

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
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NAME OF PROVIDER OR SUPPLIER  FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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(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
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K010000	<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: 01/14/14</p> <p>Facility Number: 011387 Provider Number: 155762 AIM Number: 200853180</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Forest Park Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke</p>	K010000		
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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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K010025 SS=E	<p>detectors in all resident rooms. The facility has a capacity of 107 and had a census of 56 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 attic smoke barriers in the healthcare portion of the facility were constructed to provide at least a one hour fire resistance</p>	K010025	ELEMENT 1: Closure of 6"x30' hall attic smoke barrier wall for hall 200, 11 residents. Contractor completed work for K025 deficiency on 2-4-14. Please see attached pictures reflecting the	02/13/2014			

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	<p>rating. This deficient practice affects 11 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the director of plant operations on 01/14/14 at 11:45 a.m., the 200 Hall attic smoke barrier wall had a six inch by thirty foot area along the entire length of the attic smoke barrier with no drywall covering the wooden trusses. This was verified by the director of plant operations at the time of observation and acknowledged by the director of nursing at the exit conference on 01/14/14 at 12:05 p.m.</p> <p>3.1-19(b)</p>		<p>correction of the smoke barrier deficiency for hall 200. ELEMENT 2: On Jan 14, 2014, a Life Safety Code Survey was completed with surveyor (M.B), and Director of Operations (M.W.) for Forest Park Health Center. During the survey, all additional resident halls, i.e. 100, 300 and service hall attic space were verified as K025 deficiency free.ELEMENT 3: Compliance verification with regulation K025 will be completed by Forest Park Director of Operation following all attic work completed by Forest Park personnel or Forest Park contracted service providers. HFA will ensure compliance to regulation.ELEMENT 4: Director of operations will audit monthly x4 will be completed for compliance verification to K025 for attic work. Results will be communicated in monthly QA meeting. Audit form attached. HFS will ensure compliance to regulation.</p>		