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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 10/29/2014 |
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| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD | STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052 |
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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: 10/29/14</p> <p>Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare at Parkwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, 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 hard wired smoke detection in the corridors and spaces open to the corridors and Maplewood resident</p> | K010000 | <p>The facility requests that this plan of correction be considered its credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law. The facility respectfully requests a desk review.</p> <p>Thank you.</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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| K010017 SS=E | <p>rooms 61- 70; battery powered smoke detectors were provided in all other resident rooms. The facility has the capacity for 138 residents and had a census of 110 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. A detached equipment storage garage was unsprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/13/14.</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 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1,</p> | | | |

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| | <p>19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure use areas were separated from the corridors by a partition capable of resisting the passage of smoke in 1 of 12 smoke compartments as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided:</p> <p>(a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect residents, staff and 10 or more residents in the dining room and administrative offices smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:05 p.m., an L shaped dead end corridor used for storage was open to the entrance lounge in the administrative offices smoke compartment. The space where the dead end corridor terminated housed</p> | K010017 | <p>K017 Since this deficient practice could affect all residents and staff the following corrective actions will be taken: All items, wheel chair, pictures and other materials in that space have been removed. The digital television equipment tower will be moved to adjacent storage area which has a secured door and proper ventilation. To ensure the deficient practice does not recur, all vendors and/or contractors will be monitored while in facility to install any and all equipment, to ensure proper codes are met. Audit tool will be utilized to track projects of contractors and/or vendors to ensure there are no code violations. This will be presented at Quality Assurance Committee meetings monthly x 6months to ensure deficient practice does not recur.</p> | 12/03/2014 | | | |

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| K010018 SS=E | <p>a bank of digital television equipment components which stood six feet from floor to the top of the equipment bank. A wheelchair, large framed pictures and other materials were also stored in the space which was noted to be warmer than adjacent areas. No partition or door separated the storage space from the exit corridor and the space was not protected by an electrically supervised automatic detection system. The Plant Operations Director said at the time of observation, he thought a door was not installed because the ventilation provided for the space could not handle the heat put out by the equipment equipment located there.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided</p> | | | | |

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| | <p>with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 12 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the administrative offices smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:05 p.m., the double door set providing access to the family room required one door to latch manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The Plant Operations Director acknowledged at the time of observation, each door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a corridor door in 1 of 12 smoke compartments would latch into the door frame. This</p> | K010018 | <p>K018 Since residents and staff have the potential to be affected, the following corrective actions will be implemented: The double door to the Family Room will be provided with automatic door closure thus allowing it to automatically latch to second door. The second door in corridor will be provided with automatic closure along with electronic locking device and key. A strike plate was installed on the storage closet door near room 46 to ensure the door would hold in the door frame. All corridor doors throughout the facility have been inspected with any needed corrections completed at time of inspection. To ensure the deficient practice does not recur, doors will be observed during morning walk through by Maintenance Director and/or designee to note any deficiencies. Corrective measures will be implemented immediately upon discovery. Audit tool created to track door inspections and maintenance which will be reviewed by Quality Assurance Committee monthly x6 months to ensure compliance.</p> | 12/08/2014 |

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| K010021 SS=E | <p>deficient practice affects staff, visitors and 10 or more residents in the Redwing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 1:45 p.m., the door protecting the corridor opening to the storage closet near room 46 failed to latch into the door frame. The Plant Operations Director acknowledged at the time of observation, the doors was not working to hold the door in the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> | | | |

