STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155100	A. BUILDING 01 / B. WING	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BEDFORD	2111 NORTON LN BEDFORD, IN 47421

(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: 06/23/16 Facility Number: 000040 Provider Number: 155100 AIM Number: 100274460 At this Life Safety Code survey, Garden Villa 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. This one story facility with a basement was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 190 and had a census of 141 at the time of	K 0000	Preparation and submission of this plan of correction does not constitute an admission or agreement by GardenVilla of the conclusions of this survey. We respectfully submit this plan ofcorrection as proof of our compliance with the State and Federal regulations,and per the laws that mandate the submission of this plan of correction. Pleasereview the attached documents with this plan or correction, as evidence ofcompletion of this plan and evidence of compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden building used for storage which was not sprinkled. Quality Review completed on 06/29/16 - DA			
K 0014 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Based on observation and interview, the facility failed to ensure 1 of 3 basement exit ways was provided with an interior finish with a flame spread rating of Class A or Class B. This deficient practice could affect 14 residents who use the basement physical therapy room. Findings include: Based on observation on 06/23/16 at 9:35 a.m. with the maintenance supervisor, the	K 0014	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The 4 foot by 4 footarea covered in plywood has been completely covered with a suitable material(acoustic ceiling tile) per the inspector on site. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken:	07/23/2016

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	basement physical therapy room opening to the corridor had a four foot by four foot recessed area in the ceiling covered in plywood. Based on an interview with the maintenance supervisor on 06/23/16 at 9:55 a.m., there is no documentation to indicate the flame spread rating of the plywood ceiling area in the physical therapy room corridor. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		No residents will be affected by this issue in the futuredue to the repair has been made. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The deficient practice cannot reoccur because it has beenpermanently repaired How the corrective action will be monitored to ensure the deficientpractice will not recur The ceiling has beenpermanently repaired By what date the systemic changes will be completed 7/23/16	
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation, the facility failed to ensure 1 of 9 open use areas was	K 0017	What correctiveactions will be accomplished for those residents	08/01/2016

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	separated from the corridors. Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 56 residents who reside on the Station #1 Hall. Findings include: Based on observation on 06/23/16 at 12:20 p.m. with the assistant maintenance supervisor, the Station #1 Hall activity room was open to the corridor. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter		found to have been affected bythe deficient practice: The Unit 1 activityroom will be provided with the appropriate amount of additional smoke heads toensure the area is suitably protected. The work is scheduled to start August 1,2016, the first available start date. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any residents that could be affected by the lack of smokeheads. Work is to begin on August 1, 2016, the first available start date, toadd additional smoke heads. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The deficient practice cannot recur once additional smokeheads are added on August 1, 2016, the first available start date. How the corrective action will be monitored to ensure the deficientpractice will not recur The additional smokeheads are to be installed on August 1, 2016, the first available start date,will prevent the reoccurrence of this issue. By what date the systemic changes will be completed 8/1/16	

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	19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation and interview, the facility failed to maintain the vertical opening protection for 2 of 5 exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect 40 residents who reside on the Station #3 Hall, and 18 residents who reside on the Station #5 Hall. Findings include:	K 0020	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The Unit 5 door inbasement that had a painted fire rating tag has been cleaned to allow the firerating to be visible. The Unit 3 stairwell doors will be replaced at both thetop and bottom of the stairwell and will meet the required rating. The doorsare scheduled for replacement on August 15-19, 2016. How other residents having the potential to be affected bythe same deficient practice will be	08/19/2016

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	Based on observations on 06/23/16 during a tour of the facility with the maintenance supervisor and assistant from 8:40 a.m. to 1:05 p.m., the Station #5 stairway door at the bottom of the stairway fire resistance label was covered in white paint and the Station #3 stairway fire resistance label at the top of the stairway was completely scratched off and illegible. Furthermore, the basement stairway fire resistance label at the bottom of the stairway from the Station #3 Hall had a fire resistance rating of forty five minutes. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		identified and what corrective action willbe taken: All residents in the area has the potential to be affected.The fire rating tag been cleaned so it is visible. The upper and lower doors inUnit 3 stairwell will be replaced on August 15-19, 2016. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The paint has been removed from Unit 5 door fire rating tag.When the doors at the top and bottom of the Unit 3 stairwell are replaced onAugust 15-19, 2016. Fire rating tags will be observed during monthlypreventative maintenance rounds. How the corrective action will be monitored to ensure the deficientpractice will not recur: All fire doors will be monitored monthly to assure the firerating is visible and the results will be brought to the QAPI monthly meeting. By what date the systemic changes will be completed 8/19/16	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the	K 0025	What correctiveactions will be	07/23/2016

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	facility failed to ensure 3 of 5 basement room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 38 residents who use the basement Station #5 Hall activity room, which is located adjacent to the basement laundry room. Findings include: Based on observations with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 during a tour of the basement from 8:40 a.m. to 10:00 a.m., the following basement smoke barrier walls had either missing drywall, concrete, or had penetrations not fire stopped: a. The basement Unit #5 Hall boiler room south wall had four, six inch circular openings in the concrete smoke barrier wall, a two foot by four foot opening in the concrete smoke barrier wall, and the north wall had six, two inch gaps around water pipe and electrical conduit penetrations not fire stopped. b. The basement laundry room south wall had a two foot by four foot opening in the concrete smoke barrier wall and a two foot by four foot opening where two, four inch plastic sewer pipes penetrated the		accomplished for those residents found to have been affected bythe deficient practice: The openings in theUnit 5 boiler room, the laundry and Unit 5 hallway have been repaired and arenow smoke and fire stopped. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents have potential to be affected by openings insmoke barriers and/or fire rated doors or walls. Observations for openings insmoke barriers and/or fire rated doors or walls will be observed on the monthlypreventative maintenance rounds. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The Maintenance staff have been educated to look foropenings in smoke barriers and/or fire rated doors or walls during preventativemaintenance rounds monthly. How the corrective action will be monitored to ensure the deficientpractice will not recur: The inspection of smoke barriers and/or fire rated doors orwalls will be added to the monthly preventative maintenance rounds and theresults will be presented to the QAPI.	

