

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 12/29/2014
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/29/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/29/14</p> <p>Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this PSR survey, Signature Healthcare at Parkwood was found in substantial 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</p>	K010000	The facility requests that this plan of correction be considered its' credible allegation of compliance. 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.	

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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K010021 SS=B	<p>to the corridors and Maplewood resident 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 100 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 Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 01/06/15.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</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> <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</p>			

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	<p>installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure doors to hazardous areas in 1 of 12 smoke compartments, such as soiled linen/trash collection rooms 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. This deficient practice affects visitors, staff and 20 or more residents in the Maplewood smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 12/29/14 at 9:05 a.m. with the Plant Operations Director, 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 but the door when fully opened, was dragging against the floor which prevent the door from self-closing. Based on interview at the time of observation, the Plant Operations Director acknowledged the door may need to be trimmed to ensure the door will self-close.</p>	K010021	K0021 Since residents and staff have the potential to be affected, the following corrective action will be taken: the door accessing the Maplewood soiled utility room, used for the collection of soiled linen and trash receptacles was trimmed on lower edge to ensure door self closes into door frame without dragging the floor. To ensure the deficient practice does not recur, Plant Ops Director and/or designee will observe doors daily to ensure doors are functioning properly. Log form will be utilized to track maintenance of doors. This will be reviewed by the Quality Assurance Committee monthly x6mos to ensure compliance.	01/09/2015

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K010130 SS=B	<p>This deficiency was cited on 10/29/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</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> <p>Based on observation with the Plant Operations Director on 12/29/14 at 9:15 a.m., two vertical rolling fire doors protected service windows between the</p>	K010130	<p>Since residents staff and visitors, could be potentially affected by defective rolling fire door between the kitchen and adjacent dining room, the following action will be taken: Parts were ordered and repair is scheduled for Jan. 28th. When repair is completed, documentation of final inspection on both rolling fire doors will be provided. To ensure the 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>	01/28/2015

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	<p>kitchen and adjacent dining room. Based on interview at the time of observation, the Plant Operations Director indicated the rolling fire door for the dish washing window had been repaired but lacked documentation of the final inspection. The rolling fire door for the food service window had not been repaired but parts had been ordered and the facility was waiting for the parts to come in. Once repairs were complete, a final inspection of both doors would be documented. Based on review at the time of interview, the facility produced documentation showing the parts for the remaining rolling fire door had been ordered.</p> <p>This deficiency was cited on 10/29/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				