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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/04/2013 |
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| NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944 |
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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: 11/04/13</p> <p>Facility Number: 000288 Provider Number: 155743 AIM Number: 100287380</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Green-Hill Manor 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. This facility consisting of the original building and a 1999 addition, were all built prior to March 1, 2003. The facility has a fire alarm system with hard wired smoke detection in the</p> | K010000 | Submission of this plan of correction does not constitute an admission to or an agreement with the facts alleged on the survey report. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. | |

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>corridors, in spaces open to the corridors and in resident rooms 33 through 45. All other resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 64 and had a census of 32 at the time of this survey.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/07/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> | | | | |

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| K010025 SS=E | <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>1. Based on observation and interview, the facility failed to ensure an opening in the ceiling smoke barrier in 1 of 6 smoke compartments was sealed to maintain a fire resistance rating of at least 1/2 hour. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC 8.3.2 requires smoke barriers to extend from an outside wall to an outside wall. This deficient practice affects staff, visitors, and 10 or more residents in the north smoke compartment.</p> <p>Findings include: Based on observation with the</p> | K010025 | <p>K025 1. No residents were found to have been affected by the deficient practice2. No residents were found to have been affected by the deficient practice3. The pipe in the janitor room was secured to the ceiling and the bottom sealed where the wires emerge on 11-5-13. 4. Administrator will check to make sure the pipe is secured on her monthly after hours check.. QA will review for 3 months. 5. completed 11-5-13 K-25 Gap around sprinkler pipe in freezer ceiling. Corrective Measure:The gap around the sprinkler pipe in the freezer has been sealed using caulk appropriate to maintain the smoke resistance of the smoke barrier. Completion Date: 11/5/13 Measure to Prevent Reoccurrence:Maintenance Supervisor has been addressed and inspection of gaps/pipes throughout the facility added to</p> | 11/05/2013 | |

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| | <p>maintenance director and administrator on 11/04/13 at 10:25 a.m., there was an unsealed two inch hole in the janitor's closet ceiling for the passage of a bundle of wires threaded through a two inch pipe. The pipe had fallen out of the hole and rested midway between the ceiling and the panel from which the wires were run. The maintenance director agreed at the time of observation, the penetration was ineffectively sealed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure ceiling smoke barrier penetrations in 1 of 6 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors and 2 kitchen staff.</p> | | <p>the Preventative Maintenance rounds to be assessed during weekly audits, with any concerns noted to be corrected upon discovery. How Corrective Action Will be Monitored: Results of weekly audits and any corrective actions taken to be reported to the Administrator, and addressed during the quarterly Quality Assurance Meeting in an effort to maintain ongoing compliance. Completion Date: 11/5/13</p> | | | | |

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| | <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 at 12:00 p.m., the gap around the sprinkler pipe in the freezer ceiling was sealed with expandable foam. The maintenance director said at the time of observation, he did not know expandable foam was not permitted for this use.</p> <p>3.1-19(b)</p> | | | |

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| K010029 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 doors to the kitchen and soiled linen and trash storage room, hazardous areas, latched automatically into their door frames. Doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 10 or more residents in the dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director and administrator on 11/04/13 at 10:45 a.m., the self closing door to the soiled linen and trash storage room did not latch. The door could be pushed open without turning the door knob. The maintenance director said at the time of observation, the door latch had</p> | K010029 | <p>K029 1. No residents were found to have been affected by the deficient practice.2. No residents were found to have been affected by the deficient practice.3. Soiled utility room latch was repaired 11-4-13. Kitchen doors were insured to latch automatically 11-4-13. The Kitchen Staff has been in-serviced on doors being secured4. Weekend Manager report has added a check to make sure the doors are secured. Administrator will monitor daily for two weeks and weekly 1 month. QA will review for 3 months.5. Completed 11-05-13</p> | 11/05/2013 | | | |

