STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT ST GARY, IN 46404

(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
K010000	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: 01/15/14 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 Surveyor: Bridget Brown, Life Safety Code Specialist At this life Safety Code survey, Timberview Health Care 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. This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the	K010000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	corridors and in spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms while the PCU resident rooms are equipped with hard wired smoke detectors. The facility has the capacity for 174 and had a census of 130 at the time of this survey. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 11 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 47 residents in the South smoke compartment. Findings include: Based on observation with the maintenance director and administrator on 01/15/14 at 2:50 p.m., the door providing access to the South wing pantry failed to latch into the door frame. The maintenance director said after closer inspection of the latch, it had been damaged and needed repair.	K010018	Facility: Timberview HealthcarePOC for: Life Safety SurveyDate: January 31, 2014 The following Plan of Correction has been set in place for the deficiencies indicated on the CMS-2567. K 018 Facility failed to ensure doors protecting corridor openings in a smoke compartment could automatically latch into the door frame….Finding, door providing access to the South wing pantry failed to latch into the door frame. To ensure all corridor doors latch into the door frame, maintenance will make complete audit of doors throughout the building on a monthly basis, a record of the completed door audit will be maintained with a copy being provided to the administrator. Administrator will	02/03/2014

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	3.1-19(b)		monitor maintenance staff monthly to ensure maintenance is scheduled and completed the Door Audit. Corporate Consultant will monitor maintenance on the completion of the Door Audit during the routine visit to the facility. Correction to the pantry door will be completed by 2/3/2014.	
K010025 SS=E	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 Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 2 of 11 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of	K010025	K 025 Facility failed to ensure ceiling and wall smoke barrier penetrations in smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating of the smoke barrier….Findings, fire caulk around wires penetrating the smoke barrier wall above the lay in ceiling near room 131 had fallen out leaving a half inch gap, ceiling penetration by a bundle of wires was unsealed leaving a half inch gap into the attic above, and a one inch gap around conduit	02/03/2014

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	maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and 30 or more residents in north wing smoke compartment. Findings include: a. Based on observation with the maintenance director on 01/15/14 at 1:50 p.m., fire caulk around wires penetrating the smoke barrier wall above the lay in ceiling near room 131 had fallen out leaving a half inch gap. In the same area, a ceiling penetration by a bundle of wires was unsealed leaving a half inch gap into the attic above. The maintenance director acknowledged at the time of observation the openings should have been sealed. b. Based on observation with the maintenance director and administrator on 01/15/14 at 1:30 p.m., a one inch gap around conduit penetrating the commercial cooler wall was sealed with expandable foam. The maintenance director acknowledged at the time of observation this was the wrong material to seal the penetration.		penetrating the commercial cooler wall was sealed with expandable foam. To ensure all fire penetrations have been sealed with the proper fire caulk, maintenance will perform an immediate sweep of the facility and correct all gaps in smoke barrier ceiling and walls. A record of the corrections will be provided to the administrator, along with a copy of the record to be on file. The Corporate Smoke Penetration Form shall be used to ensure all smoke barrier penetrations will be properly sealed by all contractors. Administrator shall monitor maintenance by a walk thru of the building on a semi-annual basis to ensure smoke barrier areas are being properly maintained. Corporate Consultant will make a walk-thru of the building on a quarterly basis to ensure smoke barriers are being maintained. Corrections to seal all openings in smoke barriers will be completed by 2/3/2014.	

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	3.1-19(b)			
K010062 SS=E	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 1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads providing protection in the kitchen food storage supply room were maintained. This deficient practice could affect staff, visitors and 30 or more residents in the south smoke compartment. Findings include: Based on observation with the maintenance director on 01/15/14 at 2:25 p.m., two sprinkler head escutcheons were missing from the sprinkler heads in the dietary food storage room. The maintenance director acknowledged at the time of observation the escutcheons should have been in place. 3.1-19(b)	K010062	K 062 Facility failed to ensure sprinkler heads providing protection in the kitchen food storage supply room were maintained….Findings, two sprinkler heads escutcheons were missing from the sprinkler head in the dietary food storage room. Failed to ensure two sprinkler heads in the laundry washing machine room were free of corrosion. To ensure all sprinkler heads are being properly maintained, maintenance shall make a complete facility inspection on sprinkler heads. A record of the inspection shall be provided to the administrator with a copy kept on file. Administrator will monitor by making a walk-thru of the facility to inspect sprinkler heads for proper maintenance. Corporate Consultant shall inspect sprinkler heads in the building while completing a walk-thru of the building during the routine visit. Corrections to the sprinkler heads indicated during the recent survey will be	02/17/2014

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	2. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the laundry washing machine room were free of corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 30 or more residents in the south wing smoke compartment. Findings include: Based on observation with the maintenance director and administrator on 01/16/14 at 2:40 p.m., two sprinkler heads in the laundry had turned green, usually evidence of corrosion. The maintenance director acknowledged at the time of observation, the sprinkler heads did not have the same color as those provided in the spare sprinkler cabinet. 3.1-19(b)		corrected by 2/17/2014.	
K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10			

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	Based on observation and interview, the facility failed to provide 1 of 26 portable fire extinguishers with a current verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, staff and 30 or more residents in the south wing smoke compartment. Findings include:	K010064	K064 Facility failed to ensure portable fire extinguishers with a current verification of service collar have undergone the required six year maintenance….Findings, The south wing mechanical room near medical records has a portable fire extinguisher with a manufacture date of 1998. To ensure all required fire extinguishers undergo the required testing, maintenance shall perform the Monthly EEAP Audit and schedule the required service and review all paperwork from the servicing company. Maintenance supervisor shall schedule fire extinguisher inspections, review the completed work, provide a copy of the inspection report to the administrator and scan inspection report to the Corporate Office for electronic record in the Environmental Electronic Audit Program folder. Administrator shall monitor performance by inspecting fire extinguishers while performing daily rounds. Corporate Consultant shall make a review of Fire extinguishers during the routine monthly visit. Corrections to fire extinguishers shall be completed by 2/5/2014.	02/05/2014

