

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2016
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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 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: 05/24/16</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 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		

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 0017 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 98 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 completed on 06/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)</p>			

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	<p>19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p>Based on observation, the facility failed to ensure 1 of 1 East Wing Basement Elevator Equipment room was capable of resisting smoke. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 12:43 p.m., the East Wing Basement Elevator Equipment room was not smoke resistant due to two separate eight by eight inch vents open to the corridor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0017	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 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. K017 Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. The facility failed to ensure 1 of 1 East Wing Basement Elevator Equipment room was capable of resisting smoke. The East Wing Basement Elevator Equipment room was not smoke resistant due to two separate eight by eight inch vents open to the corridor. Corrective action taken: The exhaust system in the east wing basement elevator equipment</p>	06/23/2016	

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			<p>room will be redirected to the exterior of the building in order to eliminate the two eight by eight inch vents open to the corridor.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: This deficient practice could affect staff only. To ensure that this deficient practice will not recur: All other equipment rooms in the facility were checked to ensure that all vents are capable of resisting smoke. The facility Maintenance Director verified that each of these equipment rooms are in compliance with this regulation. The Maintenance Director will continue to monitor for smoke resistance penetrations in all equipment rooms, as well as facility wide, through daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.</p> <p>Completion Date: June 23, 2016 Nursing Care at Hartsfield Village 503 Otis Bowen Drive</p>	

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K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the		Munster, Indiana 46321 LifeSafety Code Survey Dates: May 24, 2016 InformalDispute Resolution (IDR) K017 Scope and Severity: D The East Wing Basement Elevator Equipment room has two eight by eightinch vents open to the corridor. Each of these vents is currently fitted withfire dampers which close upon activation of the fire alarm system. These firedampers were in place at the time of the survey. The basement floor does not contain any patient sleeping or treatmentspaces and has been separated from the 1st floor with 2-hour fireresistance construction, therefore, has been classified as an existing businessoccupancy. The Life Safety Code (LSC), Chapter 39, Sec. 39.3.6, does notspecify any corridor requirements for existing business occupancies. Thefacility respectfully requests that this citation under K017 be removed as thereare no corridor requirements.	

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	<p>passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 Dining Room corridor doors closed and latched into the door frame. This deficient practice could affect staff and up to 15 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 12:18 p.m., the Dining Room contained a set of double doors that latched into one another but neither door latched into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Servery corridor door closed and latched into the</p>	K 0018	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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.</p> <p>K018 Doors protecting corridor openings in other than required enclosures of</p>	06/23/2016

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	<p>door frame. This deficient practice could affect staff and up to 15 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 05/24/16 at 12:17 p.m., the Maintenance Director acknowledged the corridor door to the Servery had a plastic cup lid that was being used as a door stop that prevented the door from closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>vertical openings, exits or hazardous areas are substantial doors; there is no impediment to the closing of the doors; doors shall be provided with a means suitable for keeping the door closed. The facility failed to ensure 1 of 2 dining room corridor doors closed and latched into the door frame. The facility failed to ensure 1 of 1 servery corridor door closed and latched into the door frame.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The identified dining room door was repaired on 5/26/2016. The doors close and latch properly into each other as well as into the door frame.</p> <p>There was a plastic cup lid being used as a door stop that prevented the servery door from closing and latching into the door frame. The plastic cup lid was removed immediately. The servery door closes and latches properly into the door frame.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: Residents using the dining room could potentially be affected.</p> <p>To ensure that proper practices continue: All corridor doors were checked to ensure they close and latch properly</p>		

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			<p>into the door frame.</p> <p>All staff will be in-serviced regarding doors may not be propped open with any object which is an impediment to the doors closing.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% 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 100% compliance and has ensured the deficient practice will not recur.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the</p>	

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K 0021 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Boiler room and 1 of 1 Mechanical room, both hazardous areas, had no impediment to self-closing. This deficient practice was not in a resident care but could affect facility staff.</p>	K 0021	<p>MaintenanceDirector will be discussed at monthly QAA Committee meetings and implemented asneeded.</p> <p>CompletionDate: June 23, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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</p>	06/23/2016