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| | <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation and interview, the facility failed to ensure a door in 1 of 8 smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents in the Rosewood and Redwood smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 12:00 p.m., the smoke barrier door set separating the Rosewood and Redwood smoke compartments was not provided with a door coordinator. One door in the smoke barrier double door set was equipped with an astragal. When the timed sequence for closing the doors was interrupted and the door with the astragal closed first, the second door hit the astragal and could not close into the door frame to provide a continuous smoke seal between the two smoke compartments. The Plant Operations Director</p> | K010021 | <p>K021 Since residents and staff have the potential to be affected, the following corrective action will be taken: Door coordinator to be placed to ensure that door with astragal will not close prior to the door without astragal should there be an interruption. Corrective measures taken for Maplewood Shower Room and Soiled Utility room to ensure door closed properly into frame. Room 33 and adjacent room used for storage shall be provided with required closures and latching devices. To ensure the deficient practice does not recur, Plant Ops Director and/or designee will observe doors daily to ensure doors are functioning properly and ensure that only these identified areas are used for storage. Log form will be utilized to track maintenance of doors. This will be reviewed by the Quality Assurance Committee monthly x6 months to ensure compliance.</p> | 12/08/2014 |

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| | <p>acknowledged at the time of observation, the doors could not maintain the smoke resistance of the smoke barrier if the doors did not close completely.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure doors to hazardous areas in 3 of 12 smoke compartments, such as soiled linen/trash collection rooms, gas fueled equipment rooms and combustible materials storage rooms larger than 50 square feet, were held open only by devices which would allow the doors to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 20 or more residents in the Maplewood, Rosewood and administrative offices smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Plant Operations Director on 10/29/14 at 12:20</p> | | | |

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| | <p>p.m., the Maplewood shower room was used for the collection of soiled linen and trash receptacles larger than a 32 gallon capacity. The self closing door to the Maplewood shower room was tested and failed to close and latch when it hit the door frame. The Plant Operations Director acknowledged at the time of observation, the door would not automatically close.</p> <p>b. Based on observation with the Plant Operations Director on 10/29/14 at 12:20 p.m., the door accessing the Maplewood soiled utility room, used for the collection of soiled linen and trash receptacles with a capacity for more than 32 gallons was equipped with a self closer which allowed the door, when opened fully, to stand wide open. The Plant Operations Director acknowledged at the time of observation, this was a function of the self closer installed and the door would not automatically close upon activation of the fire alarm system.</p> <p>c. Based on observation with the Plant Operations Director on 10/29/14 at 12:20 p.m., the doors accessing resident room 33 and the adjacent room, each larger than 50 square feet were not equipped with self closing devices. The rooms were being used for the storage of 20 or more wooden folding chairs, and other combustible supplies. The Plant Operations Director acknowledged the</p> | | | |

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| K010025 SS=E | <p>rooms had not been protected by self closing doors.</p> <p>3.1-19</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ceiling, door, floor and wall smoke barrier penetrations in 4 of 12 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service</p> | K010025 | K025 Since all residents and staff have potential to be affected the following corrective action will be taken: Fire retardant caulking was used to seal the holes in The Bridge CNA charting areas. Facility tour conducted and any areas noted were sealed with fire retardant caulking. To ensure the deficient practice does not recur, any contractors and/or | 12/08/2014 |

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| | <p>materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to floor and outside wall to outside wall. This deficient could affect visitors, staff and 20 or more residents in the Bridges, Redwood, Service area, and administrative offices smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director between 11:30 a.m. and 3:00 p.m., ceiling, door, floor and wall penetration gaps were found:</p> <p>a. Unsealed where a two inch hole had been cut out in the ceiling of the Bridges CNA charting area. A second 1/4 annular gap was located where the escutcheon did not cover the opening made to install a sprinkler head in the same ceiling;</p> <p>b. Unsealed above the layed in ceiling where the administrative offices smoke barrier wall separated two smoke compartments. It was evident caulk had fallen away from a penetration leaving a</p> | | <p>vendors will be monitored by Plant Ops Director and/or designee to ensure all penetrations are sealed properly at time work is being performed.</p> <p>Audit tool implemented to track projects of contractors and/or vendors who created holes that need sealed. This will be reviewed by the Quality Assurance Committee monthly x 6 months to ensure compliance.</p> | |