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	Based on observation with the maintenance director and administrator on 01/15/14 at 2:45 p.m., the south wing mechanical room near medical records had a portable fire extinguisher with a manufacture date of 1998. The verification of service collar was punched to indicate the last six year service was done in 2006. The maintenance director acknowledged at the time of observation, the six year service was overdue. 3.1-19(b)			

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K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure the door providing access to 1 of 1 oxygen supply storage room was self closing. Sprinklered hazardous areas such as the oxygen storage room are required to be equipped with self closing doors. LSC 8.4.1.3 requires doors in barriers required to have a fire resistance rating shall be self closing. This deficient practice affects visitors, staff and 40 residents on the North wing. Findings include: Based on observation with the maintenance director and administrator on 01/15/14 at 1:45 p.m., four large liquid oxygen containers and six oxygen e-cylinders were stored in the oxygen storage supply room accessed from the North wing shower room. The door providing separation had no self closer.	K010076	K 076 Facility failed to ensure the door providing access to oxygen supply storage room was self closing….Findings, four large liquid oxygen containers and six oxygen e-cylinders were stored in the oxygen storage supply room accessed from the north wing shower room. The door providing separation had no self closer. To ensure all oxygen storage supply room doors close properly, maintenance shall make an immediate inspection of all oxygen storage supply rooms to ensure the room door have a self closure installed. Maintenance shall complete the require EEAP Monthly Audit, administrator monitor maintenance on maintaining the oxygen storage supply rooms while completing daily rounds, and Corporate Consultant shall make a review of the oxygen storage supply rooms during the routine visit. Correction to the oxygen storage supply door shall be completed by 2/3/2014.	02/03/2014

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	The maintenance director acknowledged at the time of observation, the door did not self close. 3.1-19(b)			
K010144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure documentation of monthly generator tests for 1 of 1 diesel powered emergency generators was completed to reflect the transfer of load using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the	K010144	K 144 Facility failed to ensure documentation of monthly generator tests for diesel powered emergency generators was completed to reflect the transfer of load….Findings, review of the Emergency Generator preventive maintenance records and contractor Load Bank Testing and inspection records with the maintenance director and administrator reflects a monthly load of 20 percent, last recorded load bank test was dated 5/17/2013. To ensure the required Load Bank Testing is being performed, maintenance supervisor shall complete the	02/03/2014

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	emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. Diesel powered installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPS load and exercised annually with supplemental loads at 25 percent of the nameplate rating for 30 minutes, followed by 50 percent of the nameplate rating for 30 minutes, followed by 75 percent of the nameplate rating, for 60 minutes, for a total of two continuous hours. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising periods and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect 60 or more residents, staff		require Monthly Load Testing Audit on the EEAP System and ensure the Annual Load Bank Testing is being scheduled and performed, once completed the testing report shall be scanned to the Corporate Office to be entered into the facility Generator file in the EEAP System. Administrator shall monitor maintenance by reviewing the Monthly EEAP System and scheduled Load Bank Testing. Corporate Consultant shall make a review of Maintenance EEAP Audit records during the routine visits. Load Bank testing for the Emergency Generator shall be scheduled and performed by 5/17/2014, unless severe weather prohibits such testing.	

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	and visitors on the north and south wings. Findings include: Based on review of the Emergency Generator preventive maintenance records and contractor Load Bank Testing and inspection records with the maintenance director and administrator on 01/15/14 at 4:15 p.m., the diesel generator serving the north and south wings had test documentation for weekly generator runs and monthly generator load tests which reflected a monthly load of 20 percent. The maintenance director said at the time of record review, an annual load bank test was done, however, the last recorded load bank test was dated 05/12/12. The maintenance director acknowledged the test was outdated and attempted to get a more current record from the testing contractor. No record was received by 01/15/14 at 5:55 p.m. when the record review was concluded. 3.1-19(b)			

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K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 30 or more residents in the main dining room smoke compartment. Findings include: Based on observation with the maintenance director on 01/15/14 at 2:35 p.m., two junction boxes above the lay in ceiling near the dining room were left uncovered with multiple wires exposed. The maintenance director acknowledged at the time of observation, the boxes should have had covers secured over the exposed wires.	K010147	K147 Facility failed to ensure electrical wiring connections were maintained in a safe operating condition which included junction boxes….Findings, two junction boxes above the lay in ceiling near the dining room were left uncovered with multiple wires exposed. Also, flexible cords were used as a substitute for fixed wiring. To ensure all junction boxes have the appropriate covers installed maintenance shall make an inspection of the entire facility and to ensure power strip extension cords are not being used in the facility maintenance shall make an inspection of the facility to remove all flexible cords and power strips. Administrator shall monitor maintenance to ensure the work has been completed in a timely matter. Administrator shall monitor maintenance's attention to prevent the use of power strips in the facility while making the routine daily rounds. Corporate Consultant shall make an inspection review of the facility during the routine	02/03/2014

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NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, 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 or more staff and visitors in the kitchen. Findings include: Based on observation with the maintenance director and administrator on 01/15/14 at 2:15 p.m., two power strip extension cords were piggybacked to supply power to computers and office equipment in the dietary manager's office located in the kitchen. The maintenance director acknowledged at the time of observation, power strips should not have been arranged in this manner. 3.1-19(b)		visits. Corrections for the junction boxes shall be completed by 2/3/2014 Correction to remove power strips shall be completed by 2/3/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/15/2014

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