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 12:33 p.m. then again at 12:38 p.m., the Boiler room contained fuel fired appliances. One of the two Boiler room corridor doors was propped open with a metallic object. Then again, the Mechanical room contained fuel fired appliances. One of the two Mechanical room doors was propped open with a battery. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>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.</p> <p>K021 Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a compliant release device. Boiler room, heater room, and mechanical equipment room doors are kept closed. The facility failed to ensure the corridor door to 1 of 1 fuel fired boiler room and 1 of 1 mechanical room had no impediment for self-closing.</p> <p>Corrective action taken: One of the two boiler room corridor doors was propped open with a metallic object. The object was removed immediately. The door is in good working order and has no impediment for self-closing.</p> <p>One of the two mechanical room doors was propped open with a</p>		

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			<p>battery. The object was removed immediately. The door is in good working order and has no impediment for self-closing.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: The deficient practice was not in a resident care area but has the potential to affect staff.</p> <p>To ensure that proper practices continue: All doors to hazardous areas were checked immediately and no impediment to self-closing was identified in any area.</p> <p>All staff will be in-service regarding doors may not be propped open with any object which is an impediment to the doors closing.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all hazardous room 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 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another 4 week period and will again be reviewed by</p>	

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K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5		<p>the QAA Committee. This practice will continue until the facility has achieved 100% compliance and has ensured the deficient practice will not recur.</p> <p>The Maintenance Director will continue to monitor hazardous rooms to ensure there is no impediment to the doors closing through daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.</p> <p>Completion Date: June 23, 2016</p>	

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	<p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 B Hall corridors was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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. This deficient practice could affect staff and at least 14 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 05/24/16 at 11:32 a.m., three separate half inch corridor penetrations across from resident room B103. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>	K 0025	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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.</p> <p>K025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating. The facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier.</p> <p>Corrective action taken: A One half inch by sixteen inch ceiling penetration around the roof drain pipe in therapy was observed.</p>	05/26/2016			

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			<p>This penetration was properly sealed on 6/9/16.</p> <p>The attic access panel was not in place in the 2nd Floor A-Wing Bathroom. The access panel was installed on 5/26/16.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected.</p> <p>To ensure that proper practices continue: The Maintenance Director checked the entire facility and did not note any additional smoke barrier wall penetrations.</p> <p>The Maintenance Director will continue to monitor for smoke barrier wall penetrations through daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2016
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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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K 0039 SS=D Bldg. 01	<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, the facility failed to ensure 1 of 1 Basement exit access corridors had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 12:36 p.m., the basement access corridor had a bed frame and mattresses stored in the corridor. The most restrictive area provided a clear width of thirty two inches. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>	K 0039	<p>implemented asneeded.</p> <p>CompletionDate: June 9, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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 of correction is prepared and/or executed solely because it is required bythe provision of federal and state law.</p> <p>K039 Width of aisles or corridors serving as exit access is at least 4 feet. The facilityfailed to ensure 1 of 1 basement exit access corridors had a clear andunobstructed exit width of</p>	06/23/2016

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			<p>at least 4 feet.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The basement exit access corridor had a bed frame and a mattress stored in the corridor. The basement exit access corridor was cleared immediately and there is an unobstructed exit width of at least 4 feet.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: This deficient practice could affect staff only.</p> <p>To ensure that proper practices continue: All exit access corridors in the facility were checked to ensure there is an unobstructed exit width of at least 4 feet.</p> <p>All staff will be in-serviced regarding nothing is to be stored in an exit access corridor which would obstruct the exit and allow for less than 4 feet unobstructed exit width.</p> <p>The Maintenance Director/Designee will initiate a monitoring tool and conduct random audits 3x/weekly for 4 weeks to ensure that all exit access corridors remain in compliance with this plan of correction. After the fourth week, the QAA Committee will review all audit tools and will</p>	

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			<p>determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% 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 100% compliance and has ensured the deficient practice will not recur.</p> <p>The Maintenance Director will continue to monitor exit access corridors to ensure there is an unobstructed exit width of at least 4 feet through daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.</p> <p>Completion Date: June 23, 2016</p>	

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K 0051 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 22 of 82 resident room, 1 of 2 1st floor C Wing, 1 of 2 Basement hallway smoke detectors was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 69 residents.</p>	K 0051	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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</p>	06/23/2016	

