STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING -- B. WING	01/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/30/24 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Emergency Preparedness survey, Hanover Nursing Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 125 certified beds. At the time of the survey, the census was 61. Quality Review completed on 02/07/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and or the execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stefanie Jenkins	Administrator	02/26/2024

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	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

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	the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

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	per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.			

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	(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID			

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	is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and			

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	maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	It is the practice of the facility to conduct exercises to test the emergency plan annually as outlined in CFR(s): 483.73(d)(2) No residents were negatively affected by the alleged deficient practice. The Maintenance Director added the drills for the activation of the disaster plan. All residents have the potential to be affected by the alleged deficient practice. On 2-2-23 Administrator re-educated the Maintenance Director on the requirements for activation of the disaster plan. The Administrator will analyze the results of the Disaster Plan Activation Drills/Tabletop	03/11/2024

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness plan on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director and Administrator present, the facility was able to provide documentation of an actual event involving a busted sprinkler pipe on 01/17/24, however, the facility was unable to provide documentation of a second exercise conducted during the past 12 month period. Based on interview at the time of record review, the Administrator confirmed there was no documentation of a second exercise conducted during the past 12 month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Exercises to ensure documentation is maintained of those drills, tabletop exercises, and emergency events, and revise the emergency plan, as needed. The findings will be reported to the Monthly QAPI Committee fir a 12 month period and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved of 100%.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation:			

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	(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel			

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	source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013.			

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	155208	A. BUILDING -- B. WING	01/30/2024

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

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	(vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency	E 0041	It is the practice of this facility to implement the emergency power system inspection, testing, and (maintenance) requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. No residents were negatively affected by this alleged deficient prectice. The Monthly Generator Load testing was completed, and an schedule for the monthly load testing created going forward. All residents, staff and visitors have the potential to be affected by this alleged deficient practice. On 2-2-2024 the Administrator re-educated the Maintenance Director on this requirement to include, a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for	03/11/2024

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	and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for January through September of 2023 for the emergency generator. There was monthly generator load test documentation for October through December of 2023, however, there was no percentage of load, transfer time, or amperage readings on the documented reports for those three month, plus, there was no cool down time listed on the December 2023 report. Based on interview at the time of record review, the Maintenance Director said he has only been in his current position as Maintenance Director since September of 2023 and was not able to find any other documentation of monthly load testing prior to October of 2023. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		inspection. The Administrator/designee shall be responsible for auditing the written record of inspection monthly, the frequency of the audit is monthly for 6 months and any issues identified will be addressed and corrected. The findings will be reported to the Monthly QAPI Committee for 6 months and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 52 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly for 52 of the past 52 weeks. Based on interview at the time of record review, the Maintenance Director confirmed there was no weekly inspection/testing documentation available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			

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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: 01/30/24 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 483.90(a), Life Safety from Fire and the 2012 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 and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 61 at the time of this visit. 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 completed on 02/07/24	K 0000	Preparation and or the execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	

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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. Based on observation and interview, the facility failed to ensure 3 of over 5 bathroom/shower room combination ceiling light and heater units were properly maintained. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect over 25 residents, staff, and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the combination ceiling mounted light and heater units in the Huntington's Unit bathroom/shower room (x1) and Wing 4 bathroom/shower room (x2) were showing signs of overheating due to the appearance of the hard plastic vents partially melting/warping and discolored. Based on interview at the time of each observation, the Maintenance Director acknowledged and agreed the light and heater unit vents appeared to have overheated and partially melted. He further said the facility would not use the units until they have been replaced. This finding was reviewed with the Administrator and Maintenance Director during the exit	K 0100	It is the practice of this facility to ensure ceiling lights and heater units are properly maintained. No residents were affected by this alleged deficient practice. On 2-12-24 the ceiling mounted light and heater unit in the bathroom on the Huntington's Disease Unit was replaced . On 2-12-24 the two hard plastic vents were replaced located on Wing 4 bathroom/shower room This alleged deficient practice has the potential to affect over 25 residents, staff, and visitors. The Maintenance Director conducted rounds and replaced other lights, heater units and vents as identified. On 2-2-24 the Administrator re-educated the Maintenance Director on ensuring to identify areas and correct them to minimize the possibility of a fire emergency requiring the evacuation of occupants. All other staff re-educated on identifying areas and reporting those areas to ensure the risk of a fire emergency is minimized by 2-26-24.	03/11/2024

