STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155746	A. BUILDING -- B. WING	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/03/23 Facility Number: 000539 Provider Number: 155746 AIM Number: 100267280 At this Emergency Preparedness survey, Parkview Haven was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 42 certified beds. At the time of the survey, the census was 41. Quality Review completed on 05/08/23	E 0000	The facility shares a common wall with the state required fire resistance rating.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/03/23 Facility Number: 000539 Provider Number: 155746 AIM Number: 100267280 At this Life Safety Code survey, Parkview Haven was found not in compliance with Requirements	K 0000	The facility shares a common wall with the state required fire resistance rating.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon McKinley	Administrator	05/19/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and the 2012 edition of the National Fire Protection Association 99, Health Care Facilities Code. This facility was located on one wing of a one story building determined to be of Type V (111) construction which was fully sprinklered. The facility is attached to a Assisted Living Facility, with which it is shares a common wall. The facility could not confirm the occupancies were separated by a Fire Wall with a Two Hour Fire Resistive Rating, and as a result, the entire facility was surveyed as an Existing Health Care Occupancy. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The building is fully protected by a 350 kW diesel-powered generator. The facility has the capacity for 42 and had a census of 41 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached maintenance garage which was not sprinklered. Quality Review completed on 05/08/23			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited			

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	155746	A. BUILDING 01 B. WING	05/03/2023

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PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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	cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation, record review and interview, the facility failed to maintain 1 of 1 kitchen commercial cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) as required by NFPA 101, Life Safety Code (2012), Section 9.2.3. NFPA 96, Section 10.2.6 states that automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A(09), Standard for Wet Chemical Extinguishing Systems where applicable. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on record review with the Maintenance Technician #1 on 05/03/23 between 10:29 a.m. and 12:50 p.m., The Kitchen Suppression System Inspection dated 01/12/23 stated that the master tank and control head was due for a 12-year hydrostatic test, but was not a part of the contract for the kitchen suppression system.	K 0324	Parkview Haven Plan of Correction for Life Safety Survey Dated May 3 2023 Prefix Tag K 324 Cooking Facility 1. What corrective Action will be accomplished for those residents found to be affected by the deficient practice? After investigating it was found that the inspection report from Brenneco Fire Protection dated 07/2022 (semiannual inspection) stated Hydrostatic Test was performed in 2016. (See attached inspection report for July 2022). After checking the actual tanks the Master Cylinder had an inspection sticker showing Hydro test was performed in 2016 (see attached photo #1. After checking Slave Cylinder it was discovered that tank did not have a sticker of Hydrostatic inspection but the date of Manufacture being 2011(see attached photo #2. This	05/21/2023

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	Based on interview at the time of record review, the Maintenance Technician #1 acknowledged the aforementioned condition and stated that the 12-year test had not been scheduled to be done as of the time of survey. Findings were discussed with the Maintenance Technician #1 at exit conference. 3.1-19(b)		being that tank will require Hydro test in 2023 but is not out of Hydro. Brenneco Fire Protection Service Annual January Inspection (see attached January 2023report) report shows one Tank out of Hydro but that is not the case. Because of the confusion we are having both Cylinder's Hydrostatic Tested on date 22 May 2023. 2. How other resident having the potential to be affected by same deficient practice will be identified and what corrective action will be taken. No residents were affected by this deficient practice, however all residents have the potential to be affected by this deficient practice. 3. Measures that will be put in place and what systemic changes will be made to insure that deficient practice doe not recur. A new Task has been written on Tels to have both Slave and Master Cylinders checked for inspection Tags and affix to cylinder annually. Comments from Task work history will be checked against Fire Protection Service Company report.	

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			4. How the corrective action be monitored to ensure deficient practice will not recur. Annual inspection of Hood Fire Suppression system will be monitored by Administrator and Maintenance Director/designee for completion via TELS maintenance program. Direct Supply Tels send weekly report to facility for review. 5. Date the systemic changes for deficiency will be completed. Per Email attachment 1 and 2 from Brenneco Fire Protection they will be on site to preform 12 year Hydrostatic Inspection on 05/22/2023	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Technician #1 on 05/03/23 at 10:03 a.m., there was no monthly or weekly inspections of the wet and dry pipe sprinkler system's gauges and valves for the months of May 2022 to October 2022. During an interview at the time of record review, the Maintenance Technician #1 stated that all of the inspections were completed, but documentation could not be found at the time of the survey. Findings were discussed with the Maintenance Technician #1 at exit conference.	K 0353	Parkview Haven Plan of Correction for Life Safety Survey Dated May 3 2023 Prefix Tag K 353 Inspection of Gauges 1. What corrective Action will be accomplished for those residents found to be affected by the deficient practice? Tasks were set in place in Oct 2022 for this requirement to insure this requirement is performed. Direct Supply TELS is used to monitor these task on a weekly bases and copies of all reports are kept in TELS cloud to insure reports are not lost in the future. 2. How other resident having the potential to be affected by same deficient practice will be identified and what corrective action will be taken. No resident was affected by this deficient practice, however, all residents have the potential to be affected by this deficient practice.	05/21/2023

