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	03/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/20/17 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Life Safety Code survey, Hanover Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 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, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 52 at the time of this visit.	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of corrections prepared and submitted because of requirement under federal and state laws. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the	

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

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which were not sprinkled. Quality Review completed on 03/23/17 - DA		plan of correction. The documentation serves to confirm the facility's allegation of compliance thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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 the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1			

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	Area Automatic Sprinkler Seperation 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 K3220) Based on observations and interview, the facility failed to ensure 1 of 4 hazardous areas such as a fuel fired equipment room was provided with a self-closing device which would cause the doors to automatically close and latch into the door frame or resisted the passage of smoke. This deficient practice affects 34 residents who use the main dining room located adjacent to the kitchen. Findings include: Based on observation on 03/20/17 10:10 a.m. with the administrator and maintenance supervisor, the kitchen used natural gas as a fuel supply for the ovens. Furthermore, the west kitchen door to the Service Hall had a two inch gap where the door self-closed into the door frame and failed to latch on three separate attempts. This was verified by the administrator and maintenance supervisor	K 0321	1. The west kitchen door was adjusted properly where the door self-closed into the door frame and latch properly. 2. All residents have the potential to be affected, but there was no harm, the following corrective actions have been taken: All the kitchen doors have been inspected and found to be in good working order with self close and latch properly. 3. As a means to ensure ongoing	03/27/2017

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	at the time of observation and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)		compliance, the Maintenance Director or designee will review the kitchen doors on a weekly basis as part of the preventative maintenance program compliance (See attachment A). 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. (See Attachment A) 5. Completion Date: March 27, 2017.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			

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	9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents in the facility. Findings include: Based on record review with the administrator and maintenance supervisor on 03/20/17 at 9:35 a.m., the facility provided fire watch documentation in the event the fire alarm system has to be placed out of service, which was labeled Fire Watch Policy & Procedure, indicated the Indiana State Department of Health, the fire department, and the insurance carrier were to be contacted in the event the fire alarm system is out of service but lacked phone numbers for the agencies to be contacted. Furthermore, the fire watch policy lacked a phone call to 911. This was verified by the administrator and maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m.	K 0346	K:346 required facility to notify authority having jurisdiction when fire alarm system is out of service for more than 4 hours in a 24-hour period and approved fire watch shall be provided for all parties let unprotected by the shutdown until the fire alarm system has been returned to service. 1. The Fire Watch Policy & Procedure has been revised to reflect the necessary components. 2. All residents have the potential to be affected but no harm to any resident, thus, Fire Watch Policy & Procedure was reviewed and updated. 3. As a means to ensure ongoing compliance, the Maintenance Director or	03/27/2017

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	3.1-19(b)		designee will in-service all staff periodically specially upon hire and thereafter. 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 27, 2017.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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.			

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	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 monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the administrator and maintenance supervisor on 03/20/17 at 9:45 a.m., the Safecare Report of Inspections of quarterly sprinkler inspections dated 03/15/17, 12/21/16, 09/12/16, 06/22/16 and 03/15/16 indicated the Service Hall sprinkler riser room five sprinkler	K 0353	1. It is the practice of the facility to maintain a sprinkler system which is installed, tested in accordance with NFPA 25. Maintenance Director will perform monthly inspections on the five sprinkler system gauges, two control valves, and the fire department connection 2. Two sprinklers heads covered in yellow paint outside resident room 23 and 24 will be replaced by Safe Care on 4/10/2017 3. The staff, residents, and visitors have the potential to be affected but there was no actual harm. All sprinkler heads were inspected to ensure no further paint was noted. 4. The inspection of all sprinkler heads will	04/10/2017

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	gauges, two sprinkler system control valves and the outside fire department connection were visually inspected during each quarterly inspection. Based on an interview with the maintenance supervisor on 03/20/17 at 9:50 a.m., it was indicated the facility does not perform monthly inspections on the five sprinkler system gauges, two control valves and the fire department connection. They are visually inspected during the quarterly sprinkler inspections. The lack of monthly sprinkler system gauge, control valve, and fire department connection inspections was acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 300 sprinkler heads in the facility covered with paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass		be completed and documented per preventative maintenance schedule. The audits and preventative maintenance logs will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. (See Attachment B) 5. Completion Date: April 10th, 2017	

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	bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 14 resident who reside on Wing 2. Findings include: Based on observation on 03/20/17 at 11:55 a.m. with the administrator and maintenance supervisor, the Wing 2 corridor outside resident room 23 and 24 had two sprinklers covered in yellow paint. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the			

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	sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the administrator and maintenance supervisor on 03/20/17 at 9:35 a.m., the facility provided fire watch documentation in the event the sprinkler system has to be placed out of service, which was labeled Fire Watch Policy & Procedure, indicated the Indiana State Department of Health, the fire department, and the insurance carrier were to be contacted in the event the sprinkler system is out of service but	K 0354	1. The Fire Watch Policy & Procedure has been revised to reflect the necessary components. 2. All residents have the potential to be affected but no harm to any resident; Fire Watch Policy & Procedure was reviewed and updated. 3. As a means to ensure ongoing compliance, the Maintenance Director or designee will in-service all staff periodically specially upon hire and thereafter. 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted	03/27/2017