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	<p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/24/16 between 11:38 a.m. and 2:09 p.m., the following smoke detectors were discovered less than 36 inches away from a HVAC vent:</p> <p>a) Inside resident rooms C101-107, D101-D103, E109, E112, E113, D107, D105, A201, A203, A206, A207, D201, D202, D205</p> <p>b) 1 of 2 Outside resident room C101</p> <p>c) 1 of 2 Basement hallway</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>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.</p> <p>K051</p> <p>A fire alarmsystem is installed with systems and components approved for the purpose inaccordance with NFPA 70, National Electric Code and NFPA 72, National FireAlarm Code to provide effective warning of fire in any part of the building.The facility failed to ensure 4 of 82 resident rooms, 1 of 2 1stfloor B Wing, 1 of 1 2nd Floor B Wing Living room smoke detectorswas not installed where air flow would adversely affect the operation.</p> <p>Corrective action taken for residents foundto have been affected by the deficient practice:</p> <p>Thefollowing smoke detectors were discovered less than 36 inches away from a HVACvent:</p> <ul style="list-style-type: none"> ·Inside resident rooms B101-104 ·1 of 2 outside resident room B105 ·1 of 1 2nd floor B Wing Living Room <p>SmokeDetector 1 of 2 outside</p>		

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			<p>resident room B105 has been relocated to greater than 36inches away from the HVAC vent on 6/23/2016 by the Maintenance Manager. Smoke Detector 1 of 1 2nd floor B Wing Living Room has also been locategreater than 36" from the HVAC vent on 6/24/2016 by the MaintenanceManager.</p> <p>A velocity studywas conducted on 6/23/2016 inside resident rooms B101-104. The velocityreadings were collected on all exhaust and returns within 36" of the smokedetector. The velocity readings ranged from -130 to +96 ft/min. ThePhotoelectric Air Velocity Range for the one detector model identified is 0 –2000 ft/min. The Air velocity was found not to affect the functionalityof the smoke detectors. Since there is no harm in keeping the detectorsin place, our proposed plan of action is not to alter the location of the smokedetectors and HVAC vents.</p> <p>TheMaintenance Director conducted facility rounds to ensure all smoke detectorsare at a distance greater than or equal to 36" from a HVAC unit.</p> <p>Identification of other residents havingthe potential to be affected by the same deficient practice: All staffand residents in the facility have the potential to be affected.</p>	

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K 0062 SS=F Bldg. 01	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 1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems	K 0062	To ensure that proper practices continue: The Director of Maintenance will continue to monitor smoke detection systems during daily rounds and routine maintenance of the facility. Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed. Completion Date: June 23, 2016 Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321 This plan of correction represents the center's allegation of compliance. The following combined plan of correction and	05/26/2016	

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	<p>10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/24/16 between 9:19 a.m. and 11:07 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed the sprinkler system is over five years old.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 private</p>		<p>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.</p> <p>K062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25. The facility failed to ensure 1 of 1 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. The facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 1 of 4 calendar quarters. The facility failed to ensure 1 of 1 sprinkler heads in the storage room across from the dining room was maintained.</p>	

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	<p>fire hydrants were 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 occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/24/16 at 1:31 p.m., the "Hydrant Inspection" annual report indicated that "2 1/2" CAP IS SEIZED AND THE HYDRANT DID NOT DRAIN." Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any</p>		<p>Corrective action taken for residents found to have been affected by the deficient practice:</p> <p>An internal inspection of the sprinkler system pipes was most recently conducted on 9/5/2013.</p> <p>The private fire hydrant was inspected by Simplex Grinnell on 5/26/16 and deemed to be unreliable operating condition.</p> <p>There was no first quarter of 2016 sprinkler inspection report available during the annual life safety survey. The sprinkler system components were most recently inspected by Simplex Grinnell on 5/2/16 without deficiency. The sprinkler system remains on contract to be inspected quarterly.</p> <p>The sprinkler head in the storage room across from the dining room was missing one escutcheon. The escutcheon was replaced on 5/26/2016.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice:</p> <p>All residents in the facility have the potential to be affected.</p> <p>To ensure that proper practices continue:</p> <p>Maintenance Staff was in-serviced on fire pump inspection, testing and documentation on 5/26/16.</p>	

