

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(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
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/10/12</p> <p>Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Timberview Health Care Center was found 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.</p> <p>This one story facility was determined to be of Type V (111) construction and sprinklered. The original building was constructed in 1980 with the 300 wing added in 1995. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and</p>	K0000	<p>Allegation of Credible Compliance this plan of correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-2 of this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capacity to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept August 3, 2012, as the date of compliance. The elevator room in the basement was found to not be in compliance with the state law in regard to sprinkler coverage. A sprinkler will be installed in the elevator room by August 3rd. Maintenance will monitor the sprinkler for any blockage of it's spray pattern and to ensure there is no dust or debris on the sprinkler head. Administrator or designee will monitor quarterly to ensure monthly monitoring is being completed. The facility was found to not be in compliance with the state law in regard to smoke detectors coverage. Battery operated smoke detectors will be</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/10/2012
NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(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>with hard wired smoke detectors in resident sleeping rooms in the 300 hall. The facility has a capacity of 180 and had a census of 125 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, or in compliance with state law in regard to smoke detector coverage.</p> <p>Areas where the residents have customary access were sprinklered but one area providing facility services, the elevator room in the basement, was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/17/12.</p>		<p>installed in all residents on the 100 and 200 hall by August 3rd. A weekly monitoring tool will be implemented to follow manufacturer guidelines. Administrator or designee will do a walk through quarterly to ensure smoke detector checks are being completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/10/2012
NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(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	
K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident ' s room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. The facility also failed to ensure all areas providing services to the facility were sprinklered. These two deficient practices could affect 127 residents in the facility.</p> <p>Findings include:</p>	K9999	<p>Allegation of Credible Compliance this plan of correction is prepared and executed because it is required by the provision of State and Federal law and not because Timberview Health Care Center agrees with the allegations and citations listed on pages 1-2 of this statement of deficiency. Timberview Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capacity to ender adequate care. This plan of correction shall also operate as the facility's written credible allegation of compliance, please accept August 3, 2012, as the date of compliance. The elevator room in the basement was found to not be in compliance with the state law in regard to sprinkler coverage. A sprinkler will be installed in the elevator room by August 3rd. Maintenance will monitor the sprinkler for any blockage of it's spray pattern and to ensure there is no dust or debris on the sprinkler head. Administrator will monitor quarterly to ensure monthly monitoring is being completed. The facility was found to not be in compliance with the state law in regard to smoke detectors coverage. Battery operated smoke detectors will be</p>	08/03/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(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>a. Based on observations with the Assistant Maintenance Director on 07/10/12 from 1:20 p.m. to 2:05 p.m., the following resident rooms were not provided with smoke detectors: 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 118, 119, 120, 121, 122, 123, 125, 126, 127, 128, 129, 130, 201, 202, 203, 204, 205, 206, 207, 208, 210, 212, 213, 214, 217, 218, 220, 221, 224, 225, 227, 228, 229, 230, 231. Based on interview during the time of observations, the Assistant Maintenance Director acknowledged not all the resident rooms were provided with smoke detectors.</p> <p>b. Based on observation with the Maintenance Assistant at 2:05 p.m. on 7/10/12, the basement electrical room housing components of the facility's elevator was not sprinklered. Three of the walls were cinder block construction, however, the wall which contained the entrance door to the room was not of the same material. There was no evidence presented during the tour that the construction materials of the wall containing the door met requirements for a 2 hour separation, or that the door to the room was a two hour rated fire door. The Maintenance Assistant present during the observation confirmed the room was not sprinklered.</p>		<p>installed in all residents on the 100 and 200 hall by August 3rd. A weekly monitoring tool will be implemented to follow manufacturer guidelines. Administrator will do a walk through quarterly to ensure smoke detector checks are being completed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(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
	3.1-19(ff)			