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	lacked phone numbers for the agencies to be contacted. Furthermore, the fire watch policy lacked a phone call to 911. This was verified by the administrator and maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)		accordingly, if warranted. 5. Completion Date: March 27, 2017	
K 0361 SS=B Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 Wing 1 corridor opening was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke	K 0361	1. The open area in wing 1 was a nurse's station before the Wing 1 Hall residents were moved out and Wing 1 Hall was used for staff only was covered by two wired smoke detector (was already installed). 2. All residents have the potential to be affected but no harm to	03/27/2017

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	detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice affect staff only who have offices in the Wing 1 Hall, which is unoccupied by residents. Findings include: Based on observation with the administrator and maintenance supervisor on 03/20/17 at 11:40 a.m., the Wing 1 corridor had a fourteen foot by sixteen foot open area near the exit door, which was open to the corridor. Based on an interview with the maintenance supervisor at the time of observation, the open area was a nurses' station before the Wing 1 Hall residents were moved out and the Wing 1 Hall was used for staff only. Furthermore, LSC 19.3.6.1(7) was not met because the open area was not protected by an electrically supervised automatic smoke detection system. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)		any resident; the area was covered by smoke detectors. 3. As a means to ensure ongoing compliance, the Maintenance Director or designee will check the smoke detectors once a month as his preventative maintenance routine schedule. 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 27, 2017	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			

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	Based on observation and interview, the facility failed to ensure 1 of 26 Service Hall room corridor doors and 1 of 2 nurses' station medicine room corridor doors would resist the passage of smoke and latch into the door frame. This deficient practice affects 34 residents who use the main dining room located adjacent to the kitchen and 10 residents who reside on Wing 4. Findings include: Based on observations on 03/20/17 during a tour of the facility from 9:35 a.m. to 1:20 p.m. with the administrator and maintenance supervisor, the small dining room corridor door lacked latching hardware and the Station 4 nurses' station medicine room door had a one half inch circular hole above the door knob. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)	K 0363	1. The new door handle and latch was installed on the small dining room corridor lock and the nurse station on wing 4 medicine room door which has half inch circular hole above the door knob was filled with fire caulk. 2. All 34 residents who use the main dining room located adjacent to the kitchen and 10 residents who reside on Wing 4 have potential to be affected but there was no actual harm. 3. The maintenance director or designee will make sure that all doors close and latch properly and there are no more holes on the door during his round and weekly checks as preventative maintenance schedule.	03/27/2017

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 27, 2017	
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 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 Based on observation and interview, the facility failed to ensure 1 of 13 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires	K 0374	1. The service hall set of smoke barrier door, the adjustment was made to the door closer to close and	03/27/2017

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	03/20/2017

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	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 affects 34 residents who use the main dining room located adjacent to the Service Hall. Findings include: Based on observation on 03/20/17 at 12:10 p.m. with the administrator and maintenance supervisor, the Service Hall set of smoke barrier doors had a two inch gap along the center where the doors came together in the closed position. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)		latch the door properly when the doors come together in the closed position. 2. All residents, employees, and visitors have the potential to be affected but there was not actual harm. The adjustment was made to the door closer to close and latch door properly when doors come together in closed position. 3. The maintenance director or designee will make sure that all doors close and latch properly during his round and weekly checks as preventative maintenance schedule. 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted	

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			accordingly, if warranted. 5. Completion Date: March 27, 2017 and on going.	
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 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms 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.	K 0711	1. Facility's Fire Disaster plan will be reviewed and updated with the information including the use of fire alarm system by staff and residents, the transmission of the alarms to the fire department, staff response to alarms including resident room	04/03/2017

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	8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on record review on 03/20/17 at 10:05 a.m. with the administrator and maintenance supervisor, the facility's fire safety plan labeled Fire Disaster Plan lacked the use of the fire alarm system by staff and residents, the transmission of the alarms to the fire department, staff response to alarms including the resident room battery operated smoke detectors, and the fire extinguisher use including the kitchen staff use of the K Class fire extinguisher and staff use of fire extinguishers including the type and location. This was verified by the administrator and maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 03/20/17 at 1:20 p.m. 3.1-19(b)		battery operated smoke detectors, and the fire extinguisher use including the kitchen staff use of K Class fire extinguisher and staff use of fire extinguishers including the type and location. 2. All residents, staff, and visitors have potential to be affected but there was no actual harm. An In-service was provided to all staff about the use of fire alarm system, response to battery operated smoke detectors, and about fire extinguishers and how to operate them. An in-service was also provided to all staff about different kind of fire extinguisher including K Class fire extinguisher. 3. The maintenance director or designee will be responsible to	

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			provide in-service to all staff periodically and upon new hire. 4. The in-service records will be reviewed during the quarterly quality assurance meeting with adjustment to the audits made as needed. 5. The above corrective actions will be completed by 04/03/2017 and on going.	