

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155746	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/01/2016
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946
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K 0000  Bldg. 01	<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: 09/01/16</p> <p>Facility Number: 000539 Provider Number: 155746 AIM Number: 100267280</p> <p>At this Life Safety Code survey, Parkview Haven 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 facility was located on one wing of a one story building determined to be of Type III (211) construction which was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 42 and had a census of 41 at the time of this survey.</p>	K 0000	<p>The preparation and execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensure of the long term care facility and this Plan of Correction in its entirety, constitutes this providers credible allegation of compliance. Completion dates are provided for procedural purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is of the opinion that it was in compliance with the requirements of participation. We are requesting a desk review to clear any and all proposed or implemented remedies that have</p>	
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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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K 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. The facility has one detached maintenance garage which was not sprinklered.</p> <p>Quality Review completed on 09/07/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 23 resident room corridor doors closed and latched into the door frame. This deficient practice could affect staff and up to 38 residents.</p>	K 0018	<p>been presented to date.</p> <p>- The door stop has been removed from the corridor door to the administrative offices. - All residents Have been identified as having had the potential to be affected. - Maintenance staff have been informed of the prohibition on the use of door</p>	09/12/2016

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	<p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 12:44 p.m. then again at 12:48 p.m., resident room 211 failed to latch into the frame when tested. Then again, resident room 207 failed to latch into the frame when tested. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Administrative office corridor door did not have an impediment to latching. This deficient practice could affect staff and up to 20 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 09/01/16 at 11:55 a.m., the Director of Maintenance acknowledged the corridor door to the Administrative office had a rubber door stop installed that prevented the corridor door from closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>stops on corridor doors. Maintenance will not be permitted to purchase/install door stops. - Maintenance staff, during monthly rounds, will monitor for the inappropriate use of door stops. - Ongoing monthly maintenance rounds will be reviewed at the facility's QAPI meetings.</p>				

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and at least 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 11:56 a.m. then again at 1:25 p.m., a one inch ceiling penetration in the reception area. Then again, a six inch by six inch penetration at the Nurses' station. Based on interview at the time of each observation, the Director of Maintenance acknowledged and provided the measurements for each unsealed penetration.</p>	K 0025	<p>- The two ceiling penetrations identified have been repaired. - All residents have been identified as having had the potential to be affected. - All maintenance staff have been informed of the requirement to repair penetrations, whether resulting from leaks, contractor services, etc., as they occur. - Ceilings will be inspected for penetrations during monthly maintenance rounds. - Monthly maintenance rounds will be reviewed during monthly QAPI meetings. The facility respectfully requests IDR, paper review, for this finding. Our request is to have the scope and severity of the finding reduced. We do not agree that a one inch and a six inch ceiling penetration in a facility of this size constitutes a pattern, or that it results in potential for more than minimal harm. Thank you for your consideration.</p>	09/15/2016			

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K 0029 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 the corridor doors to 1 of 1 fuel fired Kitchen, a hazardous area, would positively latch into the frame. This deficient practice could affect staff and up to 50 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 between 11:45 a.m. and 2:16 p.m., two of the four kitchen doors failed to latch into the frame when tested. Based on interview at the time of each observation, the Director of Maintenance acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>- Latch hardware on the two kitchen doors has been replaced.</p> <p>- All residents have been identified as having had the potential to be affected. - Door latches will be checked for proper operation during monthly maintenance rounds. - Monthly maintenance rounds will be reviewed during the facility QAPI meetings.</p>	09/13/2016			
K 0044	NFPA 101						

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SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 12:49 p.m. then again at 2:10 p.m., the fire doors near resident room 301 failed to latch when tested. Then again, the single Activities fire door failed to latch into the frame. Based on interview at the time of each observation, the Director of Maintenance acknowledged each aforementioned condition and confirmed each set of doors were fire doors.</p>	K 0044	- Repairs have been made to the two sets of fire doors identified, so that they now latch into the frames appropriately. - All residents have been identified as having had the potential to be affected. - Closing/latching of all fire doors will be monitored during monthly maintenance rounds. - Monthly maintenance rounds will be reviewed during the facility's QAPI meetings.	09/08/2016			

