

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227
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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: 02/17/14</p> <p>Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services 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 building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p>	K010000	<p>This Plan of Correction constitutes the center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and the 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. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</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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K010068 SS=D	<p>corridor. The facility has smoke detectors hard wired to the building electrical system in resident sleeping rooms 166 through 178, 180 and 182 and has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 140 and had a census of 119 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake</p>	K010068	K068 What corrective action will take place for those residents found to be affected by the deficient practice? A building	03/18/2014

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	<p>combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 2 staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 02/17/14, the outside air intake behind two natural gas fired dryers was entirely covered with secured drywall which did not provide a fresh air intake for fuel fired equipment. Based on interview at the time of observation, the Director of Maintenance stated the outside air intake was covered because of the extreme cold and acknowledged there was no fresh air intake for fuel fired dryers in the laundry.</p> <p>3.1-19(b)</p>		<p>pressure control-operable; Siemans spring return, modulation damper actuator; actuator mounting bracket and linkage kit; Dwyer Magnehelic building pressure controller and enclosure; control transformer; indoor and outdoor air pressure pick-ups automatic venting system will be installed by March 18, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?We have no other laundry rooms that could be impacted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?The building pressure control-operable; Siemans spring return, modulation damper actuator; actuator mounting bracket and linkage kit; Dwyer Magnehelic building pressure controller and enclosure; control transformer; indoor and outdoor air pressure pick-ups automatic venting system will be added to the monthly preventative maintenance program. How will the corrective actions be monitored to ensure they do not occur again?The administrator or designee will document on a QA tool the automatic venting system is functioning. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are</p>	

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K020000	<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: 02/17/14</p> <p>Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Manorcare Health Services 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 2007 addition was surveyed with Chapter 18, New Health Care Occupancies.</p>	K020000	<p>below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. By what date will the changes occur? 3/18/2014</p> <p>This Plan of Correction constitutes the center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and the 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. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	

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	<p>The 2007 addition to this one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The facility has smoke detectors hard wired to the building electrical system in resident sleeping rooms 166 through 178, 180 and has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 140 and had a census of 119 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached wooden storage sheds which were each not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020052 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 record review, observation, and interview; the facility failed to document annual functional testing of 15 of 77 single station smoke detectors installed in the facility. NFPA 72, 7-3.3 states single station smoke detectors installed in other than one and two family dwelling units shall be tested and maintained in accordance with Chapter 7. Table 7-3.2 requires all single station smoke detectors to be functional tested annually. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect 15 residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013 and 2014" with the Director of Maintenance during record review from 9:25 a.m. to 11:25 a.m. on 02/17/14, documentation of smoke detector testing for resident sleeping rooms 166 through</p>	K020052	<p>K052What corrective action will take place for those residents found to be affected by the deficient practice? The 15 smoke detector in rooms 166 to 178 and 180 and 182 were all checked and found to be in working order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?There are no other wired smoke detector in patient sleeping rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?The hard wired smoke detectors in 166 to 178 and 180 and 182 were added to the existing weekly preventative maintenance program. How will the corrective actions be monitored to ensure they do not occur again?The administrator or designee will verify preventative maintenance program on a QA tool. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95%</p>	03/18/2014			

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K020130 SS=E	<p>178, 180 and 182 was not available for review. In addition, the aforementioned resident sleeping room smoke detectors were not included in SafeCare's 05/28/13 "Annual Test & Inspection" fire alarm system inspection report. Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 02/17/14, smoke detectors installed in resident sleeping rooms 166 through 178, 180 and 182 are hard wired to the facility's electrical system. Each installed smoke detector was identified as a GENTEX Model 7100F. Review of GENTEX Corporation 7000 Series "Installation Instructions-Owner's/User's Information Manual" stated to refer to NFPA 72 for further information regarding the frequency of testing. Based on interview at the time of record review and of the observations, the Director of Maintenance acknowledged documentation of annual functional smoke detector testing for resident sleeping rooms 166 through 178, 180 and 182 was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p>		<p>threshold is achieved. The results will be reviewed by QAA committee weekly. By what date will the changes occur? 3/18/2014</p>	

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	<p>Based on record review, observation, and interview; the facility failed to implement and maintain a preventive maintenance program for smoke detectors installed in 15 of 77 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 15 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013 and 2014" with the Director of Maintenance during record review from 9:25 a.m. to 11:25 a.m. on 02/17/14, smoke detector testing and cleaning documentation for resident sleeping rooms 166 through 178, 180 and 182 was not available for review. In addition, the aforementioned resident sleeping room smoke detectors were not included in SafeCare's 05/28/13 "Annual Test & Inspection" fire alarm system inspection report. Based on observations with the Director of Maintenance during a tour of the facility from 11:25 a.m. to 2:00 p.m. on 02/17/14, smoke detectors installed in resident sleeping rooms 166 through 178, 180 and 182 are hard wired to the</p>	K020130	<p>K130 What corrective action will take place for those residents found to be affected by the deficient practice? The 15 smoke detector in rooms 166 to 178 and 180 and 182 were all checked and found to be in working order. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? There are no other wired smoke detector in patient sleeping rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? The hard wired smoke detectors in 166 to 178 and 180 and 182 were added to the existing weekly preventative maintenance program. How will the corrective actions be monitored to ensure they do not occur again? The administrator or designee will verify preventative maintenance program on a QA tool. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. By what date will the changes occur? 3/18/2014</p>	03/18/2014	

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	<p>facility's electrical system. Each installed smoke detector was identified as a GENTEX Model 7100F and had "test unit monthly" written on the unit. Based on interview at the time of record review and of the observations, the Director of Maintenance stated the aforementioned smoke detectors are not hard wired to the facility's fire alarm system and acknowledged documentation of smoke detector testing and cleaning in resident sleeping rooms 166 through 178, 180 and 182 was not available for review.</p> <p>3.1-19(a)</p>			