired. These doors now latch properly.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b></p> <p>All residents on the first floor could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b></p> <p>All fire doors in the facility were checked to ensure they latch properly.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all fire doors remain in compliance with this plan of correction. After the fourth week, the QA Committee will review all audit tools and will determine if the facility has achieved at least 90%</p>	

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K 0050 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2		<p>compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> September 17, 2015</p>	

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	<p>Based on record review and interview, the facility failed to ensure 10 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Report of Monthly Drills" forms with the Maintenance Director on 08/18/15 at 9:43 a.m., 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month. (1/28/15, 2/25/15, 4/24/15, 5/28/15, 6/30/15, 7/31/15, 8/26/14, 9/26/15, 10/31/14, 11/30/14). Based on interview at the time of record review, the Maintenance Director confirmed drills are scheduled for the end of the month and acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. K050 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The facility failed to ensure 10 of 12 fire drills were conducted under varying conditions; 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month. <b>Corrective action taken for residents found to have been affected by the deficient practice:</b> The Maintenance Director developed a schedule of fire drills for the next</b></p>	09/17/2015	

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			<p>calendar year to ensure that all dates vary in accordance with the regulation. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents in the facility have the potential to be affected. <b>To ensure that proper practices continue:</b> The Maintenance Director was in-serviced on variance requirements for fire drills. The Maintenance Director developed a schedule of fire drills for the next calendar year to ensure that all dates vary in accordance with the regulation. This schedule will be followed each month. The Maintenance Director/Designee will submit Fire Drills for each month to the monthly QA committee for review to ensure compliance with this plan of correction. After the sixth month, the QAA Committee will review all fire drills and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 6 month period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.</p> <p><b>Quality Assurance Plan to</b></p>	

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K 0062 SS=E Bldg. 01	<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 observation and interview, the facility failed to replace 1 of 2 Basement painted sprinkler heads in the 1A Stairwell. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and at least 6 residents.</p> <p>Findings include:  Based on observation and interview on</p>	K 0062	<p><b>monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. <b>Completion Date:</b> September 17, 2015</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p>	09/17/2015	

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	08/18/15 at 11:39 a.m., the Maintenance Director confirmed the 1A Basement sprinkler head was covered in paint and acknowledged the aforementioned condition.  3.1-19(b)		<p><b>K062</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The facility failed to replace 1 of 2 basement painted sprinkler heads in the 1A stairwell.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> The sprinkler head in the 1A stairwell was replaced on 8/27/2015.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents on the first floor could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b> All sprinkler heads were inspected to ensure compliance with this regulation. Sprinkler heads are on schedule to be inspected by a contracted company each quarter to ensure continued compliance with this regulation.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for further</p>		

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NAME OF PROVIDER OR SUPPLIER  NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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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
K 0067 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 100 % of fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects at least 1 residents, staff and visitors.</p>	K 0067	<p>corrective action will be discussed and implemented as needed.</p> <p><b>CompletionDate:</b> September 17, 2015</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and</b></p>	09/17/2015

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	<p>Findings include:</p> <p>Based on observations on 08/18/15 with the Maintenance Director at 3:50 p.m., the facility has fire dampers located in the HVAC return air plenum above the ceiling tiles in the corridors throughout the facility. Based on record review, the damper inspection report by Artic Engineering showed that two dampers (Ceiling by Special Care Door and In Room C201 by Hall Door) need a new switch. Based on interview at the time of record review, the Maintenance Director said they are still in the process of setting up an account to have the repair work to be done.</p> <p>3.1-19(b)</p>		<p><b>state law. K067</b> Heating, ventilating and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. The facility failed to ensure 100% of fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years. Two dampers (ceiling by Ortho Unit door and room C201) need a new switch. <b>Corrective action taken for residents found to be affected by the deficient practice:</b> All fire dampers in the facility were inspected by a contracted company to ensure compliance with this regulation. The switch that needed to be replaced on the two dampers (ceiling by Ortho Unit door and room C201) was replaced and both are functioning appropriately. <b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents in the facility could potentially be affected. <b>To ensure that proper practices continue:</b> The Maintenance Director/Designee will ensure that fire dampers are inspected and provided necessary maintenance at least every four years or as needed. <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> All Life Safety Code identified</p>	

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K 0075 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 5 corridors on second floor. This deficient practice could affect staff and at least 7 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 08/18/15 at 3:04 p.m., three adjacent 32 gallon containers of biohazardous soiled linens, biohazardous trash, and linen were</p>	K 0075	<p>deficiencies will be reviewed by the facility's QAACommittee. Recommendations for further corrective action will be discussed and implemented as needed. <b>CompletionDate:</b> September 17, 2015</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p><b>This plan of correction represents thecenter's allegation of compliance. The following combined plan of correctionand allegation of compliance is not an admission to any of the allegeddeficiencies and is submitted at the request of the Indiana State Department ofHealth. Preparation and execution of this response and plan of correction doesnot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. Theplan</b></p>	09/17/2015

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	<p>discovered outside the soiled utility room on second floor D wing. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K075</b> Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons are located in a room protected as a hazardous area when not attended. The facility failed to secure a three compartment linen and trash container; the cart was stored outside the soiled utility room on the second floor D wing.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b> The cart was moved immediately and stored properly.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All residents on the second floor could potentially be affected.</p> <p><b>To ensure that proper practices continue:</b> Nursing staff (Nurses and CNAs) will be in-serviced on proper storage of three compartment linen and trash carts when they are not in use.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all stored</p>	

