

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/16/2016
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NAME OF PROVIDER OR SUPPLIER  NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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K 0000  Bldg. 01	<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: 03/16/16</p> <p>Facility Number: 000069 Provider Number: 155148 AIM Number: 100288980</p> <p>At this Life Safety Code survey, North Park 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.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 103 and had</p>	K 0000	<p><b>Plan of Correction for North Park Nursing Center</b></p> <p><b>K000 INITIAL COMMENTS</b></p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.</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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K 0056 SS=F Bldg. 01	<p>a census of 99 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except four detached wood framed sheds used for facility storage.</p> <p>Quality Review completed on 03/21/16 - DA</p> <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 observation and interview, the facility failed to provide an automatic sprinkler system that provided sprinkler coverage in 1 of 1 sprinkler riser room. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 03/16/16 at</p>	K 0056	<p><b>K056 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <p>·Sprinkler riser closet provided</p>	03/28/2016			

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	11:45 a.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler riser closet was not provided with sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observation.  3.1-19(b)		with sprinkler coverage. <b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> · All residents have the potential to be affected by the alleged deficient practice. · Complete facility review of sprinkler system for compliance completed. <b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b> · The ED/designee to in-service Maintenance for proper sprinkler life safety code standard by March 28, 2016. <b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b> · ED/designee will be responsible for the completion of Environmental Facility Rounds CQI tool weekly times 4 weeks, monthly times 2 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.  <b>5. Date completion:</b> March 28, 2016		

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K 0075 SS=E Bldg. 01	<p><b>NFPA 101</b> <b>LIFE SAFETY CODE STANDARD</b> Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 55 gallons or more of paper recycle collection containers was not exceeded within any 64 square feet area in 2 of 8 smoke compartments. This deficient practice could affect over 25 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 03/16/16 between 11:15 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, a 55 gallon or more paper recycle collection container was observed in the lounge, which was open to the corridor, outside the Physical Therapy room, and a 55 gallon or more paper recycle collection container was observed in the corridor outside the entrance to the Cottage units. This was acknowledged by the Maintenance</p>	K 0075	<p><b>K0075 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law.</p> <p><b>1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The recycle collection containers have been moved to appropriate locations to meet life safety code standards.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the alleged deficient practice</li> <li>· Complete facility wide review completed to ensure no other trash or recycle receptacles are out of life safety code standards.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will</b></p>	03/28/2016
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K 0144 SS=C Bldg. 01	Supervisor at the time of each observation.  3.1-19(b)  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, observation and interview; the facility failed to ensure documentation for 1 of 1 emergency generators showed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC	K 0144	<b>be made to ensure that the deficient practice does not recur.</b> ·Daily rounds by Maintenance Supervisor/designee to ensure compliance is met.  <b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b> ·ED/designee will be responsible for the completion of Environmental Facility Rounds CQI tool weekly times 4 weeks, monthly times 2 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.  <b>5. Date completion:</b> March 28, 2016  <b>K0144 NFPA 101 Life Safety Code Standard</b> It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. <b>1: What corrective action(s) will be</b>	03/28/2016	

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	<p>7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. 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 Emergency Generator Monthly Load Test Log on 03/16/16 at 10:00 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested weekly for 36 minutes under load, however, there was no cool down time listed on the form. During an interview at the time of record review, the Maintenance Supervisor said the generator did have a six minute cool down time at the end of the monthly load test, but, acknowledged the documentation form did not include the cool down time information.</p>		<p><b>accomplished for those residents found to have affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Form now includes cool down time for the generator.</li> </ul> <p><b>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</b></p> <ul style="list-style-type: none"> <li>·All residents on have the potential to be affected by the alleged deficient practice.</li> <li>·Weekly and monthly cool down minutes will be recorded.</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <ul style="list-style-type: none"> <li>·Documentation form for the generator now includes cool down time for weekly and monthly test.</li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>·ED/designee will be responsible for the completion of Environmental Facility Rounds CQI tool weekly times 4 weeks, monthly times 2 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</li> </ul>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-19(b)		5. Date of completion: March 28, 2016		