

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155292	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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K010000	<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: 12/23/14</p> <p>Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, American Village 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.</p> <p>American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered. The east wing of the second floor of Washington Manor houses a</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after January 22, 2015.</p>	
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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.

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K010025 SS=D	<p>Rehab wing. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in 60 of 82 resident sleeping rooms. The facility has smoke detectors hard wired to the facility's electrical system in 22 of 82 resident sleeping rooms. The facility has a capacity of 150 and had a census of 132 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the detached storage and repair shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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	<p>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 1 of 2 ceiling smoke barriers was protected 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 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 practice could affect 5 staff and visitors in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:00 p.m. on 12/23/14, the one inch annular space surrounding two of three four inch in diameter PVC pipes and the four inch annular space surrounding one of three four inch in diameter PVC pipes each of which penetrated the ceiling of the</p>	K010025	<p>K 025 SS=D NFPA 101 LIFE SAFETY CODE STANDARD</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.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Pipes in the service corridor outside the dietary entrance are protected so there is no space between the penetrating items allowing the provider to maintain smoke resistance of the ceiling smoke barrier. Space between penetrating item and smoke barrier filled with material capable of maintaining the smoke resistance of the smoke barrier.</p> <p>How other residents having the potential to be affected by the</p>	12/24/2014

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	<p>Housekeeping Room in the service corridor next to the Dietary entrance failed to maintain the smoke resistance of the ceiling smoke barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>same deficient practice will be identified and what corrective action(s) will betaken? All residents have the potential to be affected by the alleged deficient practice. It will be the practice of this provider to ensure that smoke barriers are protected to maintain smoke resistance of the smoke barrier. Maintenance Director inspected all other ceiling smoke barriers to ensure that any spaces were filled with smoke resistant material. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Environmental Services Supervisor, Maintenance Supervisor, and Administrator to during monthly inspection to identify any areas that smoke barriers may not be sealed and bring deficient practice to the Maintenance Supervisor attention to address. How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be put intoplace? Environmental Supervisor or Designee during morning rounds will monitor smoke barriers to ensure there is no space that will limit smoke resistance. Results will be reported to monthly CQI committee. _ By what datethe systemic changes will be completed? Compliance Date:</p>	

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K010029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure 2 of 13 hazardous areas were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 5 staff and visitors in the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:00 p.m. on 12/23/14, the following was noted:</p> <p>a. the Housekeeping Room in the service corridor contained one natural gas fired furnace and the one inch annular space surrounding two of three four inch in diameter PVC pipes and the four inch annular space surrounding one of three four inch in diameter PVC pipes each of</p>	K010029	<p>December 24, 2014</p> <p>K 029 SS=D NFPA 101 LIFE SAFETY CODE STANDARD 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provider to ensure that hazardous areas are separated</p>	01/01/2015			

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	<p>which penetrated the ceiling of the Housekeeping Room failed to separate this hazardous area from other spaces with smoke resistant partitions.</p> <p>b. the east door in the corridor door set to the Mechanical Room by the Laundry Storage Room in the service hall was not equipped with a self closing device. The aforementioned Mechanical Room contained one natural gas fired furnace. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hazardous areas were not separated from other spaces with smoke resistant partitions or were not equipped with a self closing device.</p> <p>3.1-19(b)</p>		<p>from other spaces with smoke resistant partitions equipped with a self closing device. The eastside door in the service corridor set to the Mechanical Storage room by the Laundry Storage room is equipped with a self closing device. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged practice. It will be the practice of this provider to ensure that all doors to hazardous areas have a smoke resistant partition and equipped with a self closing device. Maintenance Director ensured all other hazardous areas were separated by smoke resistant partitions and smoke resistant doors. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Environmental Services Supervisor to monitor all hazardous areas to ensure that all doors have a self closing device present. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Environmental Services Supervisor will monitor through the preventive maintenance</p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 5 exit accesses was provided with a handrail. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 24 residents, staff and visitors if needing to exit the facility from the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:00 p.m. on 12/23/14, the exit discharge ramp from the 100 Hall measured a two foot rise over the eighteen foot length of the ramp</p>	K010038	<p>program. Results will be reported to monthly CQI committee By what date the systemic changes will be completed? Compliance Date: January 01,2015</p> <p>K 038 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged sothat exits are readily accessible at all times in accordance with section What corrective action(s) will be accomplished for those residentsfound to have been affected by the deficient practice? It is the practice of thisprovider to ensure that exit accesses are provided with a handrail. A handrailis provided at the exit discharge ramp from the 100 Hall. <i>(Service Call Report Included)</i> How other residents having the potential to be affected by the samedeficient practice will be identified and what corrective action(s) will betaken? All residents have the potentialto be affected by the alleged deficient practice. It will be the practice ofthe provider to ensure that all ramps with slope greater than 1 in 12 have ahandrail provided by Maintenance Director. What measures will be put into place</p>	01/09/2015	

