

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/15/12</p> <p>Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Parkview 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and</p>	K0000	Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Care Center the allegations contained in this survey report are accurate or reflect accurately the provision of care and service to the residents at Community Parkview Care Center. The facility requests the following plan of correction be considered its allegation of compliance. The facility requests that this plan of correction be approved by paper compliance due to the low severity of the tags.	

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>battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 92 and had a census of 82 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, but was in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered except for the Main dining room exit canopy. The facility has one detached garage for facility storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/22/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0029 SS=E	<p>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</p> <p>Based on observations and interview, the facility failed to ensure 2 of 6 doors leading to hazardous areas such as rooms with combustible items and kitchens were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 22 residents on 100 hall and 6 residents observed in the Main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/15/12 at 1:55 p.m. with the Maintenance Supervisor, the Activities storage room on 100 hall had fifteen cardboard boxes, was greater than fifty square feet in size and was not provided with a self closing device on the corridor door. Furthermore, the south kitchen door was equipped with a self</p>	K0029	<p>***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.1. The door to the activity storage room has a new closer and now closes automatically. 2. The door on the south kitchen exit has been re-adjusted and now closes properly.***HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN.1. All residents have the potential to be affected.2. The door to the activity storage room has a new closer and now closes automatically. 3. The door on the south kitchen exit has been re-adjusted and now closes properly.***WHAT MEASURES WILL BE PUT INTO PLACE OR</p>	09/14/2012			

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	<p>closing device, but it was adjusted so the door would be held open and unable to latch into the door frame. Based on interview on 08/15/12 at 1:58 p.m. with the Maintenance Supervisor, it was acknowledged the Activities storage room door was not provided with a door closure to automatically close and latch in the door frame and the south kitchen door was equipped with a self closing device but maladjustment of the automatic closure prevented the door from automatically closing and latching.</p> <p>3.1-19(b)</p>		<p>WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.1. An audit tool is being utilized to assure that all doors have closers that work properly. (Attachment "A")2. Any doors needing a closer will be replaced or repaired. ***HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR.1. The results of the audit tool will be presented to the QA&A committee on a quarterly basis during regular meetings with the medical director.2. The audit tool will be used 1 time weekly for an indefinite period of time but no less than 1 year to assure compliance.3. After one year, the QA&A committee will determine if it needs to continue based on results of the rounds tool and complince.</p>		

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K0056 SS=E	<p>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</p> <p>Based on observations and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 Main dining room exits with an outside canopy in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 6 residents observed in the Main dining room located on north Redbud Lane as well as visitors or staff.</p> <p>Findings include: Based on observation on 08/15/12 at 1:35</p>	K0056	<p>***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.1. Because the overhang is only attached to a brick wall and not accessible to an attic or any other kind of interior surface, Elwood Fire has given a note that it does not need to be sprinklered. (Attachment "B"), 2, However, after speaking to Dennis Austill at ISDH, it was decided that we would remove the overhang, readjust the size and put a new overhang on that part of the building that is less than 4 feet to be in compliance with the requirement.***HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PR***WHAT CORRECTIVE</p>	09/14/2012			

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	<p>p.m. with the Maintenance Supervisor, the canopy outside the west exit of the Main dining room was attached to the building and extended four feet and two inches from the the building and was constructed of wood with a vinyl ceiling and asphalt shingles. Based on interview on 08/15/12 at 1:37 p.m. with the Maintenance Supervisor, it was acknowledged there was no sprinkler head present for the canopy outside the west exit of the Main dining room to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>ACTION WILL BE ACCOMPLISHED FOR ACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN.1. Because the overhang is only attached to a brick wall and not accessible to an attic or any other kind of interior surface, Elwood Fire has given a note that it does not need to be sprinklered. 2. A new overhang that is less than 4 feet wide will be placed in that area.***WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.1. Because the overhang is only attached to a brick wall and not accessible to an attic or any other kind of interior surface, Elwood Fire has given a note that it does not need to be sprinklered. 2. Since the overhang will be less than 4 feet wide it will not need to be sprinklered.***HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR.1. Because the overhang is only attached to a brick wall and not accessible to an attic or any other kind of interior surface, Elwood Fire has given a note that it does not need to be sprinklered. 2. Since the overhang will be less than 4 feet wide it will not need to be sprinklered.</p>		