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	<p>device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/24/16 between 9:19 a.m. and 11:07 a.m., there was no first quarter of 2016 sprinkler system inspection report available. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the "Storage Room Across from the Dining Room" was</p>		<p>Sprinklersystems are on schedule to receive an internal inspection by a contractedcompany every five years to ensure continued compliance with this regulationand plan of correction. Next inspection is due in 2018.</p> <p>Private firehydrants are on schedule to be inspected and tested by a contracted companytwice annually to ensure they remain in reliable operating condition to ensurecontinued compliance with this plan of correction.</p> <p>Sprinklersystem components are on schedule to be inspected by a contracted companyquarterly to ensure continued compliance with this plan of correction.</p> <p>Allsprinkler heads in the facility were checked by the Maintenance Director toensure they were maintained; none were noted with a missing escutcheon.</p> <p>Quality Assurance Plan to monitorcompliance with this Plan of Correction: AllLife Safety Code identified deficiencies will be reviewed by the facility's QAACommittee. Recommendations for the need for further corrective action asidentified through ongoing daily facility rounds conducted by the MaintenanceDirector will be discussed at monthly QAA</p>				

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	<p>maintained. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations the Maintenance Director on 05/24/16 at 12:13 p.m., the sprinkler head in the "Storage Room Across from the Dining Room" was missing one escutcheon. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon.</p> <p>3.1-19(b)</p>		<p>Committee meetings and implemented asneeded.</p> <p>CompletionDate: May 26, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>LifeSafety Code Survey Dates: May 24, 2016</p> <p>InformalDispute Resolution (IDR)</p> <p>K062 Scope and Severity: F The surveyor stated the following, as written in the CMS-2567: Thefacility failed to ensure 1 of 1 automatic sprinkler piping systems wasinspected every five years as required by NFPA 25. The facility's automatic sprinkler piping system was most recentlyinternally inspected by SimplexGrinnell on 9/5/2013. This satisfies the requirementfor the system to be inspected every five years per NFPA 25. The surveyor didnot request proof of this inspection. The facility has enclosed this inspectionreport for review. The facility respectfully requests that this portion of the citationat K062 be removed.</p>	

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K 0072 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 1 of 1 A Hall stairwell and 1 of 1 B Hall stairwell exit paths. This deficient practice could affect staff and up to 37 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 11:19 a.m. then again at 11:34 a.m., A Hall stairwell bottom landing contained two wet floor signs, a trash can with trash in it, and a bucket of salt. Then again, B Hall stairwell bottom landing contained two large framed paintings and a trash can. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition.</p>	K 0072	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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.</p> <p>K072 Means of egress shall be continuously maintained free of all obstructions or other impediments to full instant use in the case of fire</p>	06/23/2016
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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
	3.1-19(b)		<p>or other emergency. The facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 1 of 1 A hall stairwell and 1 of 1 B hall stairwell exit paths.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: A hall stairwell bottom landing contained two wet floor signs, a trash can with trash in it, and a bucket of salt. The items were removed immediately.</p> <p>B hall stairwell bottom landing contained two large framed paintings and a trash can. The items were removed immediately.</p> <p>All stairwells and means of egress were immediately checked to ensure they were free from all obstructions or other impediments to ensure full instant use in the case of fire or emergency.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents in the facility could potentially be affected.</p> <p>To ensure that proper practices continue: All staff will be in-service regarding stairwells and means of egress shall</p>	

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 05/24/2016
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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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			<p>be continuously maintained free of all obstructions or other impediments to ensure full instantuse in the case of fire or other emergency.</p> <p>TheHousekeeping Director/Designee will initiate a monitoring tool and conductrandom audits 3x/weekly for 4 weeks to ensure that all stairwells and means ofegress remain in compliance with this plan of correction. After the fourthweek, the QAA Committee will review all audit tools and will determine if thefacility has achieved 100% compliance with practices at which time themonitoring will cease. If the QAA Committee determines that less than 100%compliance has been achieved, the monitoring tools will continue for another 4week period and will again be reviewed by the QAA Committee. This practice willcontinue until the facility has achieved 100% compliance and has ensured thedeficient practice will not recur.</p> <p>TheHousekeeping Director will continue to monitor stairwells and means of egress to ensure they remain free from obstruction through daily rounds of thefacility.</p> <p>Quality Assurance Plan to monitorcompliance with this Plan of Correction: AllLife Safety Code identified deficiencies will be reviewed by</p>	

