

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2015
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NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted 07/22/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/01/15</p> <p>Facility Number: 000545 Provider Number: 15E594 AIM Number: 100267350</p> <p>At this PSR survey, McGivney Health Care Center was found in substantial 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a lower level 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, spaces open to the corridors and hard wired smoke detectors in all resident rooms.</p>	K 0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under 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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K 0025 SS=C Bldg. 01	<p>The facility has a capacity of 37 and had a census of 28 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 except for one detached storage building.</p> <p>Quality Review completed 09/09/15 - DA</p> <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 observations and interview, the facility failed to ensure 1 of 3 smoke compartments was protected with smoke barriers which maintained the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier. This deficient</p>	K 0025	<p>K025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Corrective action for residents affected: The 3M fire block foam was removed from the three-inch diameter opening. Quick Set cement was placed to enclose the opening which was then calked</p>	09/02/2015

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	<p>practice could affect all residents as well as any staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 09/01/15 at 2:00 p.m. with the Maintenance Supervisor, the fire wall had a three inch diameter opening around a four inch diameter sprinkler pipe in the attic on the east side of the wall just south of social services office and was filled with a foam material and its fire rating could not be verified to provide a one half hour fire resistance rating to restrict the lateral movement of smoke.</p> <p>Based on interview on 09/01/15 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned area had openings in the smoke barrier walls which were not sealed with fire caulk or equivalent and the material used could not be verified to provide a fire/smoke resistant barrier.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on ---7/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>with 3M Fire Barrier CP25WB. This product has a four hour fire resistance rating. This was completed on September 2, 2015.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>All residents have the potential to be affected by this alleged deficient practice. All protrusions have adequate smoke barrier protection.</p> <p>Measures to ensure practice does not recur:</p> <p>The weekly maintenance environmental audit form includes observation of all protrusions to ensure adequate smoke barrier protection.</p> <p>This corrective action will be monitored by:</p> <p>The Maintenance Supervisor or designee will monitor that adequate smoke barriers are affixed over any protrusions weekly. Results will be documented and reviewed by the QA committee and action plans developed to improve performance, which may include education, skills validations, performance improvement, and/or disciplinary action. The need for on-going monitoring will be based upon compliance rates.</p> <p>Completion Date September 2, 2015</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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