

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2012
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303
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K0000	<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: 10/29/12</p> <p>Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Parkview Nursing 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.</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 smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident sleeping rooms. The facility has</p>	K0000	<p>Please find the attached plan of correction for the visit from your office on 10/29/2012, Survey Event ID: UBKQ21, in accordance with state law. We respectfully request that your office will accept this plan as our facilities compliance and that you will consider a desk review in view there were no tags that were deemed to be actual harm or immediate jeopardy. If you have any additional questions, please contact me at 765-289-3341. Thank your time and attention to this matter.</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.

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	<p>a capacity of 81 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services are sprinklered, except one detached house and garage used for facility storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 SS=E	<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 1¾ 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 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. Based on observation and interview, the facility failed to ensure that 1 of 15 corridor doors on 200 hall east was smoke resistive. This deficient practice could affect 22 residents on 200 hall east as well as visitors and staff.</p> <p>Finding include:</p> <p>Based on observation on 10/29/12 at 1:45 p.m. with the Maintenance Supervisor, the Ice Machine room door on 200 hall east had a twenty inch by twenty inch metal transfer grill installed in the bottom half of the corridor door which was not smoke resistant. Based on interview on 10/29/12 at 1:50 p.m. with the Maintenance Supervisor, it was acknowledged the door to the Ice</p>	K0018	The Smoke Resistive Door was ordered and installed on 11/09/2012 to replace the door found defective. All Resident room doors in the facility were inspected to ensure that they meet Life Safety Code Standard K018. The Door that leads to where the Ice Machine is located was replaced with an appropriate door for that location.	11/09/2012			

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	<p>Machine room on 200 hall east had a four hundred square inch transfer grill which would allow the passage of smoke from the Ice Machine room to the escape route corridor.</p> <p>3.1-19(b)</p>			

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K0038 SS=D	<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 observations and interview, the facility failed to ensure exit access was arranged so 2 of 11 exit access doors on Office hall were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 says means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 1 to 2 staff members in each room as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 during the tour between 12:22 p.m. to 12:33 p.m. with the Maintenance Supervisor, the Director of Nursing (DON) office door on Office hall west and the Conference room door on Office hall west had a door knob lock and a deadbolt lock on the doors leading out the rooms. Based on interview on 10/29/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged there were two locking devices on all the aforementioned nonresident room doors.</p> <p>3.1-19(b)</p>	K0038	The Director of Nurses Office and the Conference Room doors that had dead bolt locks were removed. The Maintenance Director has inspected all other facility office doors to ensure that only one lock was in place per Life Safety Code K0038.	10/29/2012			

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K0048 SS=C	<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 include the use of kitchen fire extinguishers 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 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 16 residents in the adjacent smoke compartment, as well as staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a record review of the facility's written fire disaster plan on 10/29/12 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</p>	K0048	Sinage has been placed in the Kitchen that reads, "Use Automatic Hood Suppression System Prior to Utilizing a K-Class Fire Extinguisher". Added this information to the Emergency Preparedness Manual.	11/20/2012			

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	<p>relationship with the use of the kitchen overhead extinguishing system. Based on an interview on 10/29/12 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.</p> <p>3.1-19(b)</p>			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 at 1:10</p>	K0051	The Fire Alarm System Circuit Breaker that had not been marked red to identify it as a Fire Alarm System Circuit Breaker was painted red and labeled as such on the Fire Alarm Circuit Control Panel on 11/08/2012.	11/08/2012			

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	<p>p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker could be located, however, the breaker did not have red marking and it was not identified as Fire Alarm Circuit Control. Based on interview on 10/29/12 at 1:15 p.m. with the Maintenance Supervisor, it was acknowledged the fire alarm electrical breaker was not marked in red or properly identified.</p> <p>3.1-19(b)</p>			

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K0070 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review; the facility failed to enforce 1 of 1 Portable Heating Unit policies which prohibits the use of portable heating units used in nonsleeping staff areas. This deficient practice could affect 3 residents observed in Physical Therapy as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/29/12 at 1:00 p.m. with the Maintenance Supervisor, the Physical Therapy office on 200 west hall contained one portable space heater which was plugged in, but not operating, at the time of observation. Based on interview on 10/29/12 at 1:05 p.m. with the Maintenance Supervisor, it was acknowledged the portable heating unit was present and plugged in, though not in use. Based on review of the Portable Heating Unit policy on 10/29/12 at 3:45 p.m. with the Maintenance Supervisor, it was confirmed the portable heating unit policy prohibited the use of portable heating units anywhere in the facility.</p>	K0070	The Maintenance Diirector removed the portable space heater from Therapy Department on 10/29/2012. The entire facility has been educated that there is never to be a protable space heater in any area of the facility. This informaton has also been added to the Emergency Prepardness Manual.	10/29/2012			

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	3.1-19(b)			