STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITERIVER BLVD MUNCIE, IN 47303

(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: 11/04/13 Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Parkview Nursing 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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a	K010000	"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiences cited. This submission of this plan of correction is not an admission of or an agreement with the deficiences or concludsions continued in the Department's inspection report." We respectfully request that your office will accept this plan as our facilty's compliance and that you will consider a desk review as there are not tags deemed to be actual harm or immediate jeaporday. Please reviews our attachements as each cited deficiency has an audit toolIf you have any questions, please contact me at (765)289-3341. Thank you in advance for your immediate attention in this matter.	

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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	capacity of 81 and had a census of 66 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure 1 of 12 doors to hazardous areas such as the kitchen would self close and latch securely into its frame. This deficiency could affect 8 residents in the Main dining room which was adjacent to the kitchen as well as visitors and staff. Findings include: Based on observation on 11/04/13 at 1:45 p.m. with the Maintenance Supervisor, the south kitchen door adjacent to the Main dining room was not provided with a self closing device on the door. Based on interview on 11/04/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen door was not provided with a self closer to ensure the door would close and latch without	K010029	The east kitchen door adjacent to the main dining room fire door was provided with a self closing device on the door the day of the inspection 11/4/2013. The parts had been previously ordered and had just arrived. All 12 doors to hazardous areas will be checked 3X weekly for 12 weeks, 1 x weekly for 9 months by the Maintenance Director or Designee to validate that they are able to self close and latch without assistance. An audit tool will document all checks. Please see audit tool K29. Any door found to not self close and latch without assistance will be immediately corrected by the maintenance directorThe Administrator/Designee will address any concerns involving not completing the audit tool or not immediately addressing an identified malfunction with the doors, up to and including 1:1 re-education , and/or discplinary	12/01/2013

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	assistance. 3.1-19(b)		action. The Administrator/designee will review the audit tool to verify the checks are maintained. Results of the audits will forwarded to the QPI committee monthly.Any furture action will be as determined by the QPI committee.	

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K010039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 Based on observation and interview, the facility failed to ensure 1 of 7 exit access corridors were maintained to provide at least a four foot wide clearance to evacuate the facility. This deficient practice could affect 24 residents as well as visitors and staff on 100 hall. Findings include: Based on observation on 11/04/13 at 2:46 p.m. with the Maintenance Supervisor, the emergency exit access corridor for the 100 hall was used to store resident standup lifts which limited the corridor width to three feet. Based on interview on 11/04/13 at 2:47 p.m. with the Maintenance Supervisor, it was acknowledged the width of the exit access corridor was limited to three feet because employees stored resident standup lifts against the wall of the corridor. 3.1-19(b)	K010039	The lifts in the west emergency exit access corridor for the 100 Hallway west was moved the day of the inspection 11/4/2013.Staff were inserviced on 11/12/2013 on that no equpment, such as lifts, wheelchairs, walkers, etc can be placed in any of the 7 exit access corridors.As part of daily rounds, all Department Heads will visually check all exit access cooridoors to verify that no equipment, such as lifts, wheelchairs, walker, ect. are located in the exit access coordidors and all such equipment is moved immediately.Please see attached Care Partner Rounds form.Any staff who places equipment such as wheelchairs, lifts, walkers, in the exit access corridoor will be immediatly addressed, up to including 1:1 re-education, and/or discplinary action.The Maintenance Directy or designee will review the daily rounds at morning stand up no less then 3x/week for 52 Weeks.The administrator will verify using an audit tool that rounds are reviewed 3x weeks for 52 weeks. Please see audit tool K30.Results of the review will be forwarded to the QPI commitee monthly for 12 months. Any future action will be as determined by the QPI	12/01/2013

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K010056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 5 of 8 steel armover sprinkler pipes observed in the facility were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practices could affect all residents in the building as well as staff or visitors. Findings include: Based on observations on 11/04/13 during the tour between 12:36 p.m. and 2:15 p.m. with the Maintenance Supervisor,	K010056	Koorsen's was notified of the concerns, Koorsen's corrected on 11/27/2013, all the concerns regarding the unsupported steel sprinker armovers over twenty four inches in length. In addition, Koorens' and the Maintenance Director inspected the entire sprinker system and found no other steel sprinkler heads over twenty four inches in legnth. Please see attached Koorsen service report. The Maintenance Director will inspect the steel sprinklers armovers weekly for 52 weeks to ascertain that no steel sprinker armovers are not more than twenty four inches in legnth The Administrator will sign off on the audit tool 52 weeks to acertain that the steel spinkler armovers are inspected weekly. Please see attached audit tool K56. If any steel sprinker	12/01/2013

