

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2011
--	--	---	--

NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460
---	---

(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
K0000	<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: 07/11/11</p> <p>Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Owen Valley 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 19, Existing Health Care Occupancies and 410 IAC 16.2. The original building was surveyed under Chapter 19.</p> <p>This one story facility was determined to be of Type V (111)</p>	K0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a Life Safety Code survey concluding on 07/11/2011. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 08/10/2011.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0025 SS=E	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and spaces open to the corridors. The facility has the capacity for 113 and had a census of 104 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/14/11.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure a gap in ceiling smoke</p>	K0025	Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		<input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		<input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		<input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED 07/11/2011	
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460			
(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			
	<p>barriers in 1 of 6 smoke compartments was protected with an approved material to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 20 or more residents in the administrative wing housing the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 at 2:10 p.m., the space around the pendant sprinkler pipe in the kitchen freezer ceiling had been filled with an nonrated expandable foam. The maintenance director said at the time of observation, he had not remembered the foam was used to fill the void.</p>		<p>taken:None of the 20 or more residents, visitors, or staff in the administrative hall, which houses the main dining room, suffered any ill effects from the alleged deficiency. On 07-21-2011, the unapproved material was removed from the space around the pendant sprinkler pipe in the kitchen freezer ceiling. On 07-21-2011, the Maintenance Director replaced the unapproved material with non-expanding sealant in a way that sealed the smoke barriersIdentification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:The 20 or more residents, visitors, and staff that utilize the Administrative Hall, have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance Director replaced the unapproved material from the space around the pendant sprinkler pipe in the kitchen freezer ceiling with non-expanding sealant on 07-21-2011How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Mainenance Director / Designee will complete environmental rounds to ensure that the ceiling smoke barriers remain sealed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X(2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X(3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0029 SS=E	<p>3.1-19(b)</p> <p>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 closers for doors providing access to 2 of 8 hazardous areas such as storage rooms larger than 50 square feet in size. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 52 residents in the A and C hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0029	<p>Rounds will be conducted and documented three times per week for four weeks, and then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the 52 residents on the A-Hall and C-Hall, visitors, or staff using the A-Hall and C-Hall smoke compartments suffered any ill effects from the alleged deficiency. The Maintenance Director will install automatic door closers on the doors in the Activities Storage Room on the A-Hall and the clean utility room on the C-Hall before August 10, 2011Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:The 52 residents on the A-Hall and C-Hall, visitors, and staff using the A-Hall and C-Hall have the potential to be affected by the</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
	<p>maintenance director on 07/11/11 between 1:00 p.m. and 1:45 p.m., the doors separating the eight by fourteen foot activities storage room/office on A wing and the clean utility/equipment storage room on C wing each had no self closing device. The maintenance director said at the time of observation, he didn't realize the doors were required to self close.</p> <p>3.1-19(b)</p>		<p>alleged deficient practiceNone of the 20 or more residents, visitors, or staff in the administrative hall, which houses the main dining room, suffered any ill effects from the alleged deficiency. On 07-21-2011, the unapproved material was removed from the space around the pendant sprinkler pipe in the kitchen freezer ceiling. On 07-21-2011, the Maintenance Director replaced the unapproved material with non-expanding sealant in a way that sealed the smoke barriersIdentification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:The 20 or more residents, visitors, and staff that utilize the Administrative Hall, have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance Director replaced the unapproved material from the space around the pendant sprinkler pipe in the kitchen freezer ceiling with non-expanding sealant on 07-21-2011How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Mainenance Director / Designee will complete environmental rounds to ensure that the ceiling smoke barriers remain sealed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X(2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X(3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0050 SS=F	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted on every shift during 1 of the past 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of monthly Fire Drill Reports for the past year with the maintenance director on 07/11/11 at 3:30 p.m., fire drill documentation was not found for the 3:00 p.m. to 11:00 p.m. shift during the last quarter of 2010. The maintenance director reviewed the records a second time and agreed the drill</p>	K0050	<p>Rounds will be conducted and documented three times per week for four weeks, and then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the residents suffered any ill effects from the alleged deficiencyIdentification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will conduct fire drills each month ensuring that they cover every shift every quarter. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director /</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0054 SS=E	<p>documentation was missing.