

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  07/06/2015
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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: 07/06/15</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 37 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 truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the 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 licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding 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 under the opinion it was in the requirements of participation or that the corrective action was necessaryWe are</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 0011 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>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to nonconforming buildings was protected by a two hour fire wall. This deficient practice could affect all residents, staff and visitors in the center smoke compartment where the nurses' station is located.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Person #1 on 07/06/15 at 2:20 p.m., above the ceiling tile at the fire wall entering health care there were three separate communication wires penetrating the fire barrier wall. At the time of observation, Maintenance Person</p>	K 0011	<p>requesting a desk review to clear any and all proposed or implemented remedies that have been presented to date</p> <p>Maintenance inspected the wall to make sure there were noother existing areas of penetration to break the barrier of the fire wall allareas identified were immediately sealed.</p> <p>System change :Maintenance will observe the fire wall on amonthly basis to check that no other areas of penetration exist to break thebarrier of the fire wall.</p> <p>Monitoring: TheAdministrator confirmed that the penetrations were sealed. All fire wall inspections by maintenance doneper the monthly maintenance schedule will be reviewed at the monthly QualityAssurance meeting and any issues will be corrected immediately. The QA committee will determine the need forfurther</p>	07/06/2015

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K 0018 SS=E Bldg. 01	<p>#1 acknowledged the one eight inch of annular space surrounding each wire was not firestopped.</p> <p>3.1-19(b)</p> <p>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 1¼ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 8 resident room corridor doors in the North hall closed and latched into the door frame. This deficient practice could affect any of the 15 residents on the North hall.</p>	K 0018	<p>monitoring.</p> <p>Rounds were done immediately by maintenance to check for any other doors that did not latch into door frames.</p> <p>The corridor door entering room 204 was adjusted and tested and now latches into the door frame as well as all other doors identified as not</p>	07/06/2015

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K 0025 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation and interview on 07/06/15 at 1:55 p.m., Maintenance Person #1 confirmed the corridor door entering resident room 204 failed to latch into the door frame.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall</p>	K 0025	<p>latching were adjusted and tested and now latch into the door frame System change :Maintenance will do rounds on all nursingdoors to assure they latch into the door frame on a weekly basis x 4weeks if all doors latch then the audit will be done on a monthly basis x 4months Monitoring: Theadministrator confirmed that room 204 corridor now latches into the doorframe as well as all other doors identified as not latching were adjusted and tested and now latch into the door frame. All audits of the corridor doorslatching will be reviewed at the monthly QA meeting and any issues will becorrected immediately. The QA committeewill determine the need for further monitoring.</p> <p>Maintenance inspected the wall to make sure there were noother existing areas of penetration to break the barrier of the fire wall, no other penetrations existed Maintenance did rounds to check</p>	08/03/2015	

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	<p>be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>a. Based on an observation with Maintenance Person #1 on 07/06/15 at 1:57 p.m., there was a one half inch unsealed penetrations around Internet cables in the ceiling of the Housekeeping storage room near the ambulance entrance. At the time of observation, Maintenance Person #1 acknowledged the ceiling penetration and provided the measurement.</p> <p>b. Based on an observation and interview on 07/06/15 at 1:19 p.m., Maintenance Person #1 acknowledged the escutcheon was missing sprinkler head in the bed #1 closet of resident room 215 exposing the attic above to the resident room below.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires</p>		<p>for any other missing escutcheon to sprinkler heads The area was immediately sealed. Breenco was contacted and ordered the missing escutcheon for the sprinkler head in room 215 and have ordered the part and will be on site to install it on 8-3-15 System change: Maintenance will observe the fire wall on amonthly basis to check that no other areas of penetration exist to break thebarrier of the fire wall. Maintenance will do monthly audits to check for missing escutcheon for sprinkler heads and will be replaced as needed Monitoring: TheAdministrator confirmed that the penetrations were sealed. All fire wall inspections as well as audits for missing sprinkler escutcheons by maintenance done per the monthly maintenance schedule will be reviewed at the monthly QualityAssurance meeting and any issues will be corrected immediately. The QA committee will determine the need forfurther monitoring.</p>	

