

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/26/2013
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/30/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/26/13</p> <p>Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this PSR survey, Owen Valley Health Campus 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 with 410 IAC 16.2.</p> <p>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, in spaces open to the</p>	K010000	The submission of this plan of correction does not indicate an admission by Owen Valley Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to our residents of Owen Valley Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance for this facility. It is thus submitted as a matter of statute only. We respectfully request from the Department paper compliance. All corrections have been submitted to this POC as attachments.	

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>corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 113 and had a census of 98 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services are sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 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 1¼ 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 2 of 3 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect 22 residents on B hall and 20 residents on D hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 12/26/13 during the tour between 12:00 p.m. and 2:00 p.m. with the Administrator in Training, the following sets of double leaf corridor doors required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p>	K010018	K 0018 Corrective Measures were made immediately to the double leaf corridor doors to assure the doors would latch independently into their door frames. Panic Hardware was installed on double leaf doors leading into main dining room adjacent to D Hall. Latches were also installed on double leaf doors leading into main dining room adjacent to D Hall to assure each door latches independently and securely into door frame. B hall double leaf corridor doors were corrected by installing latches to assure both doors close independently and securely into the door frame. Doors will be checked daily 5 X's week X 1 month, 3 X's week X 6 months during maintenance rounds to assure doors latch independently and securely into door frames by	01/13/2014

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	<p>a. The double leaf doors on B hall next to room # 100.</p> <p>b. The double leaf doors leading into the Main dining room adjacent to D hall. Based on telephone interview on 12/26/13 with the Maintenance Supervisor after the time of observation, it was acknowledged he was unaware the aforementioned corridor doors needed to latch independently into their door frame.</p> <p>This deficiency was cited on 10/30/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		Director of Plant Ops or Designee. Findings to be reviewed with Executive Director and forwarded to QA for monthly review and random checks to be conducted by Home Office Support Personnel. Date completed 1/13/14		