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K 0050 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all occupants.</p> <p>Findings include: Based on record review of the "Fire Drill Report" forms with the Director of Maintenance on 09/01/16 at 11:17 a.m., the documentation for a third shift fire drill for the fourth quarter of 2015 was not available for review. Based on interview at the time of record review, the Director of Maintenance acknowledged the lack of documentation.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>- The facility did conduct fire drills quarterly , on each shift, during the last four quarters. However, a time was not recorded on 11/30/15. The facility shall conduct fire drills quarterly on each shift, and ensure the documentation is complete. - No residents were identified has having the potential to be affected. - Fire drill documentation shall be reviewed to ensure complete and accurate information, by the Maintenance Director and the Administrator, prior to filing. - Fire drill documentation shall be reviewed by the facility QAPI committee for one quarter. If no issues are identified, the committee may choose to discontinue reviews. - The facility respectfully requests IDR, paper review. The fourth quarter 2015 3rd shift fire drill was</p>	09/19/2016	

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K 0051 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available.</p> <p>18.3.4, 19.3.4, 9.6</p>		<p>completed, as evidenced by the fire drill form which indicates the drill was conducted by a 3rd shift employee, and signed by other 3rd shift employees who participated in the drill. (see attached) We request this finding be eliminated, or at a minimum that the scope and severity be reduced. We feel strongly that one incomplete report throughout the course of an entire year does not constitute "widespread". Thank you for your consideration.</p>	

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K 0062 SS=F Bldg. 01	<p>Based on observation and interview, the facility failed to ensure 2 of 2 smoke detectors in the Dining room was not installed lower than 12 inches from the ceiling. NFPA 72, 2-3.4.1 requires location and spacing of smoke detectors shall be a result from an evaluation based on guidelines. Specifically (2) Ceiling height. This deficient practice could affect staff and up to 50 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 12:20 p.m., the Dining Room contained two hardwired smoke detectors which were installed on a slanted ceiling at least twenty feet from the highest point. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <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 record review and interview, the facility failed to ensure 1 of 1</p>	K 0051	<p>- Two additional smoke detectors shall be installed, not more than 12 inches from the peek of the slanted ceiling. - All residents who enter the dining room for meals or events have been identified as having the potential to be affected. - New smoke detectors will be inspected during routinely scheduled detector inspections, as required by state and federal regulation. - The next two smoke detector inspection reports shall be reviewed by the facility QAPI committee. If no issues are identified reviews may be discontinued. - The facility respectfully requests IDR, paper review, for this finding. There are currently 4 smoke detectors in the dining room, and a total of 66 smoke detectors in the facility. We feel strongly that two operational smoke detectors placed incorrectly does not constitute a pattern. We request the scope and severity of this TAG be reduced. Thank you for your consideration.</p>	09/29/2016			
		K 0062	<p>- Following the surveyor's exit, the facility's five year sprinkler pipe inspection was located. It was</p>	09/12/2016			

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	<p>automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance on 09/01/16 at 11:45 a.m., no internal pipe inspection was available for review. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition and confirmed the sprinkler system is over five years old.</p> <p>3.1-19(b)</p>		<p>completed on 2/14/12, so will be due again in 2017. (see attached) - Had the pipe inspection not been completed, all residents would be identified as having the potential to be affected. - The next required pipe inspection is being scheduled now for February of 2017. Upon completion, copies of the report will be kept in the Administrator's office, as well as with the Director of Maintenance. - The facility QAPI committee shall review the 2017 inspection report for timely completion and to ensure follow up regarding any recommendations on the report. - The facility respectfully request IDR, paper review for this TAG. Based on the fact that the sprinkler inspection was in fact completed (see attached) as required, we request that this TAG be deleted, or at a minimum that the scope and severity be reduced. We feel strongly, after reviewing the completed pipe inspection, that there is no justification for identifying this issue as "widespread". Thank you for your consideration.</p>		

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K 0068 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry room was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 09/01/16 at 1:28 p.m., the laundry room had fuel fired dryers with no fresh air intake. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0068	- A fresh air intake shall be installed in the laundry room. - No residents have been identified as having the potential to be affected, as the laundry room is in a non patient care area, where only staff are permitted. - Maintenance staff will monitor to ensure that nothing is place/stored in a manner that would obstruct air flow and that no one has tampered with the air intake system. - Maintenance staff will monitor the air intake during monthly preventive maintenance checks of the laundry.	09/30/2016			
K 0070 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p>						

