| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 10/26/2012 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374 | |

| (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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| K0000 | A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 10/26/12<br><br>Facility Number: 011387<br>Provider Number: 155762<br>AIM Number: 200853180<br><br>Surveyor: Mark Bugni, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Forest Park 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 18, New Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all | K0000 | K000 Preperation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusion set forth on the Statement of Deficiencies.This plan of correction is prepared and executed solely because it is required by the position of Federal and State Law.This plan of correction serves as the allegation of compliance effective November 25, 2012 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | resident rooms. The facility has a capacity of 107 and had a census of 68 at the time of this visit.<br><br>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/31/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K0062 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br>Based on observation and interview, the facility failed to ensure 6 of over 300 sprinkler heads in the facility were maintained. This deficient practice 58 residents who could be seated in the main dining room, located adjacent to the kitchen.<br><br>Findings include:<br><br>Based on observations on 10/26/12 during a tour of the facility from 9:30 to 2:15 p.m. with the director of plant operations, the kitchen had two sprinklers by the spice rack and two sprinklers by the small refrigerator room and two sprinklers in the boiler room near the maintenance shop with escutcheons hanging one inch from the ceiling, exposing a gap in the drywall around the sprinkler pipe penetrations. This was verified by the director of plant operations at the time of observations and confirmed by the administrator at the 1:55 p.m. exit conference on 10/26/12.<br><br>3.1-19(b) | K0062 | **K 062 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The following corrections were made to the 2 sprinklers in the kitchen by the spice rack, 2sprinklers by the small refrigerator room and 2 sprinklers in the boiler room near the maintenance shop: ensure a tight fit to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling: the Escutcheon will be adjusted to a tight fit to the drywall. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: This alleged deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.<br>**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure | 11/25/2012 |

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| | | | compliance: observe the sprinkler heads identified above to ensure a tight fit remains to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur** The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: observe the sprinkler head identified above to ensure a tight fit remains to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |