

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155461	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2012
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VILLAGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S SR 57 WASHINGTON, IN 47501
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/06/12</p> <p>Facility Number: 000302 Provider Number: 155461 AIM Number: 100286510</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Prairie Village Nursing and Rehabilitation 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 was determined to be of Type II (000)</p>	K0000		
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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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms, and spaces open to the corridors in Zones 1, 2, and 3; and in the corridors and spaces open to the corridors in Zone 4 with battery operated smoke detectors in the Zone 4 resident rooms and offices. The facility has a capacity of 70 and had a census of 60 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/10/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0021 SS=E	<p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 smoke barrier doors was held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect any of the 60 residents, as well as staff and visitors while in the dining room.</p> <p>Findings include:</p> <p>Based on observation on 02/06/12 at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant # 1, the west side smoke barrier door in the dining room was held wide open with a short chain from the</p>	K0021	. K 021 The referenced absence of the device designed /arranged to automatically close doors upon activation of the fire alarm system on the doors located on the west side smoke barrier door in the dining room will have the necessary device installed that is designed/arranged to automatically close the doors upon activation of the fire alarm system. This device will be installed and properly tested for accurate performance prior to March 7, 2012. The systemic change and corrective action taken for this citation is the device to automatically close the doors upon activation of the fire alarm system will be installed and the Maintenance Director will conduct an audit to test the device for proper functioning 1 x per week for 1 month, and monthly thereafter to ensure the automatic closure device is working properly. Any malfunctions of the	03/07/2012
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	<p>top of the door to the wall which would not allow the door to close automatically when the fire alarm system was actuated. This was acknowledged by the Maintenance Supervisor and the Maintenance Assistant # 1 at the time of observation.</p> <p>3.1-19(b)</p>		<p>device will be repaired/replaced immediately. The Maintenance Director will report the audit results to the 'QPI' Committee (Quality Assurance Committee) in the monthly meeting. Upon the end of the month of testing the 'QPI' Committee will determine if continued audits are necessary.</p>	

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen service openings, a hazardous area room opening, was provided with automatic or self closing equipment and constructed to prevent the passage of smoke. This deficient practice could affect any of the 61 residents, as well as staff and visitors while in the dining room.</p> <p>Findings include:</p> <p>Based on observation on 02/06/12 at 11:20 a.m. during a tour of the facility with the Maintenance Supervisor and the Maintenance Assistant #1, the kitchen service window was three foot wide by four foot high. The top two and a half foot portion of the window was a single pane of</p>	K0029	<p>K 029 The referenced absence of a device/equipment that is constructed/designed to automatically or self close in the kitchen service opening, a hazardous area room opening, to ensure the prevention of the passage of smoke upon the activation of the fire alarm system will have the necessary device/equipment installed/constructed that will close automatically upon activation of the fire alarm or self close to prevent the passage of smoke. This device/equipment will be installed/constructed and properly tested for accurate performance prior to March 7, 2012. The systemic change and corrective action taken for this citation is the device/equipment to automatically close upon activation of the fire alarm system or self close will be installed/constructed and the Maintenance Director will conduct an audit to test the device/equipment for proper functioning 1 x per week for 1</p>	03/07/2012			

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	<p>glass with the bottom one and a half foot section consisting of two wooden doors. The wooden doors were not provided with self closing devices and when these doors were closed there was a one fourth to one half inch gap all around both doors. This was acknowledged by the Maintenance Supervisor and Maintenance Assistant #1 at the time of observation.</p> <p>3.1-19(b)</p>		<p>month, and monthly thereafter. Any malfunctions of the device/equipment will be repaired/replaced immediately. The Maintenance Director will report the audit results monthly to the 'QPI' C ommittee (Quality Assurance Committee) in the monthly meeting. Upon the end of the month the 'QPI' Committee will determine if continued audits are necessary.</p>		

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K0052 SS=C	<p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 75 of 75 smoke detectors was correct. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection reports in the Maintenance Manual on 02/06/12 at 9:00 a.m. with the Maintenance Supervisor and Maintenance Assistant #1 present, the three most recent quarterly fire alarm system inspection reports dated 05/31/11, 08/17/11, and 11/28/11, all indicated on the cover page the facility was provided with seventy five Photo</p>	K0052	<p>K 052 The discrepancy on the quarterly fire alarm system inspection reports conducted by Safe Care of Indianapolis, dated 05/31/11, 08/17/11, and 11/28/11, inaccurately indicates on the cover page that the facility has and was provided with 75 Photo type smoke detectors and 0 Ion type smoke detectors. The discrepancy on the quarterly fire alarm system inspection report conducted by Safe Care of Indianapolis, dated 03/03/11, inaccurately indicates on the cover page the facility has 70 Ion type smoke detectors and 5 Photo type smoke detectors. However, the itemized list of smoke detectors on the sensitivity testing pages indicate the facility was provided with 68 Ion type smoke detectors and 7 Photo type smoke detectors. An audit conducted by the Maintenance Director of the facility on February 13, 2012, of all the smoke detectors located within the facility revealed the facility does, in fact, have 68 Ion type smoke dectectors and 7 Photo type smoke detectors. The Maintenance Director will contact Safe Care and will notify them of the identified discrepancies listed</p>	03/07/2012			

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	<p>type smoke detectors and zero Ion type smoke detectors. The quarterly fire alarm system inspection/smoke detector sensitivity test report dated 03/03/11 indicated on the cover page the facility was provided with seventy Ion type smoke detectors and five Photo type smoke detectors, however, the itemized list of smoke detectors on the sensitivity testing pages indicated the facility was provided with sixty eight Ion type smoke detectors and seven Photo type smoke detectors. During interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant #1 acknowledged the discrepancy in the type and numbers of smoke detectors listed on the quarterly fire alarm system inspection reports and the most recent sensitivity test report.</p> <p>3-1.19(b)</p>		<p>above and will request a new Quarterly Inspection Report to be completed by Safe Care that accurately reflects the type and number of smoke detectors located in the facility on or before March 7, 2012. The Maintenance Director will audit the Quarterly Inspection reports completed by Safe Care throughout the year 2012. Any discrepancies will be corrected immediately. The Maintenance Director will report the audit results quarterly to the 'QPI' Committee (Quality Assurance Committee) throughout the remaining 2012 year. Upon the end of the 2012 year the 'QPI' Committee will determine if continued audits are necessary.</p>		