

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2015
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NAME OF PROVIDER OR SUPPLIER PARK TERRACE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
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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: 09/29/15</p> <p>Facility Number: 000221 Provider Number: 155328 AIM Number: 100267620</p> <p>At this Life Safety Code survey, Park Terrace Village 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 96 and had a census of 65 at</p>	K 0000	<p>K-0000 Please find the attached plan of correction for the recertification and state licensure survey. Performed on September 29th, 2015. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a post survey revisit.</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 0029 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed 09/30/15 - DA</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 1 of 10 hazardous area room doors, such as a room over 50 square feet containing combustible material, was equipped with a self closing device on the door. This deficient practice could affect at least 20 residents, as well as staff and visitors while in the corridor outside the maintenance storage room.</p> <p>Findings include:</p>	K 0029	<p>K 029- Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <p>·Noresidents were affected by this deficient practice. Self closing mechanism wasinstalled on storage room door.</p> <p>How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken?</p>	10/13/2015
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K 0048 SS=F Bldg. 01	<p>Based on observation on 09/29/15 at 12:15 p.m. during a tour of the facility with the Maintenance Supervisor, the corridor door to the maintenance storage room was not provided with a self closing device. This room was over fifty square feet and contained combustible material such as cardboard boxes, paper, plastic and other items. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection</p>	K 0048	<p>·Otherresidents on the hall had the potential to be affected. Self closing door mechanism was installed ondoor. Other storage rooms were inspectedto insure all had self closing devices. Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur? ·Maintenancedirector will inspect all storage rooms to ensure self closing devices areinstalled and functioning properly. How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place? ·FacilityE.D visually inspected door closer to ensure that it was installed andfunctioning. Maintenance director will inspect all storage areas monthly for 6months to ensure self closing door mechanisms are functioning properly. Whatdate will the deficient practice be completed? Oct 13thst,2015</p> <p>K 048- Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient</p>	10/06/2015			

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	<p>of 65 of 65 residents to accurately address all life safety systems such as, the use of the K-class fire extinguisher in the kitchen, and staff response to battery operated smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Fire Procedures in the Emergency Preparedness Plan Manual on 09/29/15 at 10:30 a.m. with the Maintenance Supervisor present, the Fire Procedures did not address the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system,</p>		<p>practice?</p> <ul style="list-style-type: none"> ·Noresidents were affected by the deficient practice. <p>How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Allresident have the potential to be affected by the deficient practice. New Fire protection plan was put into placethat included sections addressing the K-class fire system in dietary, staffresponse to battery operated smoke detectors, and has the written fire safetycode requirements of NFPA 101, 2000 edition section 19.7.2.2 which addressesthe following areas, Use of alarms, Transmission of alarm to the firedepartment, Isolation of fire, Evacuation of immediate area, Evacuation of smoke compartment, Preparation of floors and building for evacuation, extinguishment of fire. <p>Whatmeasures will be put into place or what systemic changes you will make to ensurethat the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·DisasterPreparedness plans were put into place and will be kept at nurses stations andin Maintenance office. These plans willbe updated when necessary to reflect the current arrangements in regards to firesafety. <p>How thecorrective action(s) will</p>				

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K 0066 SS=E Bldg. 01	<p>and staff response to battery operated smoke detectors in most resident sleeping rooms. Furthermore, under "If you discover a fire" at #1 it states "If the fire is small and you know you can put it out quickly, do so using available sources (bed spread, blanket, sheet, fire extinguishers, etc)". Based on interview at the time of record review, the Maintenance Supervisor acknowledged the Fire Procedures was not a complete and accurate plan.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Facility maintenance director will monitor that the new emergency preparedness plan binders are in place daily during routine rounds throughout the facility on a daily basis. Any concerns will be addressed during CQI meeting.</p> <p>What date will the deficient practice be completed? Oct 6th, 2015</p>	

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	<p>smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 2 of 2 areas where cigarettes were smoked. This deficient practice could affect at least 10 residents, as well as staff and visitors at a time while in the smoking areas.</p> <p>Findings include:</p> <p>Based on observations on 09/29/15 between 11:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:</p> <p>a. At the staff smoking area outside the dietary exit there were two open metal containers with a mixture of paper and plastic trash and cigarette butts.</p> <p>b. At the residential smoking area in the enclosed courtyard there was a metal cigarette butt can with a self closing metal lid, however, the can was full of paper trash and cigarette butts. The can was so full the lid would not close. Furthermore, there was large rubber trash barrel full of paper and plastic trash with cigarette butts mixed within. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>	K 0066	<p>K 066- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · No residents were affected by this deficient practice. · New cigarette waste receptacles have been placed in the staff and resident smoking area that have a large waste paper container and a sand filled cigarette butt disposal container on top. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Other residents who smoke with the assistance of staff have the potential to be affected by the deficient practice. Residents who smoke are always monitored by staff and will be instructed to place cigarette butts in the appropriate container when finished. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · New cigarette waste receptacles have been placed in the staff and resident smoking area that have a large waste paper container and a sand filled cigarette butt disposal 	10/13/2015			

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			<p>container on top.</p> <p>·Allstaff who assist residents out to smoke have been in serviced on the importanceof properly disposing of used cigarette butts. Maintenance staff have also been in-service and instructed to do dailychecks of the two main smoking areas for staff and residents.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place? Facility E.D will monitor thesmoking area daily for 4 weeks them weekly for 6 months thereafter to ensurecompliance.</p> <p>Whatdate will the deficient practice be completed? Oct 13th,2015</p>		