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| | <p>been broken "over the weekend" and he had not yet repaired it.</p> <p>b. Based on observation with the maintenance director and administrator on 11/04/13 at 12:40 p.m., one self closing door separating the kitchen from the dining room and one self closing door separating the kitchen from the service corridor failed to latch into their door frames. The doors could be pushed open without turning the door knobs. Upon closer inspection by the maintenance director at the time of observation, it was noted that pieces of cardboard had been inserted into the latch stiles to keep the doors from latching. The administrator said at the time of observation, the practice was not permitted.</p> <p>3.1-19(b)</p> | | | |

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| K010038 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 10 or more residents using the northeast exit from the north and east smoke compartments in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 at 10:40 a.m., the concrete exit discharge surface for the northeast exterior exit was not level. A two inch change in grade and a three fourths inch gap was noted at the meeting edge of the concrete pad just outside the exit door and the first sloped concrete pad of the discharge walkway. The maintenance director acknowledged at the time of observation, the changes in grade were</p> | K010038 | <p>K038 1. No residents were found to have been affected by the deficient practice.2. No residents were found to have been affected by the deficient practice.3. Corrective action taken by changing the grade change from a drop to an incline and by closing the gap.all exterior exits will be monitored on administrator's monthly after hours check and reviewed in QA for 3 months.4. Corrected 11-13-13</p> | 11/13/2013 | | | |

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| K010039 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors was maintained to provide at least a four foot wide clearance to evacuate the facility.</p> <p>This deficient practice affects visitors, staff and 10 or more residents on the east and south halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 at 11:00 a.m., the corridor to the southeast exit was used for the storage of three wheel chairs and a wheelchair scale on both sides of the corridor within 10 feet of the emergency exit door. The arrangement diminished the exit egress width to three feet. The maintenance director acknowledged at the time of observation, the corridor width had not been kept clear for emergency use.</p> <p>3.1-(19)</p> | K010039 | <p>K039 1. No residents were found to have been affected by the deficient practice. Wheelchairs were removed from exit area.2. No residents were found to have been affected by the deficient practice. Wheelchairs were removed from exit area.3. Staff re-educated on objects placed around exit areas.4. Weekend manager will audit on weekend manager report and Administrator will audit daily for two weeks and weekly for one month and QA will review for three months. 5. Corrected 11-5-13.</p> | 11/05/2013 | | | |

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| K010046 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 10 or more residents in the east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 at 10:30 a.m., the battery powered emergency lighting failed to illuminate when tested twice in the corridor near room 34. The maintenance director said at the time of observation, the fixture worked "last month."</p> <p>3.1-19 (b)</p> | K010046 | <p>K046 1. No residents were found to be affected by deficient practice.2. Maintenance Director replaced battery 11-4-13.3. Maintenance Director will increase emergency battery monitoring to weekly.4. Maintenance Director will log monitoring weekly and monitoring will be reviewed in quality assurance meeting. Monitoring will be ongoing.5. Corrected 11-5-13</p> | 11/05/2013 | |

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| K010062 SS=E | <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>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 6 smoke compartments were free of foreign materials such as grime and corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects could affect visitors, staff, and 10 or more residents in the kitchen and southeast smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 between 10:30 a.m. and 1:30 p.m., two sprinkler heads in the activity room, three sprinkler heads in the kitchen, and one sprinkler head in the cooler were covered with a gray fuzzy grime. In addition, two sprinkler heads in the dishwashing area of the kitchen were rusted and turning green, evidence of corrosion. The maintenance director and administrator acknowledged at the time of observations, the sprinkler heads should be in better condition.</p> | K010062 | <p>K062 1. No residents were affected by the deficient practice 2. No residents were affected by the deficient practice Elwood fire was called 11-4-13 and scheduled for 11-20-13 to determine which heads need to be replaced and order new sprinkler heads. Maintenance Director cleaned units appearing to have fuzz or grime. 3. Maintenance Director will add to his weekly building checks to check all sprinkler heads. 4. Maintenance Director's weekly audits will be reviewed in QA. monitoring will be ongoing. 5. Corrected 11-20-13(sprinkler heads ordered for replacement) K-62 Sprinkler head spray pattern obstructed in kitchen storage supply room Corrective Measure:Boxes obstructing sprinkler spray pattern were removed on 11/5/13. Measures to Prevent Reoccurrence: Dietary Staff and Maintenance Supervisor addressed in regard to storage of boxes, etc., in such a manner as to not obstruct sprinkler spray pattern. Visual inspection to ensure storage does not obstruct</p> | 11/20/2013 | | | |

