

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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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: 04/01/14</p> <p>Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Northview 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, in spaces open to the corridors and battery powered smoke detectors in</p>	K010000	<p>Submission of the Plan of Correction and Credible Allegation does not constitute an admission by the certified provider at Community Northview Care Center. The Community Northview Care Center also does not constitute admission that the allegations contained in the survey report are true and accurate portrayal of the provision of nursing care and services at this health facility. Community Northview Care Center as licensed and certified provider recognizes its obligation to provide legally and medically required care services to our residents in an economic and efficient fashion. The following will serve as the plan of correction and allegation of compliance for the cited deficiencies. The facility respectfully requests a desk review for compliance. If you have questions, please contact me at 765-298-2545.</p>	
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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>all resident rooms. The facility has a capacity of 101 and had a census of 60 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the one detached garage and one barn used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/07/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010029 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 observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas on 100 north hall such as rooms with stored combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents on 100 north hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/01/14 at 12:55 p.m. with the Maintenance Supervisor, the Medical records room on 100 north hall contained thirty two cardboard boxes inside the room which was greater than fifty square feet in size did not have a self closing device on the corridor door. Based on interview on 04/01/14 at 12:58 p.m. with the</p>	K010029	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A door closure was placed on the Medical Records Office door on 4/2/14 to assure the door will automatically shut after opened. No residents had negative outcomes from this door closure.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected but no negative outcomes occurred. A door closure was place on the Medical Records Office door on 4/2/14 to assure the door will automatically shut after opened.</p>	04/02/2014
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	Maintenance Supervisor, it was acknowledged the aforementioned door leading into the Medical records room containing combustible items was not equipped with a self closing device on the door. 3.1-19(b)		What measures will be put into place or what systemic changes will be made to assure that the deficient practice does not recur? The door closure will be checked on the preventive monitoring schedule to assure proper closing weekly. All doors were closures were checked to assure the doors close properly. How the corrective action will be monitored to ensure the deficient practice will not recur? The Maintenance Director will monitor the identified doors 5 times a week for 2 weeks, 3 times a week for 2 weeks, then 1 a week on an ongoing basis for properly latching. All other doors will be monitored weekly for proper latching on an ongoing basis. The audits will be submitted to the monthly Quality Assurance Committee for review.		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This</p>	K010144	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? This paper finding had no negative resident outcomes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? This paper finding had no negative resident outcomes affecting any residents. The generator testing log has been revised to indicate the amperage used. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The generator testing log has been revised to indicate the amperage used with each generator testing. The formula, Average Volts X 1.732 X .80 X Average Amps = Watts divided by generator maximum output = percentage load, will be used to calculate amps used and recorded on the Generator Log Form. How the corrective action will be monitored to ensure the deficient practice will not recur? The Director of Maintenance is responsible for the maintenance and recording the amperage of the generator log. The generator test results will</p>	04/21/2014
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	<p>deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 04/01/14 at 2:38 p.m. with the Maintenance Supervisor, the amperage during load testing for the past twelve months was documented but it could not be verified to be 30 percent of the EPS nameplate rating. Based on interview on 04/01/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but were unaware it had to be at least 30 percent of the EPS nameplate rating. No other equivalent method was used.</p> <p>3.1-19(b)</p>		<p>be submitted to the monthly Quality Assurance Committee for six months or until the Interdisciplinary Team determines no longer necessary to report.</p>		