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	conference. 3.1-19(b)		The Maintenace will conduct Fire Safety Rounds in 10 separate areas weekly; including resident rooms, storage areas, offices, common areas and bathrooms; issues identified will be corrected upon discovery. Fire Safety Rounds will be completed weekly for 4 weeks, every other week for 8 weeks and monthly for 8 weeks. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 locked exit doors was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the Huntington's Unit east exit door was magnetically locked and could only be opened by entering a code on a keypad located adjacent to the exit door. Based on interview at the time of observation, when asked, the Maintenance Director did not know the code to release the door from the magnetic lock. He proceeded to ask at least three nursing staff and one housekeeping staff member on the Huntington's Unit if they knew the code to open the door. No staff members knew the code. The exit door did release from the magnetic locking device when the fire alarm system was activated at 4:30 p.m. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	It is the practice of this facility to ensure the means of egress are readily accessible for resident, staff and visitors. No residents were negatively affected by this alleged deficient practice. The code to activate the door release is now posted on the door frame for the exit door to Wing 3 smoking area. The code to activate the door release is now posted on the door frame for the south exit door on Wing 4 corridor. The code to activate the door is now posted on the door frame for the service hall east exit door. The code was reprogrammed for the exit door located on Wing 2 and staff is aware of the code. This alleged deficient practice has the potential to affect at least 20 residents, as well as staff and visitors. On 2-2-24 the Administrator re-educated the Maintenane Director on the egress door CFR(s): NFPA 101, related to ensuring the means of egress are readily accessible for residents,	03/11/2024

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	2. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 11 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect at least 20 residents, staff and visitors needing to exit the facility. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The exit door to the Wing 3 employee smoking area was not posted with the code to actuate the door release. b. The south exit door from the Wing 4 corridor was not posted with the code to actuate the door release. c. The Service Hall east exit door was posted with the incorrect code to actuate the door release. Based on interview at the time of each observation, the Maintenance Director acknowledged the codes either not posted or incorrect codes posted at the previously mentioned exit doors. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		staff and visitors. All other staff will be re-educated by 2-26-24. The Administrator will conduct weekly Egress Door Rounds on all exit doors to ensure the proper postings are on exit doors; unless clinical needs or security threat. The rounds will be conducted weekly or 8 weeks, every other week for 8 weeks and monthly and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 doors to the courtyard could not be mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the north outside door to the courtyard (near the west entrance to the Huntington's Unit) was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Director said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. This finding was reviewed with the Administrator	K 0293	It is the practice of this facility to have exit and directional signs displayed with continuous illumination also served by the emergency lighting system. No residents were negatively affected by this alleged deficient practice. On 2-12-24 an exit sign was installed for the West entrance to the Huntington Disease Unit. This alleged deficient practice has the potential to affect 10 residents, as well as staff and visitors. On 2-12-24 the Maintenance Director conducted rounds on all exits to ensure the exit/directional signs are displayed and in working order; no discrepancies noted. On 2-2-24 Administrator re-educated the Maintenance Director on exit signage regulation to ensure exit/directional signs are displayed with continuous illumination served by the emergency lighting system and all other staff will be re-educated by 2-26-24. The Administrator will	03/11/2024

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	and Maintenance Director during the exit conference. 3.1-19(b)		conduct weekly Exit Signage Rounds on all exit doors to ensure the proper postings are on exit doors; unless clinical needs or security threat. The rounds will be conducted weekly or 8 weeks, every other week for 8 weeks and monthly and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous area doors, such as a storage room door, was provided with a self-closing device. This deficient practice could affect up to 10 residents and staff. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, Room 59 in Wing 4 was being used as a storage room for COVID supplies. The room was over 50 square feet in size and contained at least 30 medium and large cardboard boxes. The corridor door to this room was not provided with a self-closing device. This was confirmed by the Maintenance Director at the time of observation. This finding was reviewed with the Administrator and Maintenance Director during the exit	K 0321	It is the practice of this facility to ensure hazardous area doors are self-closing or automatic-closing. No residents were negatively impacted by this alleged practice. On 2-12-24 items were removed from the room and relocated to a designated storage room equipped with self-closing door. This alleged deficient practice has the potential to affect up to 10 residents and staff. On 2-12-24 Maintenace Director conducted rounds to ensure no other non-authorized storage rooms are storing hazardous supplies. The 2-2-24 the Administrator re-educated the Maintenance Director on the enclosure of hazardous areas and all other staff	03/11/2024

