STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 01 B. WING	01/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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	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). Survey Date: 01/05/16 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Life Safety Code survey, Manor Care Health Services Summer Trace 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. This two story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in resident rooms. The facility has a capacity of 104 and had a census of 60 at	K 0000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan ofCorrection constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 01/08/16 - DA			
K 0025 SS=E Bldg. 01	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 Based on observations and interview, the facility failed to ensure 2 of 6 smoke compartments on second floor and 1 of 7 smoke walls on first floor were protected with smoke barriers which maintained the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier. This deficient practice could affect all residents as well as any staff and visitors	K 0025	**K025 NFPA 101 Life Safety CodeStandard** Itis the practice of this facility to comply with K025 for smoke barriers to beconstructed to provide at least a one half hour fire resistance rating inaccordance with 8.3. Smoke barriers may terminate at an atrium wall. Windowsare 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	02/04/2016

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	if smoke from a fire were to infiltrate the protective barriers. Findings include: Based on observations on 01/05/16 during the tour between 1:00 p.m. to 3:00 p.m. with the Maintenance Supervisor, the following smoke barriers had unprotected gaps which were not filled with a fire rated material to restrict the lateral movement of smoke from smoke compartment to smoke compartment: a. The second floor north smoke wall had twenty three cables run though the left side of the smoke wall and had a three quarters gap around the cables which were not sealed with fire caulk. b. The second floor east smoke wall had twenty three cables run through the left side of the smoke wall and had a three inch gap around the cables which were not sealed with fire caulk. c. The first floor service hall smoke wall had two cables with a three quarters gap around the cables which were not sealed with fire caulk. Based on interview on 01/05/16 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned areas had openings in the smoke barrier walls which were not sealed with fire caulk to provide a fire/smoke resistant barrier.		arenot required in duct penetrations of smoke barriers in fully ducted heating,ventilating, and air conditioning systems in accordance with 19.3.7.3,19.3.7.5, 19.1.6.3, 19.1.6.4. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Noresidents were affected by this alleged finding as it relates to smoke barriers. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken?** Residentswho reside in this facility have the potential to be affected by this allegedfinding. Red firecaulk was added on 1/21/16 to the second floor north smoke wall that wasidentified during the observation on 1/5/16. Red firecaulk was added on 1/21/16 to the second floor east smoke wall that wasidentified during the observation on 1/5/16. Red firecaulk was added on 1/21/16 to the first floor service hall smoke wall that wasidentified	

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	3.1-19(b)		during the observation on 1/5/16. TheMaintenance Supervisor (MS) has checked smoke barriers in the center for properfire caulk and sealant with no negative findings. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** MSwill be educated on complying with this alleged deficient practice relating to smokebarriers. The MSwill round, utilizing an audit tool, the building each week for two months andmonthly thereafter checking smoke barriers for any unprotected gaps in accordancewith 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4., until substantial compliance isachieved as directed by the Quality Assessment and Assurance Committee (QAA)committee. If theMS fails to comply with expectation of ensuring smoke barriers are protected withat least 1 ½ hour fire resistance rating is provided in accordance with 8.3, hewill be educated and/or progressively disciplined as indicated. **How the corrective action(s)will**	

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			be monitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put in place? Resultsof the monitoring will be reviewed for patterns/trends weekly by the Administrator/Designee. Any non-compliance identified will be addressedwith a Plan of Action to be reviewed weekly by the Administrator/Designee untilcompliance is achieved. QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendations monthly ongoing.	
K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 4 steel	K 0056	**K056 NFPA 101 Life Safety CodeStandard**	02/04/2016

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	armover sprinkler pipes observed was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors. Findings include: Based on observation on 01/05/16 at 2:15 p.m. with the Maintenance Supervisor, the steel sprinkler pipe armover observed exposed above the light fixture in east stairwell first floor was measured to be thirty six inches in length and unsupported. Based on interview on 01/05/16 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported. 3.1-19(b)		Itis the practice of this facility to comply with K056 with automatic sprinklersystems are installed in accordance with NFPA 13, Standard for the Installationof Sprinkler Systems, to provide complete coverage for all portions of thebuilding. The system is properly maintained in accordance with NFPA 25,Standard for the Inspection, Testing, and Maintenance of Water Based FireProtection Systems. It is fully supervised. There is reliable, adequate watersupply for the system. Required sprinkler systems are equipped with water flowand tamper switches, which are electrically connected to the building firealarm system. 19.3.5. **What corrective actions(s) willbe accomplished for those residents found to have been affected by thedeficient practice?** Noresidents were affected by this alleged finding as it relates to automaticsprinkler systems are installed in accordance with NFPA 13, Standard for theInstallation of Sprinkler Systems, to provide complete coverage for allportions of the building. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat**	

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			corrective action(s) will be taken? Residentswho reside in this facility have the potential to be affected by this allegedfinding. The sprinklerpipe identified on 1/5/16 was corrected and properly supported with a newhanger on 1/19/16. The MSchecked the sprinkler pipes in the remaining center to ensure that they wereproperly supported in accordance with NFPA 13, section 6-2.3.4. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** MS willbe educated on compliance NFPA 13, section 6-2.3.4 as it relates to ensuringthat the cumulative horizontal length of an unsupported armover to a sprinkler,sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12inches for copper tube. The MSwill round, utilizing an audit tool, the building each week for two months andmonthly thereafter checking sprinkler pipes for proper support in accordancewith NFPA 13,section	

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			6-2.3.4 until substantial compliance is achieved as directed by the QualityAssessment and Assurance Committee (QAA) committee. If theMS fails to comply with NFPA13, section 6-2.3.4, he will be educated and/orprogressively disciplined as indicated. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put in place?** Resultsof monitoring will be reviewed for patterns/trends weekly for non-compliance bythe Administrator/Designee. Anynon-compliance identified will be addressed with a Plan of Action to bereviewed by the Administrator/Designee until compliance is achieved. QualityAssessment and Assurance Committee will review for ongoing compliance andaccept and/or make recommendations monthly ongoing.	