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K 0076 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in the 1st floor nurse's station medication room containing nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice</p>	K 0076	<p>the facility's QAACommittee. Recommendations for the need for further corrective action asidentified through ongoing daily facility rounds conducted by the HousekeepingDirector will be discussed at monthly QAA Committee meetings and implemented asneeded</p> <p>CompletionDate: June 23, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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</p>	06/23/2016	

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	<p>could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 05/24/16 at 11:53 a.m., the 1st floor nurse's station medication room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>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.</p> <p>K076 Medical gasstorage and administration areas hall be protected in accordance with NFPA 99,Standard for Health Care Facilities. The facility failed to ensure 1 of 1cylinders in the 1st floor nurses' station medication roomcontaining nonflammable gases such as oxygen were properly chained or supportedin a proper cylinder stand or cart.</p> <p>Corrective action taken: The oneoxygen cylinder observed in the 1st floor nurses' station medicationroom was removed immediately.</p> <p>All otherareas of the facility were immediately checked; no oxygen is being storedimproperly.</p> <p>Identification of other residents havingthe potential to be affected by the same deficient practice: Allresidents have the potential to be affected.</p> <p>To ensure that proper practices</p>	

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			<p>continue:</p> <p>Nursingstaff (Nurses and CNAs) will be in-serviced on proper storage of oxygen.</p> <p>The Directorof Nursing/Designee will initiate a monitoring tool and conduct random audits3x/weekly for 4 weeks to ensure that oxygen is being stored in accordance withthis plan of correction. After the fourth week, the QAA Committee will reviewall audit tools and will determine if the facility has achieved 100% compliancewith practices at which time the monitoring will cease. If the QAA Committedetermines that less than 100% compliance has been achieved, the monitoringtools will continue for another 4 week period and will again be reviewed by theQAA Committee. This practice will continue until the facility has achieved 100%compliance and has ensured the deficient practice will not recur.</p> <p>The Directorof Nursing will continue to monitor oxygen storage to ensure storage methodsremain in compliance with this plan of correction through daily rounds of thefacility.</p> <p>Quality Assurance Plan to monitor compliancewith this Plan of</p>	

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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include: Based on record review with the Maintenance Director on 05/24/16 at</p>	K 0144	<p>Correction: AllLife Safety Code identified deficiencies will be reviewed by the facility's QAACommittee. Recommendations for the need for further corrective action asidentified through ongoing daily facility rounds conducted by the Director ofNursing will be discussed at monthly QAA Committee meetings and implemented asneeded.</p> <p>CompletionDate: June 23, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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</p>	06/10/2016	

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	<p>10:03 a.m., the monthly testing forms failed to include the transfer time for twelve months of the last twelve months of testing. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p>		<p>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.</p> <p>K144 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. The facility failed to ensure the monthly generator testing form included the transfer time for twelve months of the last twelve months of testing. The facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The generator was tested on 5/24/16 with a 5 minute cool down period after a load test. The maintenance staff were educated on generator operation and maintenance on 5/24/16.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</p> <p>To ensure that proper practices continue: The monthly generator test form was</p>	

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K 0154 SS=C Bldg. 01	<p>Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Director on 05/24/16 at 10:03 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be</p>	K 0154	<p>revised to include clear indication of the following: transfer time, documentation of 5 minute cool down period after a load test.</p> <p>All Maintenance Staff have been in-serviced on completion of the revised monthly generator test form.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for the need for further corrective action as identified through ongoing monitoring by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.</p> <p>Completion Date: June 10, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p>	06/23/2016			

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	<p>followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 98 of 98 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director on 05/24/16 between 9:19 a.m. and 11:07 a.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; contacting the Indiana Department of Health. Based on interview at the time of record review,</p>		<p>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.</p> <p>K154 Where are required automatic sprinkler system is out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction is notified and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. The facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period.</p>		

