STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(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: 02/16/16 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Life Safety Code survey, Hanover Nursing Center 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 one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 60 at the time of this visit.	K 0000	Submission of this plan of correction does not constituteadmission or agreement by the provider of the truth of facts alleged orcorrections set forth on the statement of deficiencies. The plan of correctionis prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance.Please find enclosed this plan of correction for this survey. Due to the lowscope and severity of the survey findings, please find the sufficientdocumentation providing evidence of compliance with the plan of correction. Thedocumentation serves to confirm the facility's allegation of compliance thus,the facility respectfully requests the granting of paper compliance. Should additionalinformation be necessary to confirm said compliance, feel free to contact me.	

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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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which were not sprinkled. Quality Review on 02/18/16 by Lex Brashear, LSC Specialist			
K 0029 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 15 Wing 1 hazardous areas, such as a storage room for combustibles over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice does not affect any residents in the unoccupied Wing 1 but could affect staff who use the Wing 1 storage areas	K 0029	K029 requires the facility to ensure corridor doors,hazardous areas, storage room for combustibles over 50 square feet in size was provided with selfclosing devices which would cause the door to automatically close and latchinto the doorframe. 1.The 2 wing 1 storage rooms have been repaired so each door will latch independently into the doorframe with a self closing device.	03/11/2016

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	and office areas. Findings include: Based on observations on 02/16/16 during a tour of Wing 1 from 10:20 a.m. to 11:20 a.m. with the maintenance supervisor, the two Wing 1 storage rooms, which each measured two hundred twenty square feet and stored eight cardboard boxes of paper supplies, Christmas decorations, a plastic container of wooden table legs, four cloth recliner chairs, a couch and eight plastic tables, each lacked a self closing device on the doors. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/16/16 at 1:20 p.m. 3.1-19(b)		2.All residents and staff utilizing the 2 wing storage rooms have the potential to be affected. All storage doors were inspected by the maintenance director to ensure proper latching occurred. 3.The inspection of all corridor doors has been completed and documented per the preventative maintenance schedule and repairs completed as needed. 4.The preventative maintenance log will be reviewed during the quarterly quality assurance meeting with adjustments to the audits made, as warranted. 5.The above corrective measures will be completed by 3-11-16.	
K 0062 SS=E 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 Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected,	K 0062	K062 requires 1 of over 300 sprinklers in the facility covered in paint. 1.SafeCare was contacted to replace the sprinkler head. 2.The staff, residents, and visitors have the potential to be	03/11/2016

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	tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 22 residents who reside on the Wing 3 Hall. Findings include: Based on observation on 02/16/16 at 12:35 p.m. with the maintenance supervisor, the Wing 3 Hall soiled linen room sprinkler head was completely covered in white paint. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/16/16 at 1:20 p.m. 3.1-19(b)		affected. All sprinkler heads were inspected to ensure no further paint was noted. 3.The inspection of all sprinkler heads will be completed and documented per the preventative maintenance schedule and repairs completed as warranted. 4.The preventative maintenance logs will be reviewed during the quarterly quality assurance meetings with adjustments to the audits made as warranted. 5.The above corrective actions will be completed on or before 3-1-16.	
K 0069 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen automatic extinguishing system was electrically connected to the fire alarm signaling system. NFPA 96, 1998 Edition at 7.6.2 requires where a fire	K 0069	K069 requires the facility to ensure kitchen automaticextinguishing system is electronically connected to the fire alarm signalingsystem. 1.The automatic extinguishing system was connectedto the fire alarm signaling system.	03/11/2016

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	alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system. This deficient practice could affect 44 residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 02/16/16 at 12:10 p.m. with the maintenance supervisor, the kitchen automatic extinguishing system at the kitchen stove lacked an electrical connection to the extinguishing container. Based on an interview with the maintenance supervisor on 02/16/16 at 12:15 p.m., the range hood suppression system inspection does not have an electrical connection to the facility fire alarm system when the range hood suppression system is activated. The lack of the kitchen automatic extinguishing system having an electrical connection to the facility fire alarm system and activate when the kitchen automatic extinguishing system is activated was verified by the administrator at the exit conference on 02/16/16 at 1:20 p.m. 3.1-19(b)		2.All residents, staff, and visitors have thepotential to be affected. Safe Care onand before 3-11-16 serviced they system to ensure the kitchen automaticextinguishing system is electronically connected to the fire alarm system. 3.The inspection of the fire of the fire alarmsignaling system ensuring the kitchenautomatic extinguishing system isconnected will be completed and documented per the preventative maintenanceschedule and repairs completed, as warranted. 4.The preventative maintenance log will bereviewed during the quarterly quality assurance meetings with adjustments tothe audits made, as warranted. 5.The above corrective actions will be complete onor before March 11, 2016.	

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K 0074 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. Based on observation and interview, the facility failed to ensure window curtains in 36 of 98 corridor resident rooms or resident common areas were flame retardant. This deficient practice could affect all resident in the facility. Findings include: Based on observations with the maintenance supervisor on 02/16/16	K 0074	K074 requires that the facility to ensure window curtains in corridor, resident rooms or resident common areas is flame resistant. 1.All curtains in the facility have been removed from corridors, resident rooms and resident common areas that do not meet the standard. 2.Any staff, residents, and visitors have the potential to be affected. When window	03/11/2016

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	during a tour of the facility from 10:00 a.m. to 1:00 p.m., resident room 16, resident room 17, resident room 19, resident room 21, resident room 22, resident room 23, resident room 24, resident room 25, resident room 26, resident room 27, resident room 31, resident room 32, resident room 33, resident room 34, resident room 35, resident room 36, resident room 37, resident room 41, resident room 42, resident room 44, resident room 46, resident room 47, resident room 48, resident room 49, resident room 52, resident room 54, resident room 55, resident room 56, resident room 69, resident room 71, the Wing 2 day room, and the director of nursing office had window curtains which lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the maintenance supervisor, there was no documentation regarding flame retardant window curtains throughout the facility. This was acknowledged by the administrator at the exit conference on 02/16/16 at 1:20 p.m. 3.1-19(b)		coverings are applied to any of the resident rooms, corridors, and resident common areas, the window coverings will meet the standard. 3.Upon treatment of the removed curtains, the maintenance supervisor will ensure no untreated curtains are hung in the facility. 4.The preventative maintenance logs will be reviewed during the quarterly quality assurance meetings with adjustments to the audits made as warranted. 5.The above corrective actions will be completed on or before 3-1-16.	