

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2013
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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720
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(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
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K010000	<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: 03/07/13</p> <p>Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pine Haven Health and Rehabilitation 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), and 410 IAC 16.2. The original two story section and Stocker Addition I were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This building consists of two sections; the original portion of the building a two story, fully sprinklered building determined to be of Type I (332) construction, and the Stocker Addition I a</p>	K010000		
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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>one story, fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms in the Stocker Addition I, plus battery operated smoke detectors in all resident sleeping rooms in the original two story section. The facility has a capacity of 120 and had a census of 73 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except, two detached buildings used for facility storage. Furthermore, a ten and a half foot by nine and a half foot canvas canopy attached to the building outside the Activity Room exit door, and the elevator equipment room were not provided with sprinkler coverage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/13/13.</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=B	<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 1 of over 100 doors to the corridor was equipped with a positive latch and would latch into the door frame. This deficient practice could affect up to 10 residents at a time, as well as staff and visitors while in the Activity room.</p> <p>Findings include:</p> <p>Based on observation on 03/07/13 at 11:30 a.m. during a tour of the facility with the Maintenance Director, the door from the corridor into the Activity room was not provided with a positive latch, furthermore, the Activity room was not provided with a smoke detector. This was acknowledged by the Maintenance</p>	K010018	<p>K018</p> <p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice:</i></p> <p><i>A positive latch has been installed on</i></p> <p><i>The Activity room door</i></p> <p><i>How other residents having the potential to be affected will be</i></p>	04/06/2013			

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	Director at the time of observation. 3.1-19(b)		<p><i>identified and what corrective action will be taken:</i></p> <p>No other residents were found to be affected.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</i></p> <p>Maintenance will continue to audit Facility for any other doors needing Positive latches</p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place:</i></p> <p>N/A</p>		

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K010038 SS=B	<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 observation and interview, the facility failed to ensure 2 of 2 doors to the Stocker I courtyard were provided with signs indicating "NO EXIT". LSC 7.10.8.1 requires any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. Such sign shall have the word NO in letters 2 inches high with a stroke width of 3/8 inch and the word EXIT in letters 1 inch high, with the word EXIT below the word NO. This deficient practice could affect any of the 11 residents, as well as staff and visitors in the Stocker I addition.</p> <p>Findings include:</p> <p>Based on observations on 03/07/13 between 12:15 p.m. and 12:45 p.m. during a tour of the facility with the Maintenance Director, the two doors from the Stocker I lobby area and connecting corridor to the Stocker I courtyard were not provided with signs stating "NO EXIT". This was acknowledged by the Maintenance Director at the time of each observation.</p>	K010038	<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice: Signs stating "No Exit" were placed on the two doors to the Stocker II courtyard and the Stocker II Dining room courtyard. How other residents having the potential to be affected will be identified and what corrective action will be taken: No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: N/A How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>	04/06/2013			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 areas outside and attached to the building and constructed of partially combustible material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs exceeding four feet in width. This deficient practice could affect up to 51 residents, as well as staff and visitors from the original two story portion of the facility while using the large original courtyard.</p> <p>Findings include:</p> <p>Based on observation on 03/07/13 at 12:50 p.m. during a tour of the facility with the Maintenance Director, there was a ten and a half foot by nine and a half</p>	K010056	<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice: The Canopy has been removed. A supervised Automatic sprinkler system will be installed as soon as Contractor can provide the work. How other residents having the potential to be affected will be identified and what corrective action will be taken: No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: N/A How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>	06/01/2013			

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	<p>foot canvas canopy attached to the building in the original large courtyard near the Activity Room exit door. There was no sprinkler coverage provided under the canopy. Based on interview at the time of observation, the Maintenance Director said there was no documentation available to show the canopy was flame retardant and also acknowledged there was no sprinkler coverage under the canopy.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 6 smoke compartments in the original portion of the facility. This deficient practice could affect mostly staff while in the elevator equipment room since the elevator equipment room is protected by a two hour fire barrier and the door to the elevator equipment room opens only to the outside.</p> <p>Findings include:</p> <p>Based on observation on 03/07/13 at 1:15 p.m. during a tour of the facility with the Maintenance Director, the elevator equipment room was not provided with sprinkler coverage. This was acknowledged by the Maintenance</p>						

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	Director at the time of observation. 3.1-19(b)			

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/07/13 between 11:00 a.m. and 1:15 p.m. during a tour of the facility with the Maintenance Director, the two spare sprinkler head cabinets in the facility had six spare sprinkler heads each, however, there was only one green vial upright sprinkler head in the Stocker I riser room sprinkler cabinet and no quick response upright sprinkler heads in either riser room sprinkler cabinet. The remaining sprinkler heads were a mixture of other pendent type sprinkler heads and upright</p>	K010062	<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice: One green vial sprinkler head and Two quick response sprinkler heads Were added to the sprinkler cabinet. How other residents having the potential to be affected will be identified and what corrective action will be taken: No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: N/A How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>	04/06/2013			