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	01/30/2024

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

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	conference. 3.1-19(b)		re-educated by 2-26-24. The administrator will conduct weekly Enclosure for Hazardous Areas Rounds on all exit doors to ensure the proper postings are on exit doors; unless clinical needs or security threat. The rounds will be conducted weekly or 8 weeks, every other week for 8 weeks and monthly and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101	K 0345	It is the practice of this facility on a semi-annual basis to visually inspect the fire alarm system and	03/11/2024

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	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 02/22/23 by the facility's fire alarm inspection vendor, however, there was no documentation available to show that a semi-annual visual inspection of the facility's fire alarm devices was performed about six months after the annual fire alarm system inspection. Based on interview at the time of record review, the Maintenance Director confirmed there was no semi-annual visual inspection of the facility's fire alarm system devices available to review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		ensure the records of system acceptance, maintenance and testing are readily available. No residents were negatively affected by this alleged deficient practice. The vendor (IEI) was contacted to schedule the semi-annual visual inspection of the fire alarm system This alleged deficient practice has the potential to affect at least 10 residents, as well as staff, and visitors. On 2-2-2024 the Administrator re-educated the Maintenance Director on completing semi-annual inspections of the fire system with the supportive documentation. The Administrator will review the documentation after completion of both inspections conducted annually. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 100%.	

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	2. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect at least 10 residents, as well as staff, and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the ceiling mounted smoke detector in the Wing 4 corridor outside room 56 was hanging from its wires about three inches from the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the smoke detector hanging by its wires from the ceiling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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	01/30/2024

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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Bldg. 01	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 36 of the past 52 weeks for the sprinkler system's pressure gauges, and during 2 of the past 12 months for the sprinkler system's control valves. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its	K 0353	It is the practice of this facility to complete the maintenance and testing of the automatic sprinkler and standpipe systems in accordance with NFPA 25. No residents were negatively affected by this alleged deficient practice. On 2-20-24 the Maintenace Director started inspecting the facility's dry sprinkler system gauges. On 2-20-24 the Maintenace Director started monthly sprinkler system control valves. On 2-20-24 the escutcheon ring in the sprinkler head located in the Service Hall outside the Laundry Room was resecured, no gap around the sprinkler pipe through the ceiling.	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 36 of the past 52 week period. Based on interview at the time of record review, the Maintenance Director confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 36 of the past 52 weeks. Based on observations with the Maintenance Director during a tour of the facility between 2:00 p.m. and 5:45 p.m. the facility had four pressure gauges at the sprinkler riser. b. Based on record review on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no monthly sprinkler system control valves inspection documentation for 2 of the past 12 months (February and March 2023). Based on interview at the time of record review, the Maintenance Director confirmed the lack of sprinkler system inspections on the control valves during two of the past 12 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the		On 2-20-24 the escutcheon ring replaced in the kitchen near the dishwashing area , no gap around the sprinkler pipe On 2-20-24 the 2, 2-to-3-inch holes in the ceiling repaired by the Physical Therapy closet. On 2-20-24 the sprinkler pipe support rods in Wing 4 corridor the gaps were repaired. On 2-20-24 the 3, 3-inch holes in the ceiling were repaired. Contractor scheduled for 2-27-24 to resolve the issues identified in the electrical room. This alleged deficient practice has the potential to affect all residents, staff, and visitors. On 2-2-24 the Administrator reeducated the Maintenance Director on the maintenance and testing of the automatic sprinkler and standpipe systems. The Maintenance Director will conduct weekly Sprinkler System, to include, no gaps around pipe, no holes in ceiling, electrical conduit/wires not resting on sprinkler piping and escutcheon rings are in place, for 8 weeks, every other for 8 weeks and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will	

