

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 10/29/2012
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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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K0000	<p>A Life Safety Code Recertification and State Licensure Survey plus the Post Survey Revisit (PSR) to the Quality Assurance Walk-thru visit conducted on 07/10/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/29/12</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered.</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>The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident rooms.</p> <p>The facility has a capacity of 140 and had a census of 134 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0018 SS=E	<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 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 90 resident room doors located in the west wing of the PCU side of the facility were provided with positive latching hardware. This deficient practice had the potential to affect 4 residents in the west wing of the PCU side.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 with the Maintenance Supervisor during the tour from 9:00 a.m. to 11:10 a.m., the doors to esident rooms 301 and 306 lacked a positive latching mechanism and did not latch into the frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged</p>	K0018	<p>K018 The facility failed to ensure two resident room doors were provided with positive latching hardware. The two resident room doors lacked a positive latching mechanism and did not latch into the frame. Maintenance shall install new latching mechanisms to provide a positive latching system to ensure the doors latch into the frame. Maintenance shall make a review of resident room and common area doors for proper latching into the frame during the Monthly Resident Room Preventative Maintenance Audits. Such audits shall be recorded in the electronic TELS Program. Monitoring of the Monthly Audits shall be completed by the administrator or the assigned staff on a quarterly basis. During the routine visit from the Corporate</p>	11/15/2012

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	the doors to resident rooms 301 and 306 were not provided with positive latching hardware. 3.1-19(b)		Environmental Consultant a review of an average number of doors will be made to ensure proper latching is being maintained.		

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K0066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect any staff utilizing the designated employee smoking area adjacent to the resident dining area exit during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 with</p>	K0066	<p>K066 The facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided where smoking was permitted.</p> <p>The smoking area is twenty five feet outside of the resident dining area and twenty eight cigarette butts scattered about the staff bench seat area, and throughout the grass area.</p> <p>Maintenance shall cleanup all cigarette butts in and around the smoking area.</p>	11/15/2012			

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	<p>the Maintenance Supervisor during the tour from 9:00 a.m. to 11:10 a.m., the smoking area is twenty five feet outside of the resident dining area and had twenty eight cigarette butts scattered about the staff bench seat area, and throughout the grass area. Based on interview on 10/29/12 concurrent with the observations, the Maintenance Supervisor acknowledged the facility's employees disposed of cigarette butts on the ground and throughout the grass area instead of using the approved long neck vessel which was provided.</p> <p>3.1-19(b)</p>		<p>Maintenance shall make an inspection of the smoking area during the Daily Preventative Maintenance Task and complete the daily record.</p> <p>Monitoring shall be made by the administrator or assigned staff of the smoking area on a monthly routine basis. During the routine visit the Corporate Environmental Consultant will make an inspection of the smoking area to ensure the area is being maintained.</p>		

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K0211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand sanitizers in the PCU north soiled utility room was not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice had the potential to affect 34 residents in the PCU north corridor.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 with the Maintenance Supervisor during the tour from 9:00 a.m. to 11:10 a.m., an alcohol based hand sanitizer was located</p>	K0211	<p>K211 The facility failed to ensure an alcohol based hand sanitizer was not installed over an ignition source.</p> <p>An alcohol based hand sanitizer was located approximately two inches directly above the light switch in the PCU north soiled utility room.</p> <p>Maintenance shall immediately remove the alcohol based hand sanitizer from above the light switch and reinstall the dispenser in a proper location away from all ignition sources. Maintenance shall make an inspection of all alcohol based hand sanitizers to ensure proper installation.</p> <p>Monitoring shall be made by the administrator or assigned staff on</p>	11/15/2012			

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	<p>approximately two inches directly above the light switch in the PCU north soiled utility room. The Maintenance Supervisor confirmed at the time of observation, the hand sanitizer was alcohol based.</p> <p>3.1-19(b)</p>		<p>a quarterly basis. During the routine visit the Corporate Environmental Consultant shall make an inspection of various alcohol based hand sanitizers to ensure proper installation.</p>		