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K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for	K 0147	three compartment linen carts remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved at least 90% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 90% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 90% compliance and has ensured the deficient practice will not recur.  <b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.  <b>Completion Date:</b> September 17, 2015  Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321	09/17/2015

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	<p>fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 08/18/15 between 1:19 p.m. to 2:50 p.m. the following was discovered:</p> <p>a) a surge protector powering a microwave in the Housekeeping Office</p> <p>b) an extension cord was powering a coffee pot in the Maintenance Office</p> <p>c) an extension cord powering a coffee pot and a multiplug powering a microwave and refrigerator in the MDS office</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p> <p><b>K147</b></p> <p>Electrical wiring and equipment is in accordance with regulation. The facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw.</p> <p><b>Corrective action taken for residents found to have been affected by the deficient practice:</b></p> <p>A surge protector powering a microwave in the housekeeping office was removed immediately. The microwave was removed from this office.</p> <p>An extension cord powering a coffee pot in the Maintenance Office was removed immediately. The coffee</p>		

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			<p>pot was removed from this office. An extension cord powering a coffee pot and a multiplug powering a microwave and a refrigerator in the MDS office were removed immediately.</p> <p><b>Identification of other residents having the potential to be affected by the same deficient practice:</b> All persons working in these office have the potential to be affected.</p> <p><b>To ensure that proper practices continue:</b> All managers working in offices were in-serviced on the requirement for electrical equipment in personal offices to be plugged into fixed wiring.</p> <p>Administrator conducted a review of all offices to ensure compliance with this plan of correction.</p> <p><b>Quality Assurance Plan to monitor compliance with this Plan of Correction:</b> All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for further corrective action will be discussed and implemented as needed.</p> <p><b>Completion Date:</b> September 17, 2015</p>	

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K 0000  Bldg. 02	<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: 08/18/15</p> <p>Facility Number: 010758 Provider Number: 0155662 AIM Number: 200229550</p> <p>At this Life Safety Code survey, Nursing Care At Hartsfield Village 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. The new addition, consisting of a six bed addition in rooms B209 to B214 on the second floor and a therapy gym on the first floor was surveyed with Chapter 18, New Health Care Occupancies</p> <p>This two story addition was determined to be of Type II (111) construction and fully sprinklered. Because the one story and two sections of the building are not separated by two hour rated construction, the building is considered one building of</p>	K 0000	<p>Thank you for considering this Plan of Correction Please do not hesitate to contact me should you have questions or require additional information Sincerely, Susan Finn - Administrator</p>	
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K 0050 SS=B Bldg. 02	<p>Type II (000) construction. The facility has a fire alarm system with automatic smoke detection in the corridors, in resident sleeping rooms and in areas not separated from the corridor. The facility has a capacity of 112 beds and had a census of 105 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>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure 10 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:  Based on record review of the "Report of</p>	K 0050	Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 <b>This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the</b>	09/17/2015			

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	<p>Monthly Drills" forms with the Maintenance Director on 08/18/15 at 9:43 a.m., 10 of 12 fire drills conducted over the past four quarters were conducted near the end of the month. (1/28/15, 2/25/15, 4/24/15, 5/28/15, 6/30/15, 7/31/15, 8/26/14, 9/26/15, 10/31/14, 11/30/14). Based on interview at the time of record review, the Maintenance Director confirmed drills are scheduled for the end of the month and acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p><b>Indiana State Department of Health. Preparation and execution of this response and plan of correction doesnot constitute an admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth in the statement of deficiencies. Theplan of correction is prepared and/or executed solely because it is required bythe provision of federal and state law. K050 Fire drillsare held at unexpected times under varying conditions, at least quarterly oneach shift. The facility failed to ensure 10 of 12 fire drills were conductedunder varying conditions; 10 of 12 fire drills conducted over the past fourquarters were conducted near the end of the month.</b></p> <p><b>Corrective action taken for residents foundto have been affected by the deficient practice:</b> The MaintenanceDirector developed a schedule of fire drills for the next calendar year toensure that all dates vary in accordance with the regulation. <b>Identification of other residents havingthe potential to be affected by the same deficient practice:</b> All residentsin the facility have the potential to be affected. <b>To ensure that proper practices continue:</b> TheMaintenance Director was in-serviced on variance requirements for fire</p>		

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			<p>drills. TheMaintenance Director developed a schedule of fire drills for the next calendaryear to ensure that all dates vary in accordance with the regulation. Thisschedule will be followed each month. TheMaintenance Director/Designee will submit Fire Drills for each month to themonthly QA committee for review to ensure compliance with this plan ofcorrection. After the sixth month, the QAA Committee will review allfire drills and will determine if the facility has achieved at least 90%compliance with practices at which time the monitoring will cease. If the QAACommittee determines that less than 90% compliance has been achieved, themonitoring tools will continue for another 6 month period and will again bereviewed by the QAA Committee. This practice will continue until the facilityhas achieved at least 90% compliance and has ensured the deficient practicewill not recur.</p> <p><b>Quality Assurance Plan to monitorcompliance with this Plan of Correction:</b> Identifiedconcerns shall be reviewed by the facility's QAA Committee. Recommendations forfurther corrective action will be discussed and implemented as needed. <b>CompletionDate:</b> September 17, 2015</p>	