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	facility failed to ensure the ceiling in 3 of 9 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The escutcheon ring in the sprinkler head in the Service Hall outside the Laundry Room was hanging down at least one inch which created a one half inch gap around the sprinkler pipe through the ceiling. b. The escutcheon ring was missing from the sprinkler head in the kitchen near the dishwashing area which created a one half inch gap around the sprinkler pipe through the ceiling. c. There were two, 2 to 3 inch holes in the ceiling within the Physical Therapy closet where piping from the water softener used to run through the ceiling. d. There were at least eight sprinkler pipe support rods in the Wing 4 corridor between rooms 56 and 72 where the escutcheons from the support rods had slid down which created a 1/4 inch to 1/2 inch gap through the ceiling around each support rod. e. The Electrical Room had three, three inch holes in the ceiling, one around wires, one around a conduit, and one that was just a hole. Based on interview at the time of each observation, the Maintenance Director acknowledged the gaps penetrating the previously mentioned ceiling areas. This finding was reviewed with the Administrator and Maintenance Director during the exit		be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect staff while in the Electrical Room. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, in the Electrical Room there was a two to three inch metal conduit emerging from a large electrical bank. The metal conduit protruded out from the electrical bank about four feet and then turned and ran across the room approximately one foot below the ceiling. There were three electrical wires which emerged from the conduit and ran into a metal box. The metal box was tethered to a sprinkler pipe with two zip ties. Based on interview at the time of the observation, the Maintenance Director acknowledged the metal box with electrical wires tethered to the sprinkler pipe with zip ties and said he had no idea why the conduit, wires, and metal box were protruding from the electrical bank, but would call an electrician to correct the issue. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	3.1-19(b)			
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.			

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 1 of 2 kitchen corridor doors had no impediment to closing. This deficient practice could affect mostly staff in the Service Hall. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the right side door to the kitchen from the Service Hall was held open with a door wedge. Based on interview at the time of observation, the Maintenance Director acknowledged the door wedge holding open the right side kitchen door to the Service Hall. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 71 resident room corridor doors would close completely and latch into its door frame, and 1 of 2 kitchen doors was not provided with a deadbolt lock. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with	K 0363	It is the practice of this facility to ensure corridor doors have no impediment to closing and ensure resident room corridor doors close completely and latch into its door frame. No residents were negative affected by this alleged deficient practice. During the tour the door wedge was immediately removed form the kitchen corridor door. On 2-7-24 the hinges were tightened to the corridor door to resident room 26, door now completely close and latch into the door frame On 2-7-24 a locking knob was installed on the left side kitchen door from the service hall and door closes and latches automatically. This alleged deficient practice has the potential to affect up to 20 residents, staff and visitors. The Maintenance Director will conduct Rounds on Corridor Doors to ensure that there are no impediment to closing and they close completely and latch, and issues will be addressed upon discovery. On 2-2-24 the Administrator re-educated the Maintenance Director on corridor doors to ensure there are no impediment to	03/11/2024

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	01/30/2024

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

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	the Maintenance Director, the following was noted: a. The corridor door to resident room 26 would not easily close completely and latch into the door frame. The door had to be lifted and pulled into its door frame to close completely. The hinges at the top of the door were loose. b. The left side kitchen door from the Service Hall was equipped with a deadbolt lock which did not allow the door to close and latch automatically. Furthermore, the deadbolt lock was loose and could not be properly locked. Based on interview at the time of each observation, the Maintenance Director acknowledged the corridor door to room 26 failed to easily close completely and latch into its door frame and the deadbolt lock on the left side kitchen door. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		closing and they close completely and latch automatically. The Maintenance Director will conduct Corridor Door Audits weekly for 8 weeks, every other week for 8 weeks and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening			