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	the following areas were observed with unsupported steel sprinkler armover's over twenty four inches in length: 1. The southwest exit next to the Administrator's office had a steel armover in the corridor which measured thirty six inches. 2. The Laundry on 200 hall above the washing machine had a steel sprinkler armover which measured forty eight inches in length. 3. Resident room 102 had a steel sprinkler armover which measured thirty two inches in length. 4. Resident room 309 had a steel sprinkler armover which measured thirty inches in length. 5. The East nursing station in the corridor had a steel sprinkler armover which measured thirty two inches in length. Based on interview on 11/04/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armovers exceeded twenty four inches in length and were unsupported. 3.1-19(b)		armovers are observed to be more then twenty four inches in length, Koorsen's will notified and the corrections be completed immediately.If inspections are not completed weekly or any concerns found are not addressed immediately the Administrator willl address the concern, up to and including 1:1 re-education, and/or discplinary action.Reviews of the audits will be forwarded to the QPI commitee monthly for 12 months. Any future action will be determined by the QPI committee.	

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K010062 SS=F	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 Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers in 1 of 1 riser rooms in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents throughout the facility as well as staff and visitors if the sprinkler system had to be shut down because a proper sprinkler head wasn't available as a replacement. Findings include: Based on observation on 11/04/13 at 1:45 p.m. with the Maintenance Supervisor, two identical pendant type sprinkler heads with red filaments were being utilized in	K010062	Koorsens was notified of the concerns from the Life Safety survey. Koorsen's provided the pendant type sprinker heads with a red glass filament on 11/27/2013. Please see attached Koorsen report. The Maintenance Director will inspect weekly for 52 weeks the spare sprinkler cabinet located in the Riser room to ascertain that there are two spare sprinkler heads in the spare sprinkler cabinet to match all sprinkler head types in the facility. The Administrator will review and sign the audit form weekly to verify that weekly checks are done to acertain that there are two spare sprinker heads in the spare sprinker cabinet to match all sprinker head types in the facility. Please attached K62 audit tool.If inspections are not completed weekly or any concerns found are not adressed immediately, the Administrator will address the concern, up to and including 1:1 re-education, and/or discplinary action.Results of the reivew will be forwarded to the QPI commitee monthly for 12 months. Any future actrion will be as determined by the QPI committee.	12/01/2013

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	the riser room, however, there were no pendant type sprinkler heads with a red glass filament in the spare sprinkler cabinet located in the Riser room east hall. Based on interview on 11/04/13 at 1:50 p.m. with the Maintenance Supervisor, it was acknowledged the spare sprinkler cabinet located in the Riser room did not have a minimum of two pendant sprinkler heads with red glass filaments in the sprinkler box. 3.1-19(b)			

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K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 3 areas where smoking was permitted. This deficient practice could affect 5 residents observed smoking on the front porch and eight residents observed in the adjacent Main dining room as well as visitors and staff. Findings include: Based on observation on 11/04/13 at	K010066	Staff have been inserviced on 11/12/13 that no cigarette butts can be put into any contain with paper goods and that all cigarette butts must be placed in a black steel container labeled "Cigarette Butts Only". Please see attached inservice. The Maintenance Director as part of his rounds will inspect the designated smoke area at least 3x a week for 12 weeks and 1 time a week for 40 weeks there after. The Smoke aides will sign off daily 2x a day that cigarette butts are contained in the black steel container labeled "Cigarette Butts Only" and	12/01/2013

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	12:15 p.m. with the Maintenance Supervisor, fifty extinguished cigarette butts were observed deposited in a plastic container with paper debris where smoking is permitted outside the front porch of the facility. Based on review of the smoking policy on 11/04/13 at 2:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts into a metal container. Based on interview on 11/04/13 at 12:17 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees allowed the disposal of cigarette butts into a plastic container which is also used for the disposal of paper goods. 3.1-19(b)		that the cigarette butts are not being placed into a container with paper products.The Administrator will review and sign the aduit sheets 1x weekly for 52 weeks to acertain that checks are completed by the Maintenance Director and the Smoke Aides. Please see attached K66 audit tool and the Cigarette Butt Sign off form.If it is observed that staff are placing cigarette butts in containtiers with paper products, the administrator or designee will immediately address the concern, up to and including 1:1 re-education, and/or discplinary action.Results of the review will be forwarded to the QPI commitee monthly for 12 months. Any furture action will be determiend by the QPI commitee.	