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	3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Maintenance Technician #1 on 05/03/23 between 12:51 p.m. and 2:03 p.m., in the kitchen area next to the maintenance hall, a dislodged escutcheon plate left a 1 inch gap between the ceiling and the escutcheon plate. Furthermore, the sprinkler head in the kitchen next to the freezer had a 1 inch hole in the ceiling tile next to the sprinkler head. Based on interview at the time of observation, the Maintenance Technician #1 stated that he was unaware of the deficiency and acknowledged the aforementioned deficiency. Findings were discussed with the Maintenance Technician #1 at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 6 sprinkler heads in the kitchen and 3 of 5 sprinkler heads in laundry were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign		3. Measures that will be put in place and what systemic changes will be made to insure that deficient practice doe not recur. Weekly Tasks thru TELS maintenance program are currently in use for Control Valve Inspection, Nitrogen Cascade system, Dry Sprinkler Gauge check and Wet System gauge checks. See attached Tasks 1-4 for these required Task. 4. How the corrective action be monitored to ensure deficient practice will not recur. Assigned weekly task will be monitored by the Administrator/ Maintenance Director/Designee thru TELS maintenance program. Direct Supply TELS sends weekly completion reports for reviewed weekly/ongoing to ensure this deficient practice does not recur. 5. Date the systemic changes for deficiency will be completed. 5-21-2023 Parkview Haven Plan of	

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	materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to approximately 15 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Technician #1 on 05/03/23 between 12:51 p.m. and 2:03 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) Two sprinkler heads in the kitchen next to the dishwashing area were loaded with dirt and could not see the color of the bulb. b) Three sprinkler heads in the laundry room were covered with dust and lint which left the bulb not completely visible. Based on interview at the time of observation, the Maintenance Technician #1 confirmed the aforementioned sprinkler heads showed dirt accumulation and loading. 3.1-19(b)		Correction for Life Safety Survey Dated May 3 2023 Prefix Tag K 353 Sprinkler Head and Escutcheon 1. What corrective Action will be accomplished for those residents found to be affected by the deficient practice? All sprinkler Heads in affected area will be clean this will include all heads in Dietary and Laundry (see work orders attachment's). All Escutcheon in affected area will also be cleaned and checked for proper fit to ceiling. Ceiling drywall will be repaired at entrance to dietary from maintenance hall (see photo 1). Ceiling tile will be replaced above Freezer in two location (see photo 2 and 3). 2. How other resident having the potential to be affected by same deficient practice will be identified and what corrective action will be taken. No Resident was affected by this deficient practice, however, all residents have the potential to be affected by this deficient practice.	

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			3. Measures that will be put in place and what systemic changes will be made to insure that deficient practice do not recur. A Task on Direct supply TELS has been written to have Sprinkler heads inspected and escutcheons check on a semiannual basis. See TELS Task attachment. 4. How the corrective action be monitored to ensure deficient practice will not recur. Assigned semiannual task will be monitored by Administrator/ Maintenance Director/designee thru TELS maintenance program. Direct Supply TELS report will be reviewed weekly/ongoing to ensure this deficient practice does not recur. 5. Date the systemic changes for deficiency will be completed. 17 May 2023	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of 10 resident room corridor	K 0363	Parkview Haven Plan of Correction for Life Safety Survey	05/21/2023

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	doors on the Northeast wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 residents in rooms 219 and 220. Findings include: Based on observation with the Maintenance Technician #1 on 05/03/23 between 12:51 p.m. and 2:03 p.m., the corridor door to resident rooms 219 and 220 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Technician #1 agreed both corridor doors would not latch into the door frame and stated the door latching mechanisms needed to be adjusted. The finding was reviewed with the Maintenance Technician #1 during the exit conference. 3.1-19(b)		Dated May 3 2023 Prefix Tag K 363 Corridors and Doors 1. What corrective Action will be accomplished for those residents found to be affected by the deficient practice? Latch speed was adjusted on door closure. Doors on rooms 219 and 220 were tested 6 times each after adjustment to ensure proper latching. 2. How other resident having the potential to be affected by same deficient practice will be identified and what corrective action will be taken. Two Residents were affected by this deficient practice, however, all residents have the potential to be affected by this deficient practice. 3. Measures that will be put in place and what systemic changes will be made to insure that deficient practice doe not recur. Resident Room Door Inspection will be conducted Bi-Weekly verses monthly. Doors will also be checked for proper latching during a Fire Drill.	

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			4. How the corrective action be monitored to ensure deficient practice will not recur. Bi-Weekly inspection will be monitored for completion by Administrator and Maintenance Director Thru TELS maintenance program. These reports will be reviewed Bi-weekly/ongoing to ensure this deficient practice does not recur. 5. Date the systemic changes for deficiency will be completed. 05/11/2023	