

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 07/26/2012
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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 Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/26/12</p> <p>Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Parkview Nursing Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).</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 all resident rooms. The facility has a capacity of 81 and had a census of 76 at the time of this survey.</p>	K0000	<p>K000 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Parkview Nursing Center desires this Plan of Correction to be considered the facilities Allegation of</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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	<p>The facility was found in compliance with state law in regard to smoke detector coverage and not in compliance with state law in regard to sprinkler coverage.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>The facility had one detached house and garage for facility storage which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist–Medical Surveyor on 07/31/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>Compliance. Compliance is effective July 30, 2012.</p> <p>Please find the attached plan of correction for a visit from your office on July 26, 2012, Survey Event ID# UTLB21, in accordance with state law. We respectfully request that your office will accept this plan as our facility's 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.</p>		

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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 ensure 1 of 2 outside canopies were provided with automatic sprinkler heads to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 12 residents in the main dining room which is adjacent to the southwest entrance as well as visitors or staff.</p>	K9999	<p>1.The corrective action taken for those 12 residents who were in the main dining room was to remove the canopy from the southwest entrance. None of the residents were in the hallway near the awning.</p> <p>2.No other residents were affected by the canopy that was removed.</p> <p>3.The entire facility was assessed by the maintenance director to determine no other canopy's were attached to the facility that extended more than 4 feet from the building. No other residents were affected by this canopy.</p> <p>4.The facility removed the canopy from the facility on July 30, 2012.</p> <p>5.7-30-2012</p>	07/30/2012	

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	<p>Findings include:</p> <p>Based on observation on 07/26/12 at 2:00 p.m. with the Maintenance Supervisor, the canopy outside the southwest entrance was attached to the building and was not provided with sprinkler head coverage. The eight foot overhang outside the southwest entrance was attached to the building and constructed of aluminum supports with a vinyl roof. Based on interview on 07/26/12 concurrent with the observation with the Maintenance Supervisor, it was acknowledged there was no sprinkler head present for the aforementioned canopy to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(ff)</p>						