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	<p>type sprinkler heads. Green vial upright sprinkler heads and quick response sprinkler heads were observed in both portions of the facility during the tour. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>			

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K010144 SS=C	<p>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.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include: Based on review of the facility's</p>	K010144	<p><i>The corrective action accomplished</i></p> <p><i>for those residents found to have been affected by the deficient practice:</i></p> <p><i>The maintenance director will Test weekly and document the Generator being exercised under Operating conditions or not less Than 30 percent of the EPS nameplate</i></p> <p><i>Rating for a minimum of 30 minutes..</i></p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i> No other residents were found to be affected.</p> <p><i>What measures will be put into place or what systemic changes will</i></p>	04/06/2013			

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	<p>Generator Log on 03/07/13 at 10:45 a.m. with the Maintenance Director present, the generator log form documented the generator was tested weekly under load, however, there was no documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since March of 2012. During an interview at the time of record review, the Maintenance Director confirmed the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>		<p><i>be made to ensure the deficient practice does not recur: Maintenance will test and Document on generator log</i></p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>		

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K020000	<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: 03/07/13</p> <p>Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pine Haven Health and Rehabilitation 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), and 410 IAC 16.2. The Stocker Addition II was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>This portion of the facility was one story and determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in corridors, areas</p>	K020000					

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	<p>open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 73 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except, two detached buildings used for facility storage. Furthermore, a ten and a half foot by nine and a half foot canvas canopy attached to the building outside the Activity Room exit door, and the elevator equipment room were not provided with sprinkler coverage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720			
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K020038 SS=B	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 doors to the Stocker II courtyard and Stocker II Dining Room courtyard were provided with signs indicating "NO EXIT". LSC 7.10.8.1 requires any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. Such sign shall have the word NO in letters 2 inches high with a stroke width of 3/8 inch and the word EXIT in letters 1 inch high, with the word EXIT below the word NO. This deficient practice could affect any of the 11 residents, as well as staff and visitors in the Stocker II addition.</p> <p>Findings include:</p> <p>Based on observations on 03/07/13 between 12:15 p.m. and 12:45 p.m. during a tour of the facility with the Maintenance Director, the two doors from the Stocker II main courtyard and the single door from the Stocker II Dining Room courtyard were not provided with signs stating "NO EXIT". This was acknowledged by the Maintenance</p>	K020038	<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice: Signs stating "No Exit" were placed on the two doors to the Stocker II courtyard and the Stocker II Dining room courtyard. How other residents having the potential to be affected will be identified and what corrective action will be taken: No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: N/A How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>	04/06/2013			

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	Director at the time of each observation. 3.1-19(b)				

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K020062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/07/13 between 11:00 a.m. and 1:15 p.m. during a tour of the facility with the Maintenance Director, the two spare sprinkler head cabinets in the facility had six spare sprinkler heads each, however, there was only one green vial upright sprinkler head in the Stocker I riser room sprinkler cabinet and no quick response upright sprinkler heads in either riser room sprinkler cabinet. The remaining sprinkler heads were a mixture of other pendent type sprinkler heads and upright</p>	K020062	<p><i>The corrective action accomplished for those residents found to have been affected by the deficient practice: One green vial sprinkler head and Two quick response sprinkler heads Were added to the sprinkler cabinet. How other residents having the potential to be affected will be identified and what corrective action will be taken: No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: N/A How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>	04/06/2013
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	<p>type sprinkler heads. Green vial upright sprinkler heads and quick response sprinkler heads were observed in both portions of the facility during the tour. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>			

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K020144 SS=C	<p>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.</p> <p>Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's</p>	K020144	<p><i>The corrective action accomplished</i></p> <p><i>for those residents found to have been affected by the deficient practice:</i></p> <p><i>The maintenance director will Test weekly and document the Generator being exercised under Operating conditions or not less Than 30 percent of the EPS nameplate</i></p> <p><i>Rating for a minimum of 30 minutes..</i></p> <p><i>How other residents having the potential to be affected will be identified and what corrective action will be taken:</i> No other residents were found to be affected.</p> <p><i>What measures will be put into place or what systemic changes will</i></p>	04/06/2013
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	<p>Generator Log on 03/07/13 at 10:45 a.m. with the Maintenance Director present, the generator log form documented the generator was tested weekly under load, however, there was no documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since March of 2012. During an interview at the time of record review, the Maintenance Director confirmed the weekly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>		<p><i>be made to ensure the deficient practice does not recur: Maintenance will test and Document on generator log</i></p> <p><i>How the corrective action will be monitored, i.e., what quality assurance program will be put into place: N/A</i></p>		