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 2 of 6 smoke compartments were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 26 or more residents in administrative and C wings.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 3:00 p.m.,</p>	K0054	<p>Designee will conduct fire drills on every shift each quarter continuously. A report detailing the times, dates, attendance, and outcome from each fire drill will be reported to theQAA Committee each month for review to ensure that the standard is being met.</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the visitors, staff, or 26 or more residents which utilize the C-Hall or the Administrative Hall suffered any ill effects from the alleged deficiency. The Maintenance Director will install deflector sheilds to the air vents located on the Administrative Hall and the air vent located on the C-Hall corridor near room C116 before August 10, 2011.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:The 26 or more residents, staff, and visitors that utilize the Administrative Hall and the C-Hall have the potential to be affected by the alleged deficiencyMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0062 SS=E	<p>an administrative wing corridor smoke detector near the east exit was located six inches from a ceiling air vent. A corridor smoke detector near room C116 was located immediately adjacent to a ceiling air supply vent. The maintenance director confirmed the distance measurements and agreed at the time of observations, the air flow could impede the function of the smoke detectors.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 6 smoke compartments were maintained. This deficient practice could affect all staff, visitors and 20 or more residents in the administrative wing where therapy, laundry and the main dining room were located.</p>	K0062	<p>Director will install deflector shields to the air vent located on the Administrative Hall and the air vent located on the C-Hall corridor near room C116 before August 10, 2011 How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Maintenance Director / Designee will complete environmental rounds to ensure deflector shields remain in place. Rounds will be conducted three times per week for four weeks and then weekly for four weeks. Results will be submitted to the QAA Committee each month</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: 1) None of the 20 or more residents in the Administrative Hall, staff, or visitors suffered any ill effects from the alleged deficiency of failing to ensure the facilities sprinkler heads were properly maintained. 2) None of the 20 or more residents in the South and Northwest smoke compartments, staff, or visitors suffered any ill</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
	<p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 2:55 p.m., sprinkler head escutcheons were missing, leaving a gaps of 1/2 to 3/4 inches into the attic space above in the physical therapy room (one) and in the kitchen (two). The maintenance director said at the time of observations, one sprinkler in the kitchen had been replaced temporarily until a head with the correct pipe length was received and the escutcheon was not included with the temporary installation. He had been unaware of the missing escutcheon in the therapy room.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review, and interview; the facility failed to ensure sprinkler heads in 2 of 4 smoke compartments were free of paint and/or corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint. This deficient practice affects visitors, staff and 20 or more residents in</p>		<p>effects from the alleged deficiency of failing to ensure the facilities sprinkler heads remain free of paint and/or corrosion Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:1) The 20 or more residents utilizing the Administrative Hall, staff, and visitors have the potential to be affected by the alleged deficient practice of failing to ensure the facilities sprinkler heads are properly maintained2) The 20 or more residents utilizing the South and Northwest smoke compartments, staff, and visitors have the potential to be affected by the alleged deficient practice of failing to ensure sprinkler heads remain free of paint and/or corrosionMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:1) The Maintenance Director will install sprinkler head escutcheons to the sprinkler heads in the therapy room and kitchen2) The Maintenance Director will clean all of the sprinkler heads in the laundry and therapy rooms.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will complete environmental rounds to ensure that the sprinkler heads are intact and clean. Rounds will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
	<p>the south and northwest smoke compartments which includes the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 2:45 p.m., two of three sprinkler heads located in the laundry were covered with a white fuzzy material and one of six sprinkler heads in the physical therapy room had a white paint or spackling material on the sprinkler head and bracket. The maintenance director said at the time of observations, he had been unaware of the condition of these sprinkler heads.</p> <p>3.1-19(b)</p>		<p>conducted three times per week for four weeks, and then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was posted with a sign indicating oxygen transferring was taking place and provided with continuous mechanical ventilation to the outside. This deficient practice affects staff, visitors and 20 or more residents on the administrative wing where the main dining room is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 at 2:20 p.m., liquid oxygen supply containers and oxygen e-cylinders were stored in a room on the</p>	K0143	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the 20 or more residents on the Administrative Hall suffered any ill effects from the alleged deficiency. The Maintenance Director will install a sign outside the door to the oxygen room stating that oxygen transferring was taken place. He will also install a mechanical ventilation system which vents to the outside. Identification of other residents having the potential to be affcted by the same alleged deficient practice and corrective actions taken:The 20 or more residents, staff, and visitors utilizing the Administrative Hall have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0000	<p>administrative wing near the main dining room. The maintenance director identified the room as the site for oxygen transfilling of portable oxygen tanks. There was no sign to provide notice the room was used for oxygen transfer. There was a 12 by 12 inch vented opening in the outside wall providing natural ventilation. The room was hot on this day where outside temperatures were reported to be 95 degrees Fahrenheit by the local radio station. A second vent was observed in the ceiling. The maintenance director said time of observation, he did not know if the mechanical vent was working and assumed, but did not know for certain, it would exhaust to the outside.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State</p>	K0000	<p>practice does not recur:The Maintenance Director posted a sign on the oxygen room stating that oxygen transferring taking place. The Maintenance Director will install a system to mechanically ventilate to the outside.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will complete environmental rounds to ensure that the oxygen room has a sign stating that oxygen transferring is taking place and that the room has continuous ventilation to the outside. Rounds will be conducted three times per week for 4 weeks then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