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K0064 SS=E	<p>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</p> <p>Based on observations and interview, the facility failed to ensure 2 of 14 portable ABC class fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 28 residents on Redbud lane and 6 residents observed on the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility on 08/15/12 between 12:15 p.m. to 3:00 p.m. with the Maintenance Supervisor, the gauge on the ABC Class portable fire extinguisher in sprinkler riser room on 200 hall and the gauge on the ABC Class portable fire extinguisher in the Main dining room next to the west exit showed the extinguishers to be overcharged. Based on interview on</p>	K0064	<p>***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.1. No residents were affected by this practice.***HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PR***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR ACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN.1. All residents could have been affected.2. Elwood Fire Equipment company has returned and checked every ABC fire extinguisher to assure that they are not overcharged. ***WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.1. All fire extinguishers will be checked monthly to assure the charge is correct.2. An audit was added to TELS to assist with these checks. (Attachment "C") ***HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT</p>	09/14/2012			

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	08/15/12 concurrent with the observations with the Maintenance Supervisor, it was agreed the gauge readings were not in the normal operating range and not known if it would affect the operation of the fire extinguisher. 3.1-19(b)		RECUR.1. The audit will be added to the preventative maintenance schedule on our TELS reports.2. The results of the audit will be discussed during the quarterly QA&A committee meetings with the Medical Director to assure compliance. 3. This will continue indefinitely with no stop date.		

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K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 2 dryers in the laundry room on 100 hall was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 22 residents on 100 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/15/12 at 2:57 p.m. with the Maintenance Supervisor, the gas fueled dryer in the laundry room did not have a fresh air intake. Based on interview on 08/15/12 at 2:59 p.m., it was acknowledged by the Maintenance Supervisor the fuel fired dryer did not have a fresh air intake.</p> <p>3.1-19(b)</p>	K0068	<p>***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.1. No residents were affected.***HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PR***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR ACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN.1. All residents could be affected.2. A fresh air intake has been added to the laundry room for the gas dryer. ***WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.1. The Maintenance Director will check this vent during regular rounds to assure it is working properly.***HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR.1. Now that the vent has been installed, there should be no further issues. 2. All gas dryers will have a fresh air intake.3. Any issues will be</p>	09/14/2012	

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			brought before the QA committee with the Medical Director for further discussion.	

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation, record review and interview; the facility failed to ensure the window curtains in 3 of 88 rooms were maintained in a fire resistant condition. This deficient practice could affect 12 residents on 300 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/15/12 during the tour between 12:10 p.m. and 12:50 p.m. with the Maintenance Supervisor, the window curtains installed in the skilled dining room, the ADON office and the conference room, all on 300 hall, lacked attached documentation</p>	K0074	<p>***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.1. No residents were affected.***HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PR***WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR ACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN.1. All residents could be affected.2. All curtains and other materials will be flame retardant. The solution has been applied, however, documentation was lacking. That documentation</p>	09/14/2012

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	<p>confirming they were inherently flame resistant. Based on record review on 08/15/12 at 3:45 p.m. with the Maintenance Supervisor the aforementioned window curtains are not inherently flame resistant and require the application of a fire resistant solution after each washing. The curtains are washed every three months, however, documentation for reapplication of the fire resistant solution ended at 10/21/08. Based on interview on 08/15/12 at 3:45 p.m. with the Maintenance Supervisor, it was acknowledged there was no documentation available since 10/21/08 regarding the reapplication of a flame retardant solution after each washing to maintain a fire resistant condition for the curtains.</p> <p>3.1-19(b)</p>		<p>will now be done on a quarterly basis as products are laundered or sooner if necessary. ***WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR.1. The application of product will be applied after every item is laundered and if purchasing new products.2. An audit tool has been added to the preventative maintenance schedule (Attachment "D") ***HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR.1. The Maintenance Supervisor will be responsible for applying the product.2. The Administrator will monitor this compliance on the preventative maintenance program</p>		