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	<p>the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>Corrective action taken for residents found to have been affected by the deficient practice: The facility Fire Watch Policy was revised to include the following language: "Any time the fire alarm system or sprinkler system is out of service for more than four hours in a twenty four hour period all authorities having jurisdiction will be contacted including the Indiana State Department of Health, the local Fire Department, and the State Fire Code Official. A fire watch will also be instituted".</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</p> <p>To ensure that proper practices continue: All staff will be in-service regarding the revision to the Fire Watch Policy.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for the need for further corrective action as identified through ongoing monitoring will be discussed at monthly QA Committee meetings and implemented as</p>	

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K 0155 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 98 of 98 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase</p>	K 0155	<p>needed.</p> <p>CompletionDate: June 23, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>This plan of correction represents thecenter's allegation of compliance. The following combined plan of correction andallegation of compliance is not an admission to any of the alleged deficienciesand is submitted at the request of the Indiana State Department of Health.Preparation and execution of this response and plan of correction does notconstitute an admission or agreement by the provider of the truth of the factsalleged or conclusions set forth in the statement of deficiencies. The plan ofcorrection is prepared and/or executed solely because it is required by theprovision of federal and state law.</p>	06/23/2016
			K155	

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	<p>to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy" with the Maintenance Director on 05/24/16 between 9:19 a.m. and 11:07 a.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; contacting the Indiana Department of Health. Based on an interview record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>Where arequired fire alarm system is out of service for more than 4 hours in a 24 hourperiod, the authority having jurisdiction is notified and the building isevacuated or an approved fire watch system is provided for all parties leftunprotected by the shutdown until the fire alarm system has been returned toservice. The facility failed to provide a complete written policy indicatingprocedures to be followed in the event the fire alarm system has to be placedout of service for 4 hours or more in a 24 hour period.</p> <p>Corrective action taken for residents foundto have been affected by the deficient practice: The facilityFire Watch Policy was revised to include the following language: "Any time thefire alarm system or sprinkler system is out of service for more than fourhours in a twenty four hour period all authorities having jurisdiction will becontacted including the Indiana State Department of Health, the local FireDepartment, and the State Fire Code Official. A fire watch will also beinstituted".</p> <p>Identification of other residents havingthe potential to be affected by the same deficient practice: Allresidents have the potential to be affected.</p> <p>To ensure that proper practices</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: 05/24/16</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</p>	K 0000	<p>continue: All staff will be in-serviced regarding the revision to the Fire Watch Policy.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for the need for further corrective action as identified through ongoing monitoring will be discussed at monthly QA Committee meetings and implemented as needed.</p> <p>Completion Date: June 23, 2016</p>	

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K 0025	<p>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 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 98 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 completed on 06/01/16 - DA</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2016
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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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SS=D Bldg. 02	<p>LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 05/24/16 at 11:42 a.m. then again at 2:05 p.m., one half inch by sixteen inch ceiling penetration around the roof drain pipe in</p>	K 0025	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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.</p> <p>K025</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating. The facility failed to ensure the penetrations caused by the passage of wire and/or conduit</p>	06/09/2016

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	<p>Therapy Storage. Then again, the attic access panel was not in place in the 2nd floor A Wing Bathroom. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>through 1 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier.</p> <p>Corrective action taken: A One half inch by sixteen inch ceiling penetration around the roof drain pipe in therapy was observed. This penetration was properly sealed on 6/9/16.</p> <p>The attic access panel was not in place in the 2nd Floor A-Wing Bathroom. The access panel was installed on 5/26/16.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected.</p> <p>To ensure that proper practices continue: The Maintenance Director checked the entire facility and did not note any additional smoke barrier wall penetrations.</p> <p>The Maintenance Director will continue to monitor for smoke barrier wall penetrations through daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified</p>	

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K 0051 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 4 of 82 resident</p>	K 0051	<p>deficiencies will be reviewed by the facility's QAACommittee. Recommendations for the need for further corrective action asidentified through ongoing daily facility rounds conducted by the MaintenanceDirector will be discussed at monthly QAA Committee meetings and implemented asneeded.</p> <p>CompletionDate: June 9, 2016</p> <p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive</p>	06/23/2016	