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1. Based on observation and interview, the facility failed to ensure 2 of 11 sets of smoke barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The set of smoke barrier doors at the north end of the Wing 4 corridor would not close completely when tested. There was a one inch gap between the doors when closed fully. b. The south door of the set of smoke barrier doors near the DON office did not close fully when tested. There was a one inch gap between the doors when closed fully. The south door was sticking at the top of the door frame. This was acknowledged by the Maintenance Director at the time of each observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0374	It is the practice of this facility to ensure that all smoke barrier doors close completely to form a smoke resistant barrier and fire rated tags not covered by paint. No residents were negatively affected by the alleged deficient practice. On 2-23-24 the smoke barrier doors were inspected by Regional Maintenance Director and identified new closures needed and ordered the closures. On 2-20-24 the Maintenance Director ensured fire testing tags located on Wing 3 no longer are covered by paint. This alleged deficient practice has the potential to affect 20 residents, as well as staff and visitors. The Maintenance Director and Regional Maintenance Director conducted rounds on all smoke barrier doors close completely to form a smoke resistant barrier and other fire rated tags are not covered by paint, any issues were corrected upon discovery. On 2-2-24 the Administrator re-educated the Maintenace Director on compliance with smoke barrier doors; specifically related to ensuring they close completely to form a smoke resistant barrier and fire rated tags will not be covered by paint. The Maintenance Director will	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2. Based on observation and interview, the facility failed to ensure 2 of 11 sets of smoke barrier doors did not have paint on the fire rating tags to ensure the doors would resist fire for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The south door in the set of smoke barrier doors in the Wing 3 corridor leading to the smoking exit had paint covering the fire rating tag. b. Both doors in the set of smoke barrier doors in the Wing 3 corridor near rooms 43 and 44 had paint covering the fire rating tags. Based on interview at the time of observations, the Maintenance Director acknowledged the paint covering the fire rating tags on the sets of smoke barrier doors. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		complete the Smoke Barrier and Fire Rated Tag audit tool weekly for 8 weeks, every other week for 8 weeks and monthly going forward; any issues identified will be addressed immediately. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	01/30/2024

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	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical wiring was protected in 3 of 9 smoke barriers. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observation on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The Maintenance Office/Shop had a light hanging from the ceiling from its wires. b. The Wing 4 corridor between rooms 56 and 72 had three areas on the ceiling where light fixtures used to be that had wires exposed and hanging down at least six inches. c. Room 105 had a loose receptacle and hung out from the wall about a half inch. The receptacle had tape on it trying to keep it on the wall. d. The Wing 1 Dining Room had a loose receptacle hanging out from the wall about a half inch. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned conditions. This finding was reviewed with the Administrator and Maintenance Director during the exit	K 0511	It is the practice of this facility to ensure electrical wiring is protected and overall compliance with NFPA 70 No residents were negatively affected by the alleged deficient practice. On 2-12-24 the ceiling light in the Maintenance Shop was replaced and not hanging by wires. On 2-12-24 on Wing 4 corridor between rooms 56 and 72 light fixtures installed and no wires exposed or hanging down from the ceiling. On 2-12-24 the loose receptacle in Room 105 was tightened and is flush to the wall. On 2-12-24 the loose receptacle in Wing 1 Dining Room was tightened and is flush to the wall. This alleged deficient practice has the potential to affect at least 20 residents, staff, and visitors. The Maintenance Director conducted rounds of the facility and any identified loose receptacle and/or exposed wires identified were immediately addressed. On 2-2-24 the Administrator reeducated the Maintenance Director on ensuring electrical wiring is protected and in compliance with NFPA 70, National Electric Code. All other staff also will be in-serviced by 2-26-24 on NFPA 70 and	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	conference. 3.1-19(b)		completing work orders if an issue is identified. The Maintenance Director will conduct Receptacle Faceplate and Exposed Wire Audit weekly for 8 weeks, every other week for 8 weeks and monthly for 8 weeks, any issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific	K 0711	It is the practice of this facility to have a written plan for the	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Safety/Disaster Plan" on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, the plan stated under "Duties of Staff Members on Departmental Basis as Follows:" for		protection of all patients and their evacuation in the event of an emergency. No residents were negatively affected by the alleged deficient practice. On 2-20-24 the Disaster plan was updated to include the following; the removal of equipment from the corridor in the event of an emergency and the staff response to the activation of a battery operated smoke alarm within a resident room. This alleged deficient practice has the potential to affect all occupants in the event of an emergency. On 2-2-24 the Administrator re-educated the Maintenance Director on the written plan for the protection of all residents and for their evacuation in the event of an emergency as outlined in NFPA 101. All other staff in serviced on this process by 2-26-26. This process will be monitored by the administrator during monthly drills and if issues are identified re-educated will be completed as indicated. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is	

