

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155746	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2014
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CONSTITUTION DR FRANCESVILLE, IN 47946
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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: 08/28/14</p> <p>Facility Number: 000539 Provider Number: 155746 AIM Number: 100267280</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Parkview Haven 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 facility was located on one wing of a one story building determined to be of Type III (211) construction which was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The</p>	K010000	<p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in the requirements of participation or that the corrective action was necessaryWe are requesting a</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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K010029 SS=E	<p>facility has the capacity for 42 and had a census of 41 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached maintenance garage which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic closer's for doors in 2 of 4 smoke</p>	K010029	<p>desk review to clear any and all proposed or implemented remedies that have been presented to date</p> <p>Corrective Action: A contractor was called and installed automatic door closures on both doors on 9-5-14 Identification:</p>	09/17/2014			

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	<p>compartments providing access to hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the same smoke compartment as the main dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 08/28/14 at 11:45 a.m., the door separating the five and one half foot by eleven foot physical therapy supply storage room had no self closing devices. The room stored paper, plastic and cardboard wrapped supplies and a mattress. The maintenance director said at the time of observation, he didn't know doors to these storage rooms were required to self close.</p> <p>b. Based on observation with the maintenance director on 08/28/14 at 12:30 p.m., the self closer for the door separating the eight by eight foot medical records storage room from the corridor had been disabled by removing the self closer arm. The maintenance director said at the time of observation, he was</p>		<p>Rounds were made by the Maintenance Supervisor to make sure there were no other doors that were lacking automatic closures No other automatic closures were needed System change: Maintenance will do rounds on a weekly basis to check all doors that need automatic closures ensuring they are on the doors and working properly All Staff inservice to be held 9-17-14 to instruct on need to monitor for lack of automatic door closures and that they are intact and functioning if problems noted to notify maintenance immediately Monitoring: The Administer confirmed that the automatic door closures were installed All door inspections done on weekly maintenance rounds will be reviewed at the Quality Assurance Meeting monthly beginning 9-18-14 and any issues will be corrected immediately The QA committee will determine the need for further monitoring. DOC: 9-17-14</p>				

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K010068 SS=E	<p>unaware the self closer had been disabled.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and 10 or more residents in the Zone 3 smoke compartment which included the resident beauty shop and TV room.</p>	K010068	<p>Corrective Action: A contractor was called to inspect laundry room and install vent Identification: Facility rounds were complete on 8-29-14 to look for any other areas that may need outside air ventilation, no other areas were identified Systemic change: Contractor installed vent in laundry room to provide for fresh air intake on 9-11-14 Monitoring: Administrator confirmed the installation of the vent in the laundry room to provide for fresh air intake The Quality Assurance team will assess the need for further monitoring on 9-18-14 DOC: 9-11-14</p>	09/11/2014

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K010130 SS=F	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/14 at 12:35 p.m., the laundry room had two, gas fueled dryers with no fresh air intake. The maintenance director said at the time of observation, he saw no means to provide fresh air for the two gas fueled dryers.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review, and interview, the facility failed to ensure 3 of 3 pressure vessels such as water heaters and a boiler had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/14 at 1:25 p.m., two service water heaters and a boiler in the mechanical room had certificates of inspection which expired</p>	K010130	<p>Corrective Action: Maintenance Director located the certificate of Inspections with the expiration dates of 1-17-16 and 6-10-15 for boiler and water heaters (see attached)</p> <p>Identification: Certifications were located behind glass on wall beside the holding tank in the boiler room</p> <p>System change: Maintenance has located current certifications and will put on maintenance schedule to assure they do not expire.</p> <p>Monitoring The Administrator confirmed certifications were in place and not expired. A review will be done at the Quality Assurance meeting on 9-18-14 to determine need for further monitoring.</p> <p>DOC: 8-29-14</p>	08/29/2014			

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K010147 SS=E	<p>07/1/12 and 03/23/12. The maintenance director said at the time of observation, he had no record of a current certification for the vessels and could not say whether an inspection had been done.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 4 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice could affects visitors, staff and 10 or more residents on he East hall.</p>	K010147	<p>Corrective action: Items were removed from East Hall storage room freeing up access to electrical panels on 8-28-14</p> <p>Identification: Rounds were completed of facility on 8-28-14 to ensure all electrical panels/equipment were easy to access and free from being blocked</p> <p>System change: Maintenance will complete rounds weekly checking all electrical panels/equipment making sure they are all free from being blocked and that they are easy to access All staff to be inserviced on 9-17-14 on keeping items from blocking all electrical panels/equipment</p> <p>Monitoring: The Administer confirmed that all electrical panels/equipment were free from being blocked and they were easily accessed.</p>	09/17/2014

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/14 at 12:10 p.m., the East hall storage room housed two electrical panels. Access was blocked by a walker, computer stand, and chair stored in front of the electrical panels. The maintenance director acknowledged at the time of observation, the stored equipment would have to be moved to access the electrical panels.</p> <p>3.1-19(b)</p>		<p>Weekly maintenance rounds will be reviewed at the monthly QA meetings beginning 9-18-14. The QA committee will determine the need for further monitoring.</p> <p>DOC: 9-17-14</p>		