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 04/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 W CROSS ST ANDERSON, IN 46011

(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
K010000	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). Survey Date: 04/03/13 Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150 Surveyor: Phillip Komsiski, Life Safety Code Specialist 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. 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, spaces open to the corridors and battery powered smoke detectors in all	K010000	First page of POC 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 it obligation to provide legally and medically required care and 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. If you have any questions, please contact me. Thank you!	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	resident rooms. The facility has a capacity of 101 and had a census of 66 at the time of this survey. 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 which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/05/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	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 Based on observation and interview, the facility failed to ensure 2 of 8 doors leading to hazardous areas such as the Kitchen adjacent to 100 hall were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 16 residents on 100 hall south as well as visitors and staff. Findings include: Based on observation on 04/03/13 during the tour between 12:55 p.m. and 1:20 p.m. with the Maintenance Supervisor, the northeast Kitchen corridor door and the south Kitchen door had closing devices on the doors, however, when the doors were released from an open position the doors failed to close completely and latch into the door frame.	K010029	**K029** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The kitchen corridor door closer was replaced on 4/12/2013 to assure proper latching. The south kitchen door closer was adjusted to assure latching. No negative outcomes had resulted from the finding. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All other doors were latching properly and will be continually monitored for proper closing. Residents are not allowed in the kitchen area. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance staff was in-serviced on 4/19/2013 using a monitoring tool to verify and	04/22/2013

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	Based on interview on 04/03/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen doors would not completely close and latch into their door frames. 3.1-19(b)		document proper latching on a weekly basis. 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? The Maintenance Director will monitor the identified doors 5 times a week for 2 weeks, 3 times a week for 2, 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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K010048 SS=E	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 include the use of the K-class fire extinguisher in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (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 This deficient practice could affect 8 residents in the dining room adjacent to the kitchen as well as staff and visitors. Findings include: Based on a review of the facility's written fire disaster plan on 04/03/13 at 3:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the	K010048	**K 048** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Fire Policy and Procedure Policy was revised on 4/18/2013 to include to A, B, C and K fire extinguishers types and proper use for the types of fires. No negative outcomes/event had occurred prior to this finding. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The employees were educated on 4/19/2013 on the use of K fire extinguisher and the use on cooking oils and fats, location of extinguisher and how to pull the level. The policy was updated on 4/18/2013. Residents are not allowed in the kitchen area. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The employees were educated on 4/19/2013 on the use of K fire extinguisher and the use on cooking oils and fats, location of extinguisher and how to pull the level. The Fire Policy and Procedure was revised on 4/18/2013. 4. How the corrective action will be monitored	04/22/2013

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	kitchen overhead extinguishing system. Based on an interview on 04/03/13 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K-class fire extinguisher. 3.1-19(b		to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place? The fire extinguishers are checked monthly by the maintenance staff. If any changes or needs are identified they are immediately reported to the Administrator. The Fire Policy and Procedure is reviewed annually and as indicated for any updates in fire safety and protection. Any events requiring the use of the fire extinguisher will be reviewed by the Quality Assurance Committee as indicated.	

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K010050 SS=C	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 Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports on 04/03/13 at 3:04 p.m. with Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months from 03/12 to 03/13 indicated the fire alarm system had been	K010050	**K050** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Fire Drill/Actual Form was revised on 4.18.2013 to include transmission to the fire alarm service. The maintenance staff will call and verify that the service has indeed received the signal, the time it was received and the name representative of the service responding to the call. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? A fire drill was conducted on 4/18/2013 to ensure the safety of all residents. The maintenance director called the service to verify the signal transmitted, time the signal was received, and recorded the name of	04/22/2013

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	activated, but verification of the transmission of the signal was not documented. Based on interview on 04/03/13 at 3:05 p.m. it was acknowledged by Maintenance Supervisor, the fire drill reports did not document the transmission of the signal was received by the monitoring station. 3.1-19(b) 3.1-51(c)		the vendor representative. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The fire drill form was updated on 4/18/2013 and will be used with each drill or actual event to assure the fire alarm service receives signal that a facility event is occurring. 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? The Fire Drill/Actual Form will be monitored monthly by the maintenance director. The reports will be reviewed at the monthly Quality Assurance Committee on an ongoing basis.	

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K010144 SS=F	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 document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure. Findings include: Based on review of Generator Log records on 04/03/13 at 3:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load was not documented. Based on interview	K010144	**K 144** 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility updated the Generator Test Log on 4/4/2013 to include the documenting the time of activation to the time of start up of the generator during tests. No negative outcomes/events have been noted in reference to this finding.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Weekly generator checks include the seconds to for the generator to actually start once activation has occurred to assure emergency power in the event of an power outage. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance staff was in-serviced on completing the revised tool on 4/19/2013. Weekly checks of seconds to start load began on 4/4/2013 with all loads starting within 10 seconds.4. How the corrective action will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance	04/22/2013

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	on 04/03/13 at 3:33 p.m. with the Maintenance Supervisor, it was acknowledged the information on the time of load transfer had not been recorded for the past twelve months and the Maintenance Supervisor was unaware it needed to documented. 3.1-19(b)		program will be put into place? The maintenance staff will conduct weekly generator load runs and report any issues immediately to the Administrator. The generator load runs will be reported to the monthly Quality Assurance Committee for 6 months.	