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	smoke barrier wall with no fire stopping. c. The basement Unit #5 Hall activity room corridor had five, one inch circular openings in the south wall. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 Based on observations and interview, the facility failed to ensure 6 of 18 corridor doors to either combustible storage rooms over 50 square feet or a repair shop were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or the room was provided with smoke resistant partitions. This	K 0029	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The basement residentclothing room, the housekeeping supply room, the 1st floor activityhall kitchen storage and the storage room on Unit 6 will all have self-closuresinstalled the earliest start date is August 15-19,2016. The	08/19/2016

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	deficient practice could affect 12 residents who use the basement physical therapy room, 30 residents who use the basement Station #5 Hall activity room, and 38 residents who reside on the Station #6 Hall. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor , the following combustible storage rooms over fifty square feet failed to latch and self-close into the door frames or lacked a self-closing device; a. The basement resident clothing storage room, which measured three hundred eighty square feet and stored seventeen shelves of clothing, lacked a self-closing device on the door. b. The basement housekeeping supply room, which measured two hundred ninety square feet and stored fifteen shelves of combustible cardboard boxes of plastic and paper housekeeping supplies, lacked a self-closing device on the door. c. The basement maintenance repair shop door frame had a two inch gap around the inside of the door frame which was unfinished with wooden studs exposed and a one inch gap around the door		basementmaintenance shop door has been repaired and now there are no gaps. The oldlaundry storage area has had drywall added to all areas where drywall wasmissing and now meets the requirements. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents have the potential to be affected. The drywallhas been completed and the self-closures to the doors are scheduled to bestarted on August 15-19, 2016, the earliest start date available. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The Preventative maintenance log will be updated to includeto monitor for missing drywall. The other areas of concern have been repairedand will not be a deficient practice. How the corrective action will be monitored to ensure the deficientpractice will not recur The preventative maintenance for missing drywall will bemonitored and brought to monthly QAPI. By what date the systemic changes will be completed 8/19/16	

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	frame. d. The first floor old laundry storage room, which measured three hundred square feet and stored twenty two shelves of cardboard boxes of paper and plastic laundry, nursing and housekeeping supplies, had a thirty foot south wall unfinished with wooden studs exposed, a twenty foot by one foot area of drywall missing along the center of the room on both walls and ceiling, and an eleven foot unfinished north wall with wooden studs exposed. e. The first floor Activity Hall kitchen storage room, which measured two hundred square feet and stored twelve shelves of combustible cardboard boxes of food, lacked a self-closing device on the door. f. The Station #6 Hall storage room between resident rooms 602 and 604, which measured one hundred twelve square feet and stored eight cardboard boxes of clothing and five plastic mattresses, lacked a self-closing device on the door. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			

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K 0038 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure the sidewalk surface on 2 of 4 basement exit sidewalks were maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 38 residents who use the basement Station #5 Hall activity room. Findings include: Based on observations with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 during a tour of the basement from 8:40 a.m. to 10:00 a.m., the Station #5 basement activity room playground exit sidewalk had a twelve foot by twelve foot concrete slab twenty five feet from the exit door completely broken in pieces and	K 0038	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The concrete work isscheduled to begin on July 25, 2016 and the handrail will be installed uponcompletion of the concrete work at the exit to Unit 5 activity room playgrounddoor. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents who utilize this exit have the potential to beaffected. The concrete work is scheduled to begin July 25, 2016 and thehandrail will be installed upon completion of the concrete work. What measure will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur: The preventative maintenance monthly rounds will be updatedto include the observation of concrete for changes in elevation. How the corrective action will be monitored to ensure the deficientpractice will not recur	07/25/2016

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	had three inch depressions from the broken concrete to the nearest concrete slab sidewalk surface. Furthermore, the basement Station #5 activity room west exit had a four foot by four foot concrete slab outside the exit door and a set of concrete steps completely broken in pieces and had three inch depressions from the broken concrete to the nearest concrete slab sidewalk surface and two, four foot by four foot concrete slabs thirty feet from the exit door heaving with two inch elevation changes to the adjoining concrete slabs. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 4 basement exit accesses with stairs was provided with handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within		The monthly preventative maintenance log will be updated toinclude the observation of concrete work at the exits for elevation changes andbrought to the monthly QAPI meeting. By what date the systemic changes will be completed 7/25/16	

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	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 38 residents who use the basement Station #5 Hall activity room west exit. Findings include: Based on observation with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 at 9:40 a.m., the basement Station #5 activity room west exit had a set of three concrete steps outside the exit door which lead to the concrete sidewalk surface with no handrail. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 9 first floor fire door sets were arranged to restrict the movement of smoke. LSC 7.2.4.3.4 any	K 0044	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The set of fire doorsat the	08/19/2016

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	opening in such fire barriers shall be protected as provided in 8.2.3.2.3. 8.2.3.2.3.1 requires every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice affects 38 residents who reside on the Station #6 Hall. Findings include: Based on an interview with the maintenance supervisor on 06/23/16 at 8:45 a.m., it was indicated the door sets throughout the facility separating one smoke compartment from another are fire doors with at least a two hour concrete block wall and opposite swinging fire doors with a ninety minute fire resistance