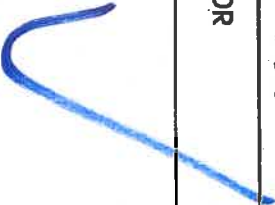


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>3-17-08</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000473</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Wells</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4120
Atlanta, Georgia 30303-8909



Refer to: 5122.LSCFed.Comp.03.13.08

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 13, 2008



Ms. Lisa Laughter, Administrator
Inman Healthcare
51 North Main Street
Inman, SC 29349

MAR 17 2008
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: LSC Imposition Notice
CMS Certification Number: 42-5122

Dear Ms. Laughter:

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act, and be in substantial compliance with each of the requirements for long term care facilities as established by the Secretary of Health and Human Services in 42 CFR section 483.1 et seq., in order to qualify to participate as a skilled nursing facility in the Medicare program and as a nursing facility in the Medicaid program.

On March 6, 2008, a Federal Life Safety Code Standard Comparative Survey was completed at Inman Healthcare, by this office. This survey found that your facility was not in substantial compliance with the participation requirements and that conditions in your facility constituted no actual harm with a potential for minimal harm, however, you will be given an opportunity to correct. A statement of the deficiencies (CMS-2567) is enclosed.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (PoC)

A PoC for the deficiencies must be submitted 10 days after receipt of the Form CMS-2567. Failure to submit an acceptable PoC by March 23, 2008 may result in the imposition of additional remedies after March 23, 2008.

Please submit your PoC to the following address:

Ms. Alfreda Walker, Branch Manager
S&C Review Branch
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Fax: (404) 562-7477

Your PoC must contain the following:

- What corrective action(s) will be accomplished by the facility to correct the deficient practice?
- How you will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken.
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Proposed Remedies

Based on the findings of this survey, if your facility fails to achieve substantial compliance by the revisit, the following remedies will be imposed:

- A civil monetary penalty in the amount of \$50-\$3,000 per day, the date when noncompliance was identified to first exist.

Remedies Imposed

- Denial of Payment for New Admissions (DPNA), effective May 6, 2008.
- Mandatory Termination effective August 6, 2008.

Informal Dispute Resolution

In accordance with 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given this opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why

you are disputing those deficiencies to our office. This request must be submitted during the same 10 days you have for submitting a PoC for the cited deficiencies. Send your request to Alfreda Walker, Branch manager, at the above address.

An incomplete informal dispute resolution process will not delay the effective date of enforcement action. Informal dispute resolution is not to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for informal dispute resolution so that we may also have counsel present. You will be advised orally of our decision concerning the dispute deficiencies. Written confirmation will follow.

Appeal Rights

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Departmental Appeals Board of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in section 498.49, et seq. A written request for a hearing must be filed no later than sixty days from the date of this letter. Such a request should be directed to:

Oliver Potts, Chief
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

Send a copy of your request to this office.

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel and a hearing at your own expense.

If you have any questions regarding this matter, please contact Ms. Sam Fitzhenry at (404) 562-7469. Information can also be faxed to (404) 562-7540.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

cc: State Survey Agency
State Medicaid Agency
Fiscal Intermediary

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2008
NAME OF PROVIDER OR SUPPLIER INMAN HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 51 NORTH MAIN ST INMAN, SC 29349		
(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 000	INITIAL COMMENTS This Comparative Federal Life Safety Code (LSC) Survey was conducted on March 6, 2008. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. This building was partially sprinklered and housed 40 beds. The deficiencies determined during the survey are as follows: K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide hazardous areas of smoke tight construction. The findings included: Approximately at 0920, it was observed that biohazard room was not smoke tight due to ceiling penetrations and air-vent at the door.	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				
TITLE				(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 029	Continued From page 1	K 029			
K 056 SS=D	<p>This was verified with maintenance staff at the time of discovery.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p>	K 056			
K 062 SS=F	<p>This STANDARD is not met as evidenced by:</p> <p>Based upon observation and staff interview it was determined during the survey that the facility failed to provide a complete sprinkler system. The findings included:</p> <p>Approximately at 0910, it was observed that riser room closet located in DON office did not have sprinkler coverage.</p> <p>Approximately at 1130, it was observed that two built-in closets located in resident room 102 did not have sprinkler coverage.</p> <p>These were verified with maintenance staff at the time of discovery.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 062			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	<p>Continued From page 2</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based upon observation and staff interview during the survey, it was determined that the facility failed to provide the sprinkler system continuously maintained in reliable operating condition. The findings included:</p> <ol style="list-style-type: none"> 1. Approximately at 1100, during record review, it was observed that facility did not have a quarterly service/maintenance program for the sprinkler system. This was verified with maintenance staff at the time of discovery. During the interview, maintenance staff indicated that facility was not aware of this requirement until recent state survey and would correct this deficiency very soon. 2. Approximately at 0925, it was observed that sprinkler heads located in resident room 107 were painted. This was verified with maintenance staff at the time of discovery. <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>	K 062			
K 147 SS=D		K 147			

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K 147	Continued From page 3	K 147		
	<p>This STANDARD is not met as evidenced by:</p> <p>Based upon observation and staff interview during the survey, it was determined that the facility failed to provide electrical wiring and equipment is in accordance with NFPA 70 . The findings included:</p> <p>Approximately at 0900, it was observed that surge protector was connected to another surge protector in the administrator's office. It was also observed that an extension cord was in use in resident room 101.</p> <p>These were verified with maintenance staff at the time of discovery.</p>			