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	<p>room, 1 of 2 1st floor B Wing, 1 of 1 2nd Floor B Wing Living Room smoke detectors was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 20 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 05/24/16 between 11:38 a.m. and 2:09 p.m., the following smoke detectors were discovered less than 36 inches away from a HVAC vent:</p> <p>a) Inside resident rooms B101-104 b) 1 of 2 Outside resident room B105 c) 1 of 1 2nd floor B Wing Living Room</p> <p>Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>Munster, Indiana 46321</p> <p>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.</p> <p>K051 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. The facility failed to ensure 4 of 82 resident rooms, 1 of 2 1st floor B Wing, 1 of 1 2nd Floor B Wing Living room smoke detectors was not installed where air flow would adversely affect the operation.</p> <p>Corrective action taken for residents found to have been</p>		

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			<p>affected by the deficient practice: The following smoke detectors were discovered less than 36 inches away from a HVAC vent:</p> <ul style="list-style-type: none"> · Inside resident rooms B101-104 · 1 of 2 outside resident room B105 · 1 of 1 2nd floor B Wing Living Room <p>Smoke Detector 1 of 2 outside resident room B105 has been relocated to greater than 36 inches away from the HVAC vent on 6/23/2016 by the Maintenance Manager. Smoke Detector 1 of 1 2nd floor B Wing Living Room has also been located greater than 36" from the HVAC vent on 6/24/2016 by the Maintenance Manager.</p> <p>A velocity study was conducted on 6/23/2016 inside resident rooms B101-104. The velocity readings were collected on all exhaust and returns within 36" of the smoke detector. The velocity readings ranged from -130 to +96 ft/min. The Photoelectric Air Velocity Range for the one detector model identified is 0 – 2000 ft/min. The Air velocity was found not to affect the functionality of the smoke detectors. Since there is no harm in keeping the detectors in place, our proposed plan of action is not to alter the location of the smoke detectors and HVAC vents.</p>	

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K 0144 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised		<p>The Maintenance Director conducted facility rounds to ensure all smoke detectors are at a distance greater than or equal to 36" from a HVAC unit.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All staff and residents in the facility have the potential to be affected.</p> <p>To ensure that proper practices continue: The Director of Maintenance will continue to monitor smoke detection systems during daily rounds and routine maintenance of the facility.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QAA Committee. Recommendations for the need for further corrective action as identified through ongoing daily facility rounds conducted by the Maintenance Director will be discussed at monthly QAA Committee meetings and implemented as needed.</p> <p>Completion Date: June 23, 2016</p>	

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	<p>under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 05/24/16 at 10:03 a.m., the monthly testing forms failed to include the transfer time for twelve months of the last twelve months of testing. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires</p>	K 0144	<p>Nursing Care at Hartsfield Village 503 Otis Bowen Drive Munster, Indiana 46321</p> <p>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.</p> <p>K144 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. The facility failed to ensure the monthly generator testing form included the transfer time for twelve months of the last twelve months of testing. The facility failed to ensure 1 of 1 emergency generators was</p>	06/10/2016

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	<p>generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Director on 05/24/16 at 10:03 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>allowed a 5 minute cool down period after a load test.</p> <p>Corrective action taken for residents found to have been affected by the deficient practice: The generator was tested on 5/24/16 with a 5 minute cool down period after a load test. The maintenance staff were educated on generator operation and maintenance on 5/24/16.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected.</p> <p>To ensure that proper practices continue: The monthly generator test form was revised to include clear indication of the following: transfer time, documentation of 5 minute cool down period after a load test.</p> <p>All Maintenance Staff have been in-serviced on completion of the revised monthly generator test form.</p> <p>Quality Assurance Plan to monitor compliance with this Plan of Correction: All Life Safety Code identified deficiencies will be reviewed by the facility's QA Committee. Recommendations for the need for further corrective action as identified through ongoing</p>		

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			<p>monitoring by the Maintenance Director will bediscussed at monthly QAA Committee meetings and implemented as needed.</p> <p>CompletionDate: June 10, 2016</p>		