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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	"Nursing Personnel in Fire Area" at "5. Remove all oxygen carts, medical equipment and clean linen as time permits". This statement does not address the removal of equipment from the corridor in the event of an emergency. Furthermore, the plan does not address staff response to the activation of a battery operated smoke alarm within a resident room. Based on interview at the time of record review, the Maintenance Director acknowledged and agreed that the fire safety plan did not address the previously mentioned items correctly. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		achieved 95% or greater.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility.	K 0712	It is the practice of this facility to conduct and document fire drills, at least quarterly on each shift at unexpected time under varying conditions. No residents were negatively	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	Findings include: Based on review of the facility's fire drill reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters: a. Second shift (evening) of the first quarter (January, February, and March), third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2023. b. Third shift (night) of the first quarter (January, February, and March), second quarter (April, May, and June), third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports and said no other fire drill reports could be located for the missing shifts and quarters of 2023. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		affected by this alleged deficient practice. Fire drills will be completed quarterly on each shift and documented on the Fire Drill Form and will be completed at unexpected times. This alleged deficient practice has the potential to affect all resident, as well as staff and visitors in the facility. On 2-2-24 the Maintenace Director was re-educated on NFPA 101; specifically related to the documentation requirements of fire drills. The Administrator will audit the monthly documentation of all fire drills prior to the end of each month to ensure they are conducted on the correct shift and to ensure staff are familiar with procedures and are aware that drills are part of the established routine. The Fire Drill Document(s) will be kept by the Maintenance Director in the Life Safety Binder. The findings will be reported to the Monthly QAPI Committee for 6 months if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 100%.	

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	155208	A. BUILDING 01 B. WING	01/30/2024

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K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 2 of 2 area where cigarettes were allowed to be smoked by residents and staff. This deficient practice could affect at least 10 residents and staff. Findings include:	K 0741	It is the practice of this facility to follow the smoking regulations as outlines in NFPA 101. No residents were affected by this alleged deficient practice. On 1-30-24 the cigarette butts in the trash can were discarded, the louver cigarette metal ashtray was	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The Wing 3 Employee smoking area had over 100 cigarette butts thrown in the trash can with paper trash, furthermore, the louvered cigarette metal ashtray was missing the louvers making it an open ashtray with over 50 cigarette butts exposed. b. The Huntington's Unit resident smoking patio, within the courtyard, had over 25 cigarette buts in the trash can. Based on interview at the time of each observation, the Maintenance Director acknowledged the cigarette butts mixed with paper trash in the trash cans at both smoking areas. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		replaced with one that does not have missing louvers, located in the smoking area on Wing 3 On 1-30-24 the cigarette butts in the trash can were discarded, located on the Huntington's Unit. All residents, staff and visitors have the potential to be affected by this alleged deficient practice. The Maintenance Director conducted rounds in all approved smoking areas to ensure no cigarettes were improperly disposed and ashtrays were in working order. On 2-2-24 the Administrator re-educated the Maintenance Director on the NFPA 101; related to the Smoking Regulation. All other staff will be re-educated by 2-26-24. During each resident supervised smoke time the designated staff is responsible for monitoring the disposal of cigarettes in the resident's smoking area and ensuring they are not disposed of in the trash can, only the ashtray. Additionally, the designed staff is responsible for reporting if the ashtray is not in working order. The Maintenace Director will conduct rounds 5 days a week for 4 weeks, weekly for 8 weeks, every other week for 8 weeks and monthly going forward as part of the Preventative Maintenance Program. The findings will be reported to the Monthly QAPI Committee for 6	

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	155208	A. BUILDING 01 B. WING	01/30/2024

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			months if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator monthly until resolved and substantial compliance is achieved 95% or greater.	
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	It is the practice of this facility to ensure annual inspection of the oxygen transfilling room fire door assembly. No residents were affected by this alleged deficient practice. All fire door assemblies located within the facility will be inspected, tested, and documented by the facility contractor. This alleged deficient practice had the potential to affect all resident, as well as staff, and visitors. On 2-2-24 the Administrator re-educated the Maintenace Director on K761 and trained on inspecting and testing fire doors. Audit results will be reviewed by the Monthly QAPI Committee for a period of 12 months.	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no			

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	documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Director between 2:00 p.m. and 5:45 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.			