	<p>Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/11/11</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Owen Valley 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), and 410 IAC 16.2. The main dining room was renovated and enlarged after March 2003 and surveyed under Chapter 18, New Health Care occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke</p>		<p>truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a Life Safety Code survey concluding on 07/11/2011. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 08/10/2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0025 SS=E	<p>detection in the corridors, sleeping rooms and spaces open to the corridors. The facility has the capacity for 113 and had a census of 104 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure a gap in a ceiling smoke barrier in 1 of 6 smoke compartments was protected with an approved material to maintain</p>	K0025	<p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:None of the 20 or more residents, visitors, or staff in the administrative hall, which houses the main dining room, suffered</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X(2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X(3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
	<p>the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 20 or more residents in the administrative wing housing the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 at 2:10 p.m., the space between the pendant sprinkler pipe in the kitchen freezer ceiling had been filled with an nonrated expandable foam. The maintenance director said at the time of observation, he had not remembered the foam was used to fill the void.</p> <p>3.1 – 19(b)</p>		<p>any ill effects from the alleged deficiency. On 07-21-2011, the unapproved material was removed from the space around the pendant sprinkler pipe in the kitchen freezer ceiling. On 07-21-2011, the Maintenance Director replaced the unapproved material with non-expanding sealant in a way that sealed the smoke barriers. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The 20 or more residents, visitors, and staff that utilize the Administrative Hall, have the potential to be affected by the alleged deficient practice. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: The Maintenance Director replaced the unapproved material from the space around the pendant sprinkler pipe in the kitchen freezer ceiling with non-expanding sealant on 07-21-2011. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Maintenance Director / Designee will complete environmental rounds to ensure that the ceiling smoke barriers remain sealed. Rounds will be conducted and documented three times per week for four weeks, and then weekly for four weeks. Results</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0050 SS=F	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted on every shift during 1 of the past 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of monthly Fire Drill Reports for the past year with the maintenance director on 07/11/11 at 3:30 p.m., fire drill documentation was not found for the 3:00 p.m. to 11:00 p.m. shift during the last quarter of 2010. The maintenance director reviewed the records a second time and agreed the drill documentation was missing.</p> <p>3.1-19(b)</p>	K0050	<p>will be submitted to the QAA Committee each month for review</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the residents suffered any ill effects from the alleged deficiencyIdentification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will conduct fire drills each month ensuring that they cover every shift every quarter. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will conduct fire drills on every shift each quarter continuously. A report detailing</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X(2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X(3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0054 SS=E	<p>3.1-51(c)</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 2 of 6 smoke compartments, were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 26 or more residents in the administrative wing which includes the dining room and C wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 3:00 p.m., an administrative wing corridor</p>	K0054	<p>the times, dates, attendance, and outcome from each fire drill will be reported to theQAA Committee each month for review to ensure that the standard is being met.</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the visitors, staff, or 26 or more residents which utilize the C-Hall or the Administrative Hall suffered any ill effects from the alleged deficiency. The Maintenance Director will install deflector sheilds to the air vents located on the Administrative Hall and the air vent located on the C-Hall corridor near room C116 before August 10, 2011. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:The 26 or more residents, staff, and visitors that utilize the Administrative Hall and the C-Hall have the potential to be affected by the alleged defecencyMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:The Maintenance Director will install deflector sheilds to the air vent located on the Administrative Hall and the air</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