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K 0029 SS=E Bldg. 01	<p>smoke barriers to be constructed in accordance with LSC Section 8-3. 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 maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two of three smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Person #1 on 07/06/15 at 2:15 p.m., above the ceiling tile at the East hall smoke barrier wall there was an unsealed penetration around a telephone wire. At the time of observation, Maintenance Person #1 confirmed there was a one half inch penetration around a telephone wire at the East hall smoke barrier wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved</p>			

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K 0050 SS=C	<p>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 door to 1 of 1 East hall hazardous areas, such as soiled linen storage room, was self closing and latch into the door frame. This deficient practice could affect any of the 24 residents in the East hall.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Person #1 on 07/06/15 at 1:35 p.m., the corridor door entering the East hall shower room, containing one soiled linen receptacle and two trash receptacles, did self close but failed to latch into the door frame. At the time of observation, Maintenance Person #1 acknowledged the soiled linen and trash receptacles are stored in the East hall shower room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 0029	<p>Rounds were done immediately by maintenance to fix any door that do not latch into door frame</p> <p>The East hall soiled linen room and the East hall shower room doors were adjusted and tested and they now latch into the door frame</p> <p>System change :Maintenance will do rounds on all doors to assure they latch into the door frame on a weekly basis x 4 weeks if all doors latch then the audit will be done on a monthly basis x 4 months</p> <p>Monitoring: The administrator confirmed that soiled linen door and the shower room door now latch into the door frame. All audits of the corridor doors latching will be reviewed at the monthly QA meeting and any issues will be corrected immediately. The QA committee will determine the need for further monitoring.</p>	07/06/2015			

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Bldg. 01	<p>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 conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview of the "Fire Drill Report" documentation on 07/06/15 during the exit conference at 2:55 p.m., the Administrator confirmed all second shift fire drills took place between 2:40 p.m. and 3:55 p.m. for four of the last four quarters.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>Fire drill times changed to include later times on secondshift. Fire drill scheduled to be performed at 6pm on 7-23-15 System change: Education given to maintenance on completing fire drills at varying times on different shifts. Fire drill records will be audited by Administrator or designee to ensure that fire drills are being performed at varying times on each shift per the regulation monthly x 6months. Monitoring: All fire drill record audits will be reviewed at the monthly Quality Assurance meeting and any issues will be corrected immediately. The QA committee will determine the need for further monitoring.</p>	07/23/2015

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K 0062 SS=D Bldg. 01	<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 replace the loaded sprinkler head in 1 of 2 closets in resident room 215. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 of 24 residents in the East hall.</p> <p>Findings include:</p> <p>Based on observation and interview on 07/06/15 at 1:29 p.m., Maintenance Person #1 confirmed the sprinkler head in closet for bed #1 in resident room 215 was corroded with a green substance.</p> <p>3.1-19(b)</p>	K 0062	<p>Rounds were made by maintenance to check for any other sprinklerhead corrosion noted.</p> <p>Brenneco was contacted and ordered a new sprinkler head to be placed in room 215 and will be on site on 8-3-15 to replace sprinkler head.</p> <p>System change: Maintenance will do monthly audits to inspect sprinkler heads for issues and get them replaced as needed.</p> <p>Monitoring: Results of audits will be reviewed monthly by the Quality Assurance committee and any issues will be addressed. The QA committee will determine the need for further monitoring.</p>	08/03/2015

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K 0147 SS=D Bldg. 01	<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 3 of 3 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 could affect 2 residents in resident room 217 and facility staff.</p> <p>Findings include:</p> <p>Based on observations on 07/06/15 at 12:29 p.m., Maintenance Person #1 acknowledged a power strip was plugged in and providing power to another power strip in the Director of Nursing office. At 1:15 p.m., Maintenance Person #1 acknowledged a portable air conditioning unit was receiving power from an extension cord power strip in resident room 217.</p>	K 0147	<p>Rounds were made by maintenance to check for any power cords being used to substitute for fixed wiring. All power cords found were removed.</p> <p>System change: Monthly audits will be done by maintenance to check to any power cords and removed as found.</p> <p>Monitoring: : Results of audits will be reviewed monthly by the Quality Assurance committee and any issues will be addressed. The QA committee will determine the need for further monitoring.</p>	07/06/2015

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

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