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K010052 SS=F	<p>and was not provided with a handrail. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned ramp had a slope of 1 in 9 and was not provided with a handrail.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to maintain 11 of 165 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains</p>	K010052	<p>or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director to ensure that all ramps with slope greater than 1 in 12 will have a handrail. All exit accesses with ramp to provide handrail. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental Services Supervisor to ensure that all exit accesses with ramp provide a handrail. Results will be reported to the CQI committee. By what date the systemic changes will be completed? Compliance Date: January 9, 2015</p> <p>K 052 SS=F NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA</p>	01/15/2015	

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	<p>smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 116 residents, staff and visitors in Harrison Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:00 p.m. on 12/23/14, the following smoke detectors were each located less than three feet from an air supply vent:</p> <ol style="list-style-type: none"> in the corridor outside the 100 Hall Mechanical Room. inside the oxygen storage room in the 100 Hall. in the 200 Hall corridor outside the MDS Office. in the 200 Hall ADON Services Office. at the 200 Hall nurses station. in the 300 Hall corridor outside the Biohazard Storage Room. inside the Biohazard Storage Room in the 300 Hall. in the Harrison Hall atrium near the 300 Hall corridor door set. in the corridor outside Room 300. in the Clinton Room. in the corridor outside the Dining Room by Therapy in Harrison Hall. 		<p>70 and 72. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provider to ensure that smoke detectors are not located in direct airflow nor closer than three feet from an air supply diffuser or return air opening Vanguard relocated smoke detectors. (<i>Service Call Report Included</i>). Smoke detectors on the ceiling in the following areas are not less than three feet from an air supply vent.</p> <ol style="list-style-type: none"> Corridor outside 100 hall mechanical room Inside the oxygen storage room on 100 hall In the 200 hall corridor outside the MDS office In the 200 hall ADON Services office At the 200 hall nurses station In the 300 hall corridor outside the Biohazard Storage Room Inside the Harrison Hall atrium near the 300 Hall corridor door set Inside the corridor outside room 300 In the Clinton Room In the corridor outside the Dining Room by Therapy in Harrison Hall <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be</p>	

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K010144 SS=E	<p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detectors were each located on the ceiling less than three feet from an air supply vent.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care</p>	K010144	<p>taken? All residents have the potential to be affected by the alleged deficient practice. It will be the practice to the provider to ensure that all smoke detectors are properly placed and operational by the Maintenance Director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Environmental Services Supervisor will monitor the location of smoke detectors. Vanguard Alarm Systems will be notified if necessary. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Environmental Services Supervisor will monitor through the Preventive Maintenance Program. Results will be reported to the CQI committee. By what date the systemic changes will be completed? Compliance Date: January 15,2015</p> <p>K 144 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30</p>	01/26/2015	

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	<p>Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect 116 residents, staff and visitors in Harrison Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:40 p.m. to 3:00 p.m. on 12/23/14, the facility has two generators to supply the facility with emergency power. The diesel fired emergency generator supplies emergency power to Harrison Hall. The remote annunciator for the diesel fired emergency generator is located in the center atrium of Harrison Hall and failed to operate when the annunciator test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned remote annunciator was inoperable.</p> <p>3.1-19(b)</p>		<p>minutes per month in accordance with NFPA 99. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this provider to ensure that any device, equipment required for compliance of this code be continuously maintained. The remote annunciator in the Harrison Hall atrium has been ordered and a service date for repair and installation has been scheduled. Services to be performed by Vanguard Alarm Systems. <i>(Service Request Included)</i> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. It is the practice of this provider to ensure that generator along with the remote annunciator is fully operable and continuously maintained. The generator and remote annunciator will continue to be inspected weekly and exercised under load by the Maintenance Director or designee. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance will monitor the remote annunciator weekly on Harrison Hall Atrium weekly. If</p>				

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			<p>there is a problem Vanguard Alarm Systems will be notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will monitor. The Preventative Maintenance Schedule will include a weekly test of the remote annunciator with the test of the generator. Results will be reported to the CQI Committee. By what date the systemic changes will be completed. January 26, 2015</p>		