K0062 SS=E	<p>smoke detector near the east exit was located six inches from a ceiling air vent. A corridor smoke detector near room C116 was located immediately adjacent to a ceiling air supply vent. The maintenance director confirmed the distance measurements and agreed at the time of observations, the air flow could impede the function of the smoke detectors.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 6 smoke compartments were maintained. This deficient practice could affect all staff, visitors and 20 or more residents in the administrative wing where therapy, laundry and the main dining room were</p>	K0062	<p>vent located on the C-Hall corridor near room C116 before August 10, 2011 How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Maintenance Director / Designee will complete environmental rounds to ensure deflector shields remain in place. Rounds will be conducted three times per week for four weeks and then weekly for four weeks. Results will be submitted to the QAA Committee each month</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: 1) None of the 20 or more residents in the Administrative Hall, staff, or visitors suffered any ill effects from the alleged deficiency of failing to ensure the facilities sprinkler heads were properly maintained. 2) None of the 20 or more residents in the South and Northwest smoke compartments,</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011	
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460			
(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			
	<p>located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 2:55 p.m., sprinkler head escutcheons were missing, leaving a gaps of 1/2 to 3/4 inches into the attic above in the physical therapy room (one) and in the kitchen (two). The maintenance director said at the time of observations, one sprinkler in the kitchen had been replaced temporarily until a head with the correct pipe length was received and the escutcheon was not included with the temporary installation. He had been unaware of the missing escutcheon in the therapy room.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review, and interview; the facility failed to ensure sprinkler heads in 2 of 4 smoke compartments were free of paint and/or corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint. This deficient practice affects visitors,</p>		<p>staff, or visitors suffered any ill effects from the alleged deficiency of failing to ensure the facilities sprinkler heads remain free of paint and/or corrosion Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:1) The 20 or more residents utilizing the Administrative Hall, staff, and visitors have the potential to be affected by the alleged deficient practice of failing to ensure the facilities sprinkler heads are properly maintained2) The 20 or more residents utilizing the South and Northwest smoke compartments, staff, and visitors have the potential to be affected by the alleged deficient practice of failing to ensure sprinkler heads remain free of paint and/or corrosionMeasures put into place and systemic changes made to ensure the alleged deficient practice does not recur:1) The Maintenance Director will install sprinkler head escutcheons to the sprinkler heads in the therapy room and kitchen2) The Maintenance Director will clean all of the sprinkler heads in the laundry and therapy rooms.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will complete environmental rounds to ensure that the sprinkler heads are intact</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		<input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		<input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		<input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED 07/11/2011	
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460			
(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			
	<p>staff and 20 or more residents in the south and northwest smoke compartments which includes the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 between 2:00 p.m. and 2:45 p.m., two of three sprinkler heads located in the laundry were covered with a white fuzzy material and one of six sprinkler heads in the physical therapy room had a white paint or spackling material on the sprinkler head and bracket. The maintenance director said at the time of observations, he had been unaware of the condition of these sprinkler heads.</p> <p>3.1-19(b)</p>		<p>and clean. Rounds will be conducted three times per week for four weeks, and then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(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	
K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was posted with a sign indicating that oxygen transferring was taking place and provided with continuous mechanical ventilation to the outside. This deficient practice affects staff, visitors and 20 or more residents on the administrative wing where the main dining room is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/11/11 at 2:20 p.m., liquid oxygen supply containers and oxygen e-cylinders were stored in a room on the</p>	K0143	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:None of the 20 or more residents on the Administrative Hall suffered any ill effects from the alleged deficiency. The Maintenance Director will install a sign outside the door to the oxygen room stating that oxygen transferring was taken place. He will also install a mechanical ventilation system which vents to the outside. Identification of other residents having the potential to be affcted by the same alleged deficient practice and corrective actions taken:The 20 or more residents, staff, and visitors utilizing the Administrative Hall have the potential to be affected by the alleged deficient practiceMeasures put into place and systemic changes made to ensure the alleged deficient</p>	08/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>administrative wing near the main dining room. The maintenance director identified the room as the site for oxygen transfilling of portable oxygen tanks. There was no sign to provide notice the room was used for oxygen transfer. There was a 12 by 12 inch vented opening in the outside wall providing natural ventilation. The room was hot on this day where outside temperatures were reported to be 95 degrees Fahrenheit by the local radio station. A second vent was observed in the ceiling. The maintenance director said time of observation, he did not know if the mechanical vent was working and assumed, but did not know for certain it would exhaust to the outside.</p> <p>3.1-19(b)</p>		<p>practice does not recur:The Maintenance Director posted a sign on the oxygen room stating that oxygen transferring taking place. The Maintenance Director will install a system to mechanically ventilate to the outside.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:The Maintenance Director / Designee will complete environmental rounds to ensure that the oxygen room has a sign stating that oxygen transferring is taking place and that the room has continuous ventilation to the outside. Rounds will be conducted three times per week for 4 weeks then weekly for four weeks. Results will be submitted to the QAA Committee each month for review</p>		