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| | <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 kitchen storage supply room sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects 2 occupants in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 at 11:45 a.m., the storage on shelves in the main kitchen supply storage room was located six inches from the only sprinkler head providing protection for the room. The maintenance director acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstructions.</p> <p>3.1-19(b)</p> | | <p>sprinkler heads added to the Preventative Maintenance rounds to be assessed during weekly audits, with any concerns noted to be corrected upon discovery. How Corrective Action Will be Monitored: Results of weekly audits and any corrective actions taken to be reported to the Administrator, and addressed during the quarterly Quality Assurance Meeting in an effort to maintain ongoing compliance. Completion Date: 11/5/13</p> | | |

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| NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944 | | | |
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| K010144 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure records for monthly load tests for 1 of 1 emergency generators were completed to demonstrate load testing was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> | K010144 | <p>K144 1. No residents were affected by this deficient practice.2. No residents were affected by this deficient practice. The maintenance Director was educated on Weekly and monthly generator tests under load for 30 minutes. 3. Maintenance Director will do weekly and monthly under load tests.4. Maintenance Director will maintain records of test results and QA will review. Monitoring will be ongoing.5. Completed 11-20-13</p> | 11/20/2013 | | | |

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| | <p>NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the Monthly Load Test records of emergency generator tests with the maintenance director and administrator on 11/04/13 at 1:10 p.m., the records for the past year included "load AC amp readings" of zero and "load volt AC Amps and Load Hertz" readings. The records did not include a note of the percent load carried during the test or, in the alternative, a minimum exhaust temperature reading. The maintenance director said at the time of record review, he did not know what the actual load was and didn't know how to calculate it to ensure it was at least the required 30% if there were no exhaust temperature readings to evidence the load testing. He provided a load test record dated 05/10/11. The administrator said at this time, the generator contractor had performed a load test this year and produced an invoice dated 04/14/13 which noted the load test was done but no record of the actual test and results. The</p> | | | | | | |

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| | <p>administrator called the contractor immediately and reported they refused to send test results until the bill for their services was paid. The corporate maintenance director e-mailed directions for calculating the percent load on 11/04/13 at 1:30 p.m., but the maintenance director said the information required by the formula was not consistent with the readings recorded during the load tests and he could not make the calculation.</p> <p>3.1-19(b)</p> | | | | |

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| K010147 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 6 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 10 or more residents, staff, and visitors in the east and west smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 11/04/13 between 10:30 a.m. and 1:20 p.m., a power strip extension cord located under the resident bed was used to supply power to equipment in the room 10. An extension cord ran under the resident bed in room 40 to supply power to the medical grade air mattress in the room. The administrator said at the time of observations, extension cords were not permitted for use in this manner.</p> <p>3.1-19(b)</p> | K010147 | <p>K147 1. No residents were found to have been affected by the deficient practice.2. No residents were found to have been affected by the deficient practice. Maintenance Director will monitor weekly to insure power strips or extension cords are not being used in the facility to power medical devices.3. Maintenance Director will monitor weekly to insure power strips are not being used in the facility to power medical devices. 4. Any negative findings noted during monitoring will be immediately reported to the administrator and removed from use. Negative findings will result in re-education and/or disciplinary action. Monitoring will be reviewed in quality assurance and will be ongoing.5. Completed 11-5-13.</p> | 11/05/2013 | | | |

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