STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN 47720

(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
K 0000 Bldg. 01	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). Survey Date: 09/06/17 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 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 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. This building consists of two sections; the original portion of the building was a two story, fully sprinklered building determined to be of Type I (332) construction, and the Stocker Addition I and Stocker Addition II were a one story, fully sprinklered building determined to be of Type V (111) construction. The	K 0000	By submitting the Plan of Correction, the facility is not admitting to the truth or accuracy of the cited deficiencies or allegations. The facility reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance.	

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

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	facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms in the Stocker Addition I and Stocker Addition II, plus battery operated smoke detectors in all resident sleeping rooms in the original two story section. The facility has a capacity of 113 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, two detached buildings used for facility storage. Quality Review completed on 09/15/17 - DA			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the			

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	door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 20 hazardous area doors, such as a storage room, was provided with a self closing device. This deficient practice could affect up to 10 residents, as well as staff and visitors in the Harmony Unit. Findings include: Based on observation on 09/06/17 at 1:08 p.m. during a tour of the facility with the Maintenance Director, the corridor door to room 115, a storage room over 50 square feet, was not provided with a self closing device. This room was full of combustible items, such as, over 20 cardboard boxes full of a variety of items.	K 0321	The corridor door to Room 115 has been provided with a self closing device. The administrator and maintenance director have toured the facility to ensure all other areas of potential concern were in compliance. The maintenance director will check all storage rooms that do not contain a self closing device to assure that here are no combustible items The administrator/designee will check store rooms without self closing doors weekly to assure there are not combustible materials for 3 months and monthly thereafter for a year.	10/05/2017

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	Based on interview at the time of observation, The Maintenance Director said he was not aware the door to this storage room required a self closer since the door was kept locked. 3.1-19(b)			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 83 of 83 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 09/06/17 at 10:55 a.m. with the Maintenance Director present, the facility provided fire watch	K 0346	The Fire Watch policy has been revised to include the web link for contacting the Indiana State Department of Heath Gateway and for contacting the facility's insurance carrier with the phone number. All residents could have been affected. The facility has revised the Fire Watch Policy to include the Indiana State Department of Health Gateway and the contact information for the facility's insurance carrier and their phone number. All Emergency Preparedness Plans will be updated with the contact information for Indiana State Dept. of Health Gateway and the facility insurance carrier	10/06/2017

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	documentation, however, it was incomplete. The plan failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health Gateway, plus contacting the facility's insurance carrier with phone number. Based on an interview at the time of record review, the Maintenance Director agreed the fire watch policy lacked the previously mentioned information. 3.1-19(b)		and phone number. The administrator will make a monthly review of the Fire Watch Policy to ensure that all above information us still present.	
K 0353 SS=F 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 _____ 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, observation and interview; the facility failed to document sprinkler system inspections in	K 0353	The Sprinkler Maintenance Company has inspected and changed the sprinkler heads in Room 214 and Room 212.	10/05/2017

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	accordance with NFPA 25 for 2 of 2 sprinkler systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that normal water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 09/06/17 at 11:45 a.m. with the Maintenance Director present, there was documentation available from Southwestern Sprinkler		The residents in room 214 and 212 could have been affected. The maintenance supervisor will inspect all sprinkler heads for paint and have them replaced if any paint is present. The maintenance supervisor will do monthly inspections of all sprinkler heads to assure there is no paint present. The administrator will randomly inspect 15 sprinkler heads monthly and address any issues promptly.	

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	Services that sprinkler inspections were performed on 09/06/16, 12/28/16, 03/14/17 and 06/06/17. Monthly wet sprinkler system gauge inspection documentation for 8 of the most recent 12 month period was not available for review, furthermore, weekly dry sprinkler system gauge inspection documentation for 48 of the most recent 52 weeks was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Maintenance Director said the facility has both a wet and dry pipe sprinkler system. Furthermore, he said there was no documentation available to show the facility performs monthly and weekly sprinkler system gauge inspections and monthly control valve inspections. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 5 of over 500 sprinkler heads in the facility were free of paint. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires			

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	any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect up to 4 residents in rooms 212 and 214. Findings include: Based on observations on 09/06/17 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, resident room 214 had one side mount sprinkler head on the south wall with paint, and resident room 212 had four upright sprinkler heads with paint. Based on interview at the time of observations, the Maintenance Director agreed the sprinkler heads in resident rooms 214 and 212 had paint on them and said he was unaware of the paint on the sprinkler heads. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the			

