

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER NORTHVIEW HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
E 0000 Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 04/09/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/20/24</p> <p>Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150</p> <p>At this PSR Emergency Preparedness survey, Northview Health and Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 101 certified beds. At the time of the PSR survey, the census was 68.</p> <p>Quality Review completed on 05/22/24</p>			E 0000	<p>This Plan of Correction constitutes the written allegation of compliance for deficiency cited May 20th, 2024. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p>		
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/09/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 05/20/24</p> <p>Facility Number: 000562 Provider Number: 155718 AIM Number: 100267150</p>			K 0000	<p>This Plan of Correction constitutes the written allegation of compliance for deficiency cited May 20th, 2024. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kimberley Carlson

HFA

05/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155718		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER NORTHVIEW HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP COD 1235 W CROSS ST ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0222 SS=E Bldg. 01	<p>At this PSR Life Safety Code survey, Northview Health and Living was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 one-story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in all resident rooms in the building. The facility has a capacity of 101 and had a census of 68 at the time of this PSR visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for two detached garages used for storage which were not sprinklered.</p> <p>Quality Review completed on 05/22/24</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155718		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER NORTHVIEW HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP COD 1235 W CROSS ST ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155718		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER NORTHVIEW HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP COD 1235 W CROSS ST ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 2 of over 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents if needing to exit the facility.</p> <p>Findings include:</p> <p>Based on observations and interviews during a tour of the facility with the Administrator on 05/20/24 between 12:30 p.m. and 1:15 p.m., the (1)</p>			K 0222	<p>K 222 (SS E) What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice: A sign will be posted at each egress with instructions on how to get out the door. Code will be easily visible for staff and visitors to exit both doors mentioned. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken: Residents were not affected by this deficient practice due door was able to open with code, though code was not posted appropriately. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Signage has been placed at each egress noted with clear directions on exiting through those doors.</p>		05/30/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155718		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER NORTHVIEW HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP COD 1235 W CROSS ST ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>Exit door from the lounge on the 300 Hall and (2) the Therapy Exit on the 300 Hall each equipped with 15 second delayed egress, failed to actuate when tested. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Administrator stated that they had the doors worked on and they would need to have the contractor come back out.</p> <p>This finding was acknowledged by the Administrator at the time of discovery and again at the exit.</p> <p>This deficiency was cited on 04/09/24. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				<p>Sign to be changed on the first day of the month per maintenance staff. (See Attachment) How will the corrective action be monitored to ensure the deficient practice will not recur? Sign with direction will be posted at each egress on the first day of the month. Visual checks will be done weekly to ensure the sign is in good condition and easy to read by staff and visitors. Will be monitored and reviewed at QAPI x 6 months. Date completed: 5-30-2024</p>		