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K 0074 SS=E Bldg. 01	<p>Based on observation and interview, the facility failed to ensure 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 12:31 p.m., a space heater was discovered in the MDS office. Based on interview at the time of observation, the Director of Maintenance was unable to provide documentation to confirm the space heater element did not exceed 212 degrees (100 degrees C).</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p>	K 0070	<p>- The space heater in question has been removed from the facility. - No residents were found to have the potential to be affected, as the space heater was not in use. - Space heaters will not be permitted in the facility, unless documentation is provided to confirm the space heater element does not exceed 212 degrees. - Documentation on space heaters will be reviewed by the Maintenance Director and approval for use of a space heater will be given only by the facility QAPI committee, after review of appropriate documentation. - The facility respectfully requests IDR, paper review. We request the TAG be eliminated, as the space heater was not in use, and therefore posed no risk. At a minimum we request a reduction in the scope and severity of this TAG, as a single space heater not in use, does not constitute a pattern. Thank you for your consideration.</p>	09/01/2016			

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	<p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 resident room 302 and 1 of 1 Beauty Shop curtains was flame retardant. This deficient practice could affect staff and up to 53 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 09/01/16 at 1:05 p.m. then again at 1:47 p.m., there was a window curtain in resident room 302. Then again, there was a window curtain in the Beauty Shop. Based on interview at the time of each observation, the Director of Maintenance acknowledged the aforementioned condition and confirmed there was no documentation was available for review.</p>	K 0074	<p>- The curtains in question shall be treated with a fire retardant product. - All residents have been identified as having had the potential to be affected. - A log will be initiated to record fire retardant treatments. This will also serve as a schedule for repeating the process, per manufacturers recommendations.</p> <p>- The Maintenance Director will review the log monthly and schedule treatments as needed.</p>	09/30/2016

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K 0130 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 3 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p>	K 0130	<p>- The identified penetrations shall be sealed with an approved fire caulk. - All residents have been identified as having had the potential to be affected. - The Maintenance Director shall inspect fire barriers immediately upon completion of any work done by outside contractors. Any newly identified penetrations will be repaired as soon as they are identified. - The Maintenance Director shall complete quarterly checks of fire barrier walls for two quarters. These checks shall be reviewed by the facility QAPI committee. If no issues are identified, checks will be limited to only after outside contractor services are performed. - The facility respectfully requests an IDR, paper review. Given the relatively small penetrations that were identified, we feel that identifying the finding as "widespread is not justified. We request the scope and severity be reduced. Thank you for your consideration.</p>	09/14/2016			

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K 0143 SS=D Bldg. 01	<p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 09/01/16 between 1:57 p.m. and 2:14 p.m., the following fire wall penetrations were discovered:</p> <p>a) a one inch penetration around conduit and a six inch by one inch penetration around conduit above the ceiling tile in the Assisted Living fire barrier.</p> <p>b) a one inch penetration above the ceiling tiles in the Activities fire barrier.</p> <p>c) two separate one inch penetrations around conduit in the fire barrier near resident room 211. Based on interview at the time of each observation, the Director of Maintenance acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one</p>			

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	<p>container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfill storage room where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 1:09 p.m., the oxygen storage/transfer room was provided with a mechanically operated fan/vent but was not working. The fans were checked with a piece of paper. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned</p>	K 0143	- The motor for the exhaust fan in the oxygen storage/transfer room will be replaced. - All residents have been identified as having had the potential to be affected. - The exhaust fan will be added to monthly preventive maintenance checks. - Monthly maintenance checks will be reviewed in the facility QAPI committee meetings for one quarter. If no issues are identified the committee may choose to discontinue reviews.	09/19/2016			

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K 0144 SS=C Bldg. 01	<p>condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 3-4.4.1.1 of 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 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 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. This deficient practice could affect all occupants.</p>	K 0144	- The facility shall maintain a complete record of monthly generator load testing, to include documentation of a minimum 5 minute cool down period. - All residents have been identified as having had the potential to be affected. - The Director of Maintenance and Administrator will review the documentation for each load test upon completion. - Generator load test documentation shall also be reviewed by the facility QAPI committee for 4 weekly tests. If no issues are identified, the committee may choose to discontinue reviews.	09/30/2016			

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	<p>Findings include:</p> <p>Based on record review of the generator log with the Director of Maintenance on 09/01/16 at 11:09 a.m., there was no documentation of a generator load test for the months of September and November 2015. Additionally, January and February of 2016. Based on an interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less)</p>			

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	<p>air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance on 09/01/16 at 11:14 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 19 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon</p>			

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K 0147 SS=D Bldg. 01	<p>discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of generator documentation on 09/01/16 at 11:14 a.m., the Director of Maintenance acknowledged only 19 weekly generator inspections were performed in the last 52 weeks.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1. Based on observation and interview, the facility failed to maintain an electrical box in 1 of 1 TV equipment room and 1 of 1 Medication room. NFPA 70, National Electrical Code 70, 1999</p>	K 0147	- Exposed wiring in the TV equipment room has been corrected. The ceiling fan in the medication room has been removed, wires have been capped and the electrical box has	09/09/2016

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	<p>edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 1:08 p.m. then again at 1:14 p.m., electrical wires were exposed in the TV equipment room on the ceiling. Then again, there was exposed wiring from a ceiling fan in the Medication room. Based on interview at the time of both observations, the Director of Maintenance acknowledged both aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, 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 affects staff only.</p> <p>Findings include:</p>		<p>been covered. The surge protectors identified have been rearranged so that one surge protector is no longer plugged into a second surge protector. - All residents have been identified as having had the potential to be affected. - Monthly maintenance checks will be completed for the 2 identified areas and for the identified surge protectors in the Boiler room. - Monthly maintenance checks shall be reviewed by the facility QAPI committee for 3 months. If no issues are identified the committee may choose to discontinue review.</p>	

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K 0154 SS=C Bldg. 01	<p>Based on observation with the Director of Maintenance on 09/01/16 at 11:53 a.m. then again at 11:59 a.m., a surge protector was powering two separate surge protectors powering the facility's phone system in the Boiler room. Then again, a surge protector was powering another surge protector powering computer components in the Training room. Based on interview at the time of each observation, the Director of Maintenance acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 98 of 98 residents. LSC 9.7.6.2 requires</p>	K 0154	- The facility's plan has been revised to include notification of the local fire department. - All residents have been identified as having had the potential to be affected. - A master copy of the facility Disaster Plan shall be maintained in the Administrator's office as a fail safe in the unlikely event that any copies of the plan were to be misplaced. - The facility QAPI committee shall	09/19/2016

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K 0155	<p>sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Maintenance on 09/01/16 at 1:24 p.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; contacting the local Fire Department. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b) NFPA 101</p>		review and approve the plan on an annual basis.		

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SS=C Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b></p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 114 of 114 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 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all occupants.</p>	K 0155	- The facility's plan has been revised to include notification of the local fire department. - All residents have been identified as having the potential to be affected. - A master copy of the facility Disaster Plan shall be maintained in the Administrator's office as a fail safe in the unlikely event that any copies of the plan were to be misplaced. - The facility QAPI committee shall review and approve the plan on an annual basis.	09/19/2016			

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW HAVEN				STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946			
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K 0211 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Director of Maintenance on 09/01/16 at 1:24 p.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; contacting the local Fire Department. Based on an interview record review, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers shall have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered.</li> </ul> <p>18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol</p>	K 0211	- The identified hand sanitizer dispenser has been removed. -	09/02/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155746		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/01/2016	
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	<p>based hand sanitizers in the Assisted Dining room was not installed above or near an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff and and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/01/16 at 12:25 p.m., an alcohol based hand sanitizer dispenser was mounted on the wall directly above an outlet in the Assisted Dining room. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>16 residents have been identified as having had the potential to be affected. - Maintenance personnel have been advised that they are not permitted to install dispensers above electrical outlets. - Maintenance staff shall monitor the position of dispensers. during monthly maintenance rounds. Monthly maintenance rounds shall be reviewed by the facility QAPI committee. - The facility respectfully request an IDR, paper review. We request that the scope and severity of this finding be reduced. We feel strongly that it is inappropriate to identify this finding as a "Pattern", as there was only one dispenser placed incorrectly out of a total of 12 dispensers in the facility. In addition, the surveyor identified the deficiency as having the potential to affect only 16 residents.</p>				