STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING -- B. WING	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/21/24 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Emergency Preparedness survey, Hamilton Grove was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 85 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 54. Quality Review completed on 05/24/24	E 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review in lieu of a post-survey revisit for compliance on or after June 30, 2023.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/21/24 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Life Safety Code survey, Hamilton Grove	K 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carlos Romero	Administrator	06/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	was not found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in corridors, areas open to the corridor, and hardwired smoke detectors in all resident rooms. A 2-hour occupancy barrier separates the assisted living portion and a business occupancy section from the healthcare part of the building. A bathing area and physical therapy for healthcare residents both are located outside of the 2-hour wall located within the business area of the building which was then surveyed as part of healthcare. The facility has a capacity of 85 and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/24/24		correction be considered the letter of credible allegation and request a desk review in lieu of a post-survey revisit for compliance on or after June 30, 2023.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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	Based on observation and interview, the facility failed to maintain latching hardware on 1 of 4 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Lead Maintenance Technician on 05/21/24 between 2:04 p.m. and 3:40 p.m., the set of smoke barrier doors next resident room 1112 was provided with latching hardware but failed to latch when tested approximately three times. Based on interview at the time of observation, the Lead Maintenance Technician agreed the smoke doors were equipped with latching devices, but the doors did not properly latch when tested and would have to be adjusted. The finding was reviewed with the Lead Maintenance Technician and Maintenance Director during the exit conference. 3.1-19(b)	K 0100	It is the practice of Hamilton Grove for all smoke barrier doors to be closed properly. The Life Safety inspection noted that the smoke barrier door by resident room 1112 failed to latch properly. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Maintenance personnel immediately adjust the door so it will latch properly. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate maintenance staff on the importance of ensuring that smoke barrier doors latch appropriately (see attachment # 1) The maintenance Director/Designee will audit (see attachment # 2) on a weekly basis for the next three months the maintenance log form ((see attachment # 3) to verify that the "*Smoke Barriers Doors"* have been checked and latched appropriately. The results will be submitted quarterly to the Quality Assurance Committee until 100% compliance is achieved.	06/14/2024

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 3 of 56 resident room doors. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Lead Maintenance Technician on 05/21/24 between 2:04 p.m. and 3:40 p.m., the corridor doors to resident rooms 1124, 1122, and 1107 all were propped open with trash bins. Based on interview at the time of observation, the Lead Maintenance Technician agreed that the doors were propped open and stated residents usually do that because the doors are heavy enough where they will not stay open by themselves and usually close. This finding was reviewed with the Lead Maintenance Technician and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	It is the practice of Hamilton Grove not to use any objects to prompt doors open. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The trash bins identified in rooms 1124, 1132, and 1107 were immediately removed. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Administrator or its designee will educate the nursing, maintenance, and housekeeping staff on the importance of not using trash bins or any other objects to keep doors open at Hamilton Grove (see attachment #4). The maintenance Director/Designee will conduct rounds in the Healthcare Building 3 times a week for the first 30 days, twice a week for the next 30 days, and once a week for the next 30 days to ensure compliance. The results will be submitted monthly to the Quality Assurance Committee until 100%	06/15/2024

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			compliance is achieved (see attachment #5).	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to 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, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of	K 0372	It is the practice of Hamilton Grove not to have walls uncovered barrier penetrations. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The barrier penetrations have been covered with appropriate materials. (see attachment #6 and attachment #6a) **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;**	06/14/2024

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	restricting the movement of smoke. This deficient practice could affect approximately 12 residents, staff and visitors. Findings include: Based on observation with the Lead Maintenance Technician on 05/21/24 between 2:04 p.m. and 3:40 p.m., above the drop ceiling of the smoke wall leading towards the healthcare entrance and the other wall located next to resident room 1135 both had barrier penetrations. The healthcare entrance barrier had two approximately one-inch penetrations and the other had one approximately half-inch penetration. Based on interview at the time of observation, the Lead Maintenance Technician confirmed that there were barrier penetrations and further stated it was from recent electrical work for a newly installed safety system for residents. The finding was reviewed with the Lead Maintenance Technician and Maintenance Director during the exit conference. 3.1-19(b)		The Director of Maintenance or its designee will educate all the maintenance personnel that uncovered barrier penetrations are not allowed. (see attachment #7).	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with			

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	NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could	K 0918	It is the practice of Hamilton Grove for the generators to have a four-hour run test conducted once every 36 months. The Life Safety inspection noted that Hamilton Grove failed to ensure a four-hour run test during the last 36 months. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	06/14/2024

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	affect approximately all building occupants. Findings include: During record review with the Lead Maintenance Technician on 05/21/24 between 09:45 a.m. and 1:56 p.m., documentation of a four hour run test for the natural gas emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of record review, the Lead Maintenance Technician was unsure when the last exercise was conducted. Later during the survey, the Maintenance Director confirmed that the exercise has not been conducted and will be scheduled later so it is completed. This finding was reviewed with the Lead Maintenance Technician and Maintenance Director at the exit conference. 3.1-19(b)		The maintenance lead person did a four-hour test run on 05/23/2024 (see attachment #8 and attachment #8a) **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate all the maintenance personnel concerning the four-hour generator test. (see attachment #9)	