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| K010027 SS=E | <p>half inch gap in the smoke barrier wall;</p> <p>c. Unsealed in the Redwood north nurses station storage room ceiling where a conduit penetration left a 3/8 inch gap into the attic above;</p> <p>d. Three, 3/8 inch holes in the Bridges smoke barrier doors where self closing hardware had been removed were sealed with expandable foam for which there was no fire rating,</p> <p>e. An uncapped two inch PVC pipe penetrating the floor adjacent to the generator power, transfer switch and circuit panels was filled with expandable foam for which there was no fire rating.</p> <p>The Plant Operations Director acknowledged the gaps and unrated expandable foam in use to seal penetrations at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood</p> | | | |

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| | <p>core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure a door in 1 of 13 smoke barrier door sets would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors and 10 or more residents in the administrative offices and adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14, one door in the smoke barrier door set separating the administrative offices smoke compartment from the adjacent smoke compartment when tested manually, failed to close when the fire alarm was activated at 2:55 p.m. The Plant Operations Director acknowledged at the time of observation, the door should have closed to maintain the smoke resistance of the smoke barrier.</p> | K010027 | <p>K027 Since residents, staff, and visitors have potential to be affected the following corrective actions will be implemented: Adjustments to automatic door closures performed to ensure proper seal of doors separating smoke compartments. All smoke compartment doors were inspected and any adjustment required were performed at time of inspection. To ensure the deficient practice does not recur, smoke compartment doors will be tested weekly by Plant Ops Director and/or designee to ensure proper seal. Weekly inspections will be noted on Plant Ops Facility Check List. Information will be presented to Quality Assurance Committee monthly x 6mos to ensure compliance.</p> | 12/08/2014 |

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| K010029 SS=E | <p>3.1-19(b)</p> <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 a door to a hazardous area in 1 of 12 smoke compartments, such as a storage room for gas fueled equipment closed and latched automatically or upon activation of the fire alarm system. Doors to hazardous areas are required to latch into their door frames when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 10 or more residents in the administrative offices</p> | K010029 | K029 Since residents, staff, and visitors have potential to be affected the following corrective actions will be taken: Proper adjustments were made to ensure that door leading to fueled service water heater storage room self-closed and latched in frame properly. Facility tour conducted to ensure proper functioning of doors into similar areas. To ensure the deficient practice does not recur, doors will be observed daily by Plant Ops Director or designee. Deficiencies | 11/28/2014 |

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| K010038 SS=E | <p>smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:25 p.m., the self closing door accessing the gas fueled service water heater storage room in the administrative offices smoke compartment failed to latch. The door could be opened by merely pushing on the door when tested twice with the Plant Operations Director. He said at the time of observation, the door latch assembly had no strike plate and needed work to ensure the door would latch.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exit door sets on the north and south Rosewood wings equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch</p> | K010038 | <p>noted will be corrected immediately by Plant Ops Director or designee. Door monitoring will be noted on facility Tour Sheet. Information will be reviewed by Quality Assurance Committee monthly x 6 months to ensure compliance.</p> <p>K038 Since residents, staff, and visitors have potential to be affected the following corrective action will be taken: the referenced keypads have been disabled from doors allowing them to be released manually as well as with the fire panel. All doors have checked for this inhibiting factor (keypads) to ensure no further residents, staff, or visitors are effected. Plant Ops Director and/or designee will</p> | 12/08/2014 |

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| | <p>or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 20 or more residents on the Rosewood wings.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Director on 10/29/14 at 1:50 p.m., the smoke barrier doors on the north and south Rosewood wings, formerly locked dementia units, were equipped with magnetic locks. Keypads to override the door locks were provided on both sides of each of the door sets. The Plant Operations Director conceded at the time of observations, if the doors were closed manually the doors would automatically lock. If the alarms failed to disengage the locks, the keypad code would be required to unlock the doors. The keypad code was not posted on these units where not all residents had a diagnosis for which locked doors might be indicated.</p> | | <p>monitor daily and report to Quality Assurance Committee monthly x 6 mos to ensure compliance.</p> | |