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period. The most recent report available was dated 06/13/22. Based on interview at the time of record review, the Maintenance Director said electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew with a few exceptions from when a receptacle had to be replaced. He further said he could not find documentation to show that annual testing per	K 0914	It is the practice of this facility to ensure complete documentation is available for all nonhospital-grade electrical receptacles in resident room locations are tested at least annually. No residents were negatively affected by this alleged deficient practice. The annual receptacles test will be tested by 2-20-24 and any issues identified will be corrected upon discovery. On 2-2-24 the Administrator re-educated the Maintenance Director on NFPA 101 Electrical Systems Maintenance and Testing specific to annually inspecting nonhospital-grade electrical receptacles in resident room locations and will continue to be monitored in accordance with NFPA standards. Any findings will be reported to the monthly QAPI Committee for further review and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator monthly until resolved and substantial compliance is achieved 95% or greater.	03/11/2024

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	155208	A. BUILDING 01 B. WING	01/30/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period. Based on observations between 2:00 p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director, there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
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 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			

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	155208	A. BUILDING 01 B. WING	01/30/2024

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	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) 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the	K 0918	It is the practice of this facility to maintain a complete written record of monthly generator load testing. No residents were negatively affected by this alleged deficient practice. The Monthly Load Testing is part of the Preventative Maintenance Program. This alleged deficient practice could potentially affect all residents, staff and visitors. On 2-2-24 the Administrator re-educated the Maintenance Director on maintaining a complete written record of monthly load testing for the generator, in accordance with NFPA 110, the Standard for Emergency and Standby Powers System, Chapter 8. and on 2-23-24 the Regional Maintenance Director trained the Maintenace Director how to perform the load testing. The administrator will review the monthly documentation for the monthly generator load testing and the required documentation, such	03/11/2024

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	authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no monthly generator load test documentation available for January through September of 2023 for the emergency generator. There was monthly generator load test documentation for October through December of 2023, however, there was no percentage of load, transfer time, or amperage readings on the documented reports for those three month, plus, there was no cool down time listed on the December 2023 report. Based on interview at the time of record review, the Maintenance Director said he has only been in his current position as Maintenance Director since September of 2023 and was not able to find any other documentation of monthly load testing prior to October of 2023. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 52 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery		as, the percentage of load, transfer time, or amperage readings on the documented reports. The findings will be reported to the Monthly QAPI Committe for 12 months for further review and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator monthly until resolved and substantial compliance is achieved 95% or greater.	

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	voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 01/30/24 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly for 52 of the past 52 weeks. Based on interview at the time of record review, the Maintenance Director confirmed there was no weekly inspection/testing documentation available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips and multi-plug adapters were not used as a substitute for fixed wiring in 4 of 9 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect over 20 resident, staff, and visitors. Findings include: Based on observations on 01/30/24 between 2:00 p.m. and 5:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. Room 47 was using a non-approved power	K 0920	It is the practice of this facility to ensure power strips in patient care vicinity are only used for components of movable patient care related electrical equipment assembles that have been assembled by qualified personnel. No resident was affected by this alleged deficient practice. On 1-30-24 the non-approved power strip was removed from room 47. On 1-30-24 the multi-plug adapter was removed from room 40. On 1-30-24 the multi-plug adapter was removed from the maintenance office. On 1-30-24 the multi-plug adapter was removed from Wing 1 Nurses	03/11/2024

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	strip with several items plugged in including a small refrigerator. b. Room 40 was using a multi-plug adapter plugged into a wall receptacle. c. The Maintenance Office/Shop had a multi-plug adapter plugged into a wall receptacle. d. The Wing 1 Nurses Station was using a multi-plug adapter plugged into a wall receptacle. Based on interview at the time of each observation, the Maintenance Director acknowledged the use of the power strip and multi-plug adapters in the previously mentioned areas. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Station. This alleged deficient practice could potentially affect over 20 residents, staff, and visitors. On 2-2-24 the Administrator re-educated the Maintenance Director on the use of power cords and extension cords outline in NFPA guidelines All other staff will be re-educated by 2-26-24. The Maintenace Director will conduct Power Cords and Extension Cord Audits weekly for 8 weeks, every other week for 8 weeks and monthly for 8 weeks. The audits will include a variety of locations; resident room, storage areas, offices, common areas, bathrooms, nursing station; issues identified will be corrected upon discovery. The findings will be reported to the Monthly QAPI Committe for 12 months for further review and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator monthly until resolved and substantial compliance is achieved 95% or greater.	