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	building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 09/06/17 at 10:55 a.m. with the Maintenance Director present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health Gateway, plus contacting the facility's insurance carrier with phone number. Based on an	K 0354	The Fire Watch policy has been revised to include the web link for contacting the Indiana State Department of Heath Gateway and for contacting the facility's insurance carrier with the phone number. All residents could have been affected. The facility has revised the Fire Watch Policy to include the Indiana State Department of Health Gateway and the contact information for the facility's insurance carrier and their phone number. All Emergency Preparedness Plans will be updated with the contact information for Indiana State Dept. of Health Gateway and the facility insurance carrier and phone number. The administrator will make a monthly review of the Fire Watch Policy to ensure that all above information us still present.	10/05/2017

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	interview at the time of record review, the Maintenance Director agreed the fire watch policy lacked the previously mentioned information. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of corridor doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This	K 0374	The set of smoke barrier doors near the Harmony Unit dining room will be equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. The residents on Harmony Unit could have been affected. All other fire doors have been inspected to ensure proper closure. The maintenance supervisor will inspect all fire doors monthly to	10/05/2017

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	deficient practice could potentially affect up to 10 residents, as well as staff and visitors in the Harmony Unit. Findings include: Based on observation on 09/06/17 at 1:06 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors near the Harmony Unit dining room closed in the same direction with an astragal on one door. These doors and frame were not equipped with a coordinator to ensure that the door that's supposed to close first, does close first. Based on interview at the time of observation, the Maintenance Director said he was not aware the set of smoke barrier doors in the Harmony Unit required a coordinator. 3.1-19(b)		ensure proper equipment and proper closure of all fire doors. The administrator will inspect all fire doors monthly to ensure proper equipment and proper closure of all fire doors.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.			

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	18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate written fire safety plan for the protection of 83 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the	K 0711	The Fire Emergency Plan has been revised to include the location of fire/smoke barrier doors and the relocation of wheeled equipment in the corridors during a fire or a similar emergency. All residents could have been affected. The Fire Emergency Plan has been revised to include the location of fire/smoke barrier doors and the relocation of wheeled equipment in the corridors during a fire or a similar emergency. All Emergency Fire Plan have been updated with locations of fire/smoke barrier doors and the relocation of equipment in the corridors. The administrator will make a monthly review of the Fire Emergency Plan to ensure that the Fire Plan revisions are still present.	10/05/2017

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	written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on record review on 09/06/17 at 10:50 a.m. with the Maintenance Director present, the facility's Fire Emergency Plan was not a complete and accurate fire safety plan. The plan did not include location of fire/smoke barrier doors, and the plan did not address the relocation of wheeled equipment in the corridors during a fire or similar emergency. Also, the plan at 2.b. stated "Move residents nearest the location of the fire first to the nearest exit." instead of beyond fire or smoke barrier doors. Based on interview at the time of record review, the Maintenance Director said the fire plan provided for review was the only fire plan available in the facility, and agreed it was not a complete and accurate fire safety plan. 3.1-19(b)			

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure power strips and extension cords were not used as a substitute for fixed wiring in 9 of 71 resident rooms, plus one resident lounge. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless specifically permitted,	K 0920	The power strips in Rooms 214, 212, 221, 220, 217, 202, 204, 208, 307 and the South Unit Lounge will be replaced with Relocatable Power Taps (RTPs) listed as UL 1363 compliant. Residents on the South Unit and the Stocker I unit could have been affected. The power strips will be replaced with RTP listed as UL 1363 compliant. The maintenance director will do a weekly inspection of power strip	10/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 09/06/17 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. Room 214 had a phone charger plugged into a power strip b. Room 212 had multiple items plugged into a power strip (no medical equipment) c. Room 221 had a TV and phone charger plugged into a power strip d. Room 220 had a TV plugged into a power strip e. Room 217 had a TV and lamp plugged into a power strip f. Room 202 had a TV and lamp plugged into a power strip g. Room 204 had a TV and phone charger plugged into a power strip h. Room 208 had a TV plugged into a power strip i. Room 307 had two power strips with a refrigerator plugged into one of the power strips j. The South Unit Lounge had a vending		usage and assure that compliant power strips are in use in 1/4 of the resident rooms and all common areas. Administrator will randomly inspected power supply cords in 10 random rooms weekly to assure only RTP listed UL 1363 compliant power strips are in use.	

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	machine plugged into a power strip Furthermore, the power strips providing power to non-resident care-related electrical equipment in resident care rooms were not Relocatable Power Taps (RTPs) listed as UL 1363 complaint. Based on interview at the time of observations, the Maintenance Director agreed the power strips did not meet the required UL rating. 3.1-19(b)			