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| K010050 SS=F | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure all fire drills were conducted, conducted at varied times and all elements of fire drills were included on documentation provided for fire drills for 2 of the past 4 quarters including the date and time the drill was conducted. LSC 4.7.2 requires drills include suitable procedures to ensure that all persons subject to the drill participate. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Reports</p> | K010050 | K050 Since all occupants have potential to be affected the following corrective actions will be taken: All fire drills will be conducted quarterly on each shift per regulation. To ensure the deficient practice does not recur hard copy of drill and signature sheet will be placed in Fire Drill Binder. To monitor compliance, Administrator will review and sign hard copy. | 11/28/2014 |

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| | <p>for the past year with the Plant Operations Director on 10/29/14 at 3:15 p.m.:</p> <p>a. Fire drill documentation did not include signatures of staff to evidence their participation for fire drills conducted on 10/31/13 during the first shift, and 11/22/13 and 8/19/14 during the second shifts;</p> <p>b. No fire drills were provided for the third shift during the fourth quarter of 2013 and during the third quarter for second and third shifts during 2014;</p> <p>c. Fire drill times were not varied as evidenced by day shift fire drills conducted at 1:39 p.m. on 1/31/14 and 1:50 p.m. on 4/21/14;</p> <p>d. Fire drill times were not varied between fire drills conducted on 2/28/14 at 2:45 p.m., and 5/29/14 at 2:30 p.m. The Plant Operations Director said at the time of record review he had provided all available fire drill records.</p> <p>3.1-19(b) 3.1-51(c)</p> | | | |

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| K010062 SS=E | <p>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</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 12 smoke compartments were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 10 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 between 12:00 p.m. and 2:35 p.m., the storage on shelves in the housekeeping storage room was located eight inches from the sprinkler head providing protection for</p> | K010062 | <p>K062 Since residents, visitors, and staff have the potential to be affected the following corrective action will be taken: Vendor scheduled to replace with new sprinkler heads to comply with regulation. Facility tour conducted on 10/30/14 to ensure standards are met with all sprinkler heads. To ensure deficient practice does not recur Plant Ops Director or designee will check sprinklers quarterly to ensure there is no corrosion. Information will be tracked on log and reviewed by Quality Assurance Committee quarterly to ensure compliance.</p> | 12/08/2014 |

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| | <p>the room. Food storage in the kitchen cooler and freezer was three inches from the sprinklers protecting the spaces. The Plant Operations Director acknowledged at the time of observation, the sprinkler heads were less than the minimum distance allowed between a sprinkler head and an obstruction.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 12 smoke compartments was free of corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in the administrative offices smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:25 p.m., the single sprinkler head protecting the service water heater room in the administrative offices smoke compartment was turning green, usually evidence of corrosion. The Plant Operations Director agreed at the time of observation, corrosion could affect the function of the sprinkler head.</p> | | | |

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| K010073 SS=E | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure flammable decorations were not used in 1 of 12 smoke compartments. This deficient practice could affect visitors, staff and 6 or more residents making use of the administrative offices entrance smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:10 p.m., four, four foot teenage mutant ninja turtle figures stood in the entrance corridor of the administrative offices smoke compartment. The masked figures were constructed of a wood frame and stuffed clothing for the bodies, plastic</p> | K010073 | <p>K073 Since visitors, staff, and residents could be potentially affected by this deficient practice the following corrections will be taken: The Ninja Turtle display was removed from facility. To ensure deficient practice does not recur, all Holiday decorations will be approved by Plant Ops or Administrator to ensure they meet criteria for fire resistance and safety.</p> | 10/30/2014 | |

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| K010130 SS=E | <p>balls for heads. Raffia, a grassy fiber used for crafts and as a packing material made up the hands and necks. The Plant Operations Director acknowledged at the time of observation, he knew of no fire resistance treatment for the construction materials or if the decorative figures were an inherently flame retardant.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain 2 of 2 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 20 or more residents in the dining room adjacent to the kitchen.</p> <p>Findings include:</p> | K010130 | <p>K130 Since residents, staff and visitors could be potentially affected by this deficient practice the following correction will be taken: the two vertical rolling fire doors protectin service windows will be repaired. To ensure deficient practice does not recur, operation of roller doors will be checked when fire drills are conducted. Results from checks will be noted on hard copy of fire drill form by Plant Ops Director or designee. Administrator will review and sign off to ensure compliance.</p> | 12/08/2014 | | | |

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| | <p>Based on observation with the Plant Operations Director on 10/29/14 between 2:25 p.m. and 2:30 p.m., two vertical rolling fire doors protected service windows between the kitchen and adjacent dining room. The door to the enclosure housing the electric mechanisms for operating the fire door on the dishwashing side of the kitchen was wide open, could not be secured closed and had pieces of wiring fall out when the Plant Operations Director tried to secure the door at the time of observation. In addition, it was obvious a button was missing from the front of this enclosure when the door was held closed. The Plant Operations Director said at the time of observation, he thought the operating mechanisms in the enclosure had parts missing or damaged based on the condition of the enclosure. A review of fire equipment inspection and testing reports with the Plant Operations Director on 10/29/13 at 3:05 p.m. did not include a report of testing for the two sets of rolling fire doors. The Plant Operations Director said at the time of record review, he could find no documentation of an inspection of the doors.</p> <p>3.1-19(b)</p> | | | |

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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.</p> <p>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 that 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.</p> | K010144 | <p>K144 Since this deficient practice could potentially affect resident, visitors and staff, the following corrective action will be taken: System from computer program will be printed and reviewed. Calculations based on Kohler 355 KW diesel generator will be provided by vendor and used as reference. To ensure deficient practice does not recur, accurate calculations will be utilized during generator load tests. Hard copy will be place in manual. To monitor Plant Ops and Administrator will sign off.</p> | 12/08/2014 |

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| | <p>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 deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 2:30 p.m., emergency power was supplied by a Kohler 355 KW diesel generator. A review of the Emergency Generator Test - Under Load documentation with the Plant Operations Director on 10/29/14 at 3:30 p.m., the Load was documented at "100%". The Plant Operations Director said at the time of record review, the load was not calculated using the amperage and voltage readings generated during the load test; it was a number brought forward from previous test records. He said he did not think the actual facility load carried on a generator with this large a load capacity was 100%. He confirmed he did not know how to calculate the actual load and would have to consult with the generator contractor to learn about the operation, capabilities, and percent load on the generator during load tests.</p> | | | |

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| K010147 SS=E | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents in the physical therapy and Rosewood smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 10/29/14 at 11:45 a.m., a power strip extension cord was used to supply power to an electric patient treatment bed located in physical therapy; at 2:00 p.m., a power strip rested against the top of the head of the</p> | K010147 | <p>K147 Since this deficient practice could potentially affect residents, visitors and staff the following corrective action will be taken: the treatment bed located in therapy department will be relocated to allow direct connection to A/C receptical. Power surge have been lowered and secured to wall via anchor on perimeter of wall providing no trip hazard, meeting other required criteria to comply with regulation. Facility tour conducted to ensure this was not a common practice. To ensure deficient practice does not recur, Plant Ops Director or designee will check daily to ensure corrections have not been altered. Notes from observations will be noted on Daily Walk Through Sheet.</p> | 12/08/2014 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 10/29/2014 |
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| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD | STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052 |
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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 |
|--------------------|---|---------------|---|----------------------|
| | <p>resident's bed in room 29 on Rosewood to provide power to a television and electric clock. The Plant Operations Director said, at the time of observation, there were no electrical outlets for the equipment on the other side of the room where the power strip might be allowed.</p> <p>3.1-19(b)</p> | | | |