

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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K0000	<p>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).</p> <p>Survey Date: 02/13/13</p> <p>Facility Number: 000069 Provider Number: 155148 AIM Number: 100288980</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, North Park Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in</p>	K0000		

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.

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	<p>all resident sleeping rooms. The facility has a capacity of 110 and had a census of 96 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except four detached wood framed sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect 11 residents, as well as staff and visitors in the A Hall, plus any residents in the B Hall while in the Activity room which has a capacity over 30 occupants.</p> <p>Findings include:</p> <p>Based on observations on 2/13/13 between 2:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall above the A Hall smoke barrier doors had a half inch gap through the wall around a four inch sprinkler pipe, furthermore, the smoke barrier wall above the B Hall smoke barrier doors had a half inch gap through the wall around a four inch sprinkler pipe, and a half inch gap</p>	K0025	<p>K 025 It is the practice of this provider to ensure that smoke barrier walls provide at least an on half hour resistance rating. What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <ul style="list-style-type: none"> All gaps in the smoke barrier walls were filled <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> Residents residing in the facility have the potential to be affected by the same alleged practice. The facility maintenance director/designee will perform an audit of the entire facility smoke barrier walls to ensure they provide at least a one half hour fire resistance rating. 	03/15/2013	

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	through the wall around a wire bundle of at least fifteen wires. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)		<ul style="list-style-type: none"> · Any smoke barrier wall found to not provide at least a one half hour fire resistance rating will be filled and corrected. <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The facility maintenance director/designee will perform an audit of the entire facility smoke barrier walls to ensure they provide at least a one half hour fire resistance rating. · Any smoke barrier wall found to not provide at least a one half hour fire resistance rating will be filled and corrected <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>To prevent recurrence the facility Maintenance Director/designee will perform a facility audit quarterly utilizing the Life Safety code audit tool for one year.</p> <p>Results from audits reviewed quarterly during the facility CQI Committee meetings. Committee will determine if other monitoring is necessary.</p> <p>Compliance date: 3/15/13</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to the kitchen, a hazardous area door, was equipped with a positive latch and latched into the door frame. This deficient practice could affect up to 28 residents, as well as staff, and visitors from the E Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/13/13 at 12:30 p.m. during a tour of the facility with the Maintenance Supervisor, the door between the kitchen dishwashing room and the generator exit short corridor was not provided with a positive latch. It was equipped with a deadbolt latch only. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0029	<p>K 029</p> <p>It is the practice of this provider to ensure that hazardous area room doors are equipped with a positive latch and latched into the door frame.</p> <p>What corrective action will be taken for those residents found to have been affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> · The facility Maintenance Director/designee installed a positive latch and latched into the door frame on the cited door to the kitchen. <p>How will you identify other residents having the same potential to be affected by the same alleged deficient practice and corrective action will be taken:</p> <ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the same alleged practice. · The facility Maintenance 	03/15/2013			

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			<p>Director/designee will perform a house wide audit of facility rooms that contain hazardous area to ensure that the doors are equipped with a positive latch and latched into the door frame.</p> <ul style="list-style-type: none"> Any hazardous area door without a positive latch that is latched into the door frame will have a positive latch that is into the door frame installed by the Maintenance Director/designee. <p>What measures will be put into place or what systemic change will you make to ensure that the alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> The facility Maintenance Director/designee will perform a house wide audit of facility rooms that contain hazardous area to ensure that the doors are equipped with a positive latch and latched into the door frame. Any hazardous area door without a positive latch that is latched into the door frame will have a positive latch that is into the door frame installed by the Maintenance Director/designee. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> To prevent recurrence the facility Maintenance Director/designee will perform a 	

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			facility audit of hazardous area doors monthly for 3 months utilizing the Life Safety Code audit tool. Results from audits reviewed quarterly during the facility CQI committee meetings. CQI committee will determine if further monitoring is necessary. Compliance date: 3/15/13	

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K0047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure an exit sign, where the exit or way to reach the exit was not apparent, was provided near 1 of 8 exit doors. LSC 19.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect 28 residents, as well as staff and visitors in the E Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/13/13 at 12:45 p.m. during a tour of the facility with the Maintenance Supervisor, there was no exit sign in the corridor leading to the generator short corridor exit door. When standing at the # 2 Nurses' Station and looking east, the way to the generator exit corridor may not be apparent to occupants. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0047	<p>K 047 It is the practice of this provider to ensure that an exit sign is provided to ensure the way to reach an exit is apparent. What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: · The facility Maintenance Director/designee installed an approved readily visible exit sign at the corridor leading to the generator short corridor exit door. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken: · Residents residing in the facility have the potential to be affected by the same alleged deficient practice. · The facility Maintenance Director/designee will perform a house wide audit to ensure that all exit corridors are marked with approved readily visible exit signs and corrected if any are found to be needed using a life safety CQI tool 1x per month for six months How will the corrective actions be monitored to ensure the deficient practice will not recur:</p>	03/15/2013	

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			<ul style="list-style-type: none"> · The facility Maintenance Director/designee will perform a house wide audit to ensure that all exit corridors are marked with approved readily visible exit signs and corrected if any are found to be needed using a life safety CQI tool 1x per month for six months · Results from audits will be reviewed monthly for six months during the facility monthly CQI committee meeting. CQI committee will determine if further monitoring is necessary. <p>Compliance date: 3/15/13</p>		

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K0050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Code Documentation book on 02/13/13 at 11:00 a.m. with the Maintenance Supervisor present, ten of twelve fire drills performed on all three shifts since February of 2012 were performed during the last four days of each month (28th, 29th, 30th, and 31st). During an interview at the time of record review, the Maintenance Supervisor acknowledged the days of each month the fire drills were performed.</p> <p>3-1.19(b)</p>	K0050	<p>K 050</p> <p>It is the practice of this provider to ensure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> The facility Maintenance Director/designee held a fire drill at an unexpected time under varying conditions. <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> Residents residing in facility have the potential to be affected by the same alleged deficient practice. The facility Maintenance Director and Executive Director held a fire drill at an unexpected time under varying conditions. <p>What measures will be put into</p>	03/15/2013			

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			<p>place or what systemic changes you will make to ensure that the alleged deficient practice does not recur:</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> To prevent recurrence the Facility Executive Director/designee will perform a monthly audit x 6 months of the fire drill being held using a Life Safety Code audit tool Results from audits reviewed monthly during the facility CQI committee meetings. CQI committee will determine if further monitoring is necessary. <p>Compliance date: 3/15/13</p>	

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K0062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect mostly staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/13/13 at 2:40 p.m. during a tour of the facility with the Maintenance Supervisor, the spare sprinkler head cabinet in the facility had eight spare sprinkler heads, but it did not have any sidewall sprinkler heads. The remaining sprinkler heads were a mixture of pendent type sprinkler heads and upright type sprinkler heads. Sidewall sprinkler heads were observed in the walk in cooler and walk in freezer within the kitchen area. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the</p>	K0062	<p>K 062</p> <p>It is the practice of this provider to ensure that storage cabinets are provided with at least two of each type of sprinkler head used in the facility.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> The facility Maintenance Director/designee placed two sidewall sprinkler heads in the spare sprinkler head cabinet to ensure availability for replacement purposes. <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> Residents residing in the facility have the potential to be affected by the same alleged practice. The facility Maintenance Director/designee placed two sidewall sprinkler heads in the spare sprinkler head cabinet to ensure availability for replacement purposes. <p>What measures will be put</p>	03/15/2013
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	Maintenance Supervisor indicated there were no other spare sprinkler heads in the facility. 3-1.19(b)		<p>into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> The facility Maintenance Director/designee placed two sidewall sprinkler heads in the spare sprinkler head cabinet to ensure availability for replacement purposes. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> The facility Maintenance Director/designee will audit the spare sprinkler head cabinet monthly x six months to ensure there are at least two spare sprinkler heads for all sprinkler head types used by the facility including the sidewall sprinkler heads are available for replacement purposes, using the CQI Life Safety Tool. Results from audits reviewed monthly during the facility CQI committee meetings. CQI committee will determine if further monitoring is necessary <p>Compliance date: 3/15/13</p>		

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure power strips and extension cords were not used as a substitute for fixed wiring in 2 of 8 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, 1999 Edition. NFPA 70, Article 400-8 requires, 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 4 residents while in resident rooms 137 and 139, as well as staff while in the Clean Utility room in the F Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/13/13 between 12:00 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor, the F Hall Clean Utility room had a power strip attached to the wall with a small refrigerator and a microwave plugged in, furthermore, resident rooms 137 and 139 in the E Hall both had power strips. At bed 1 in Room 137 there was an air mattress and a breathing machine</p>	K0147	<p>K 147</p> <p>It is the practice of this provider to ensure power strips and extension cords are not used as a substitute for fixed wiring.</p> <p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> · The Maintenance Director/designee will remove all power strips and extension cords in use as a substitute for fixed wiring · The Maintenance Director/designee will install additional power outlets to the rooms cited for having medical equipment plugged into a power strip. <p>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not occur:</p> <ul style="list-style-type: none"> · The Maintenance Director/designee will install additional power outlets to the rooms cited for having medical equipment plugged into a power strip. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> · To prevent recurrence the Facility Maintenance 	03/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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	<p>plugged into a power strip. In Room 139 at bed 2, a power strip was plugged into another power strip. At the time of observations, the Maintenance Supervisor acknowledged the use of the power strips and said he didn't know they were in these rooms.</p> <p>3.1-19(b)</p>		<p>Director/designee will complete a whole house audit of rooms to assure that no power strips or extension cords are in use as a substitute for fixed wiring and will correct any concerns noted using the life safety CQI tool completing audits 1xper month for six months and quarterly thereafter.</p> <p>Results from audits reviewed monthly for six months and quarterly thereafter during the facility CQI committee meetings. CQI committee will determine if further monitoring is necessary.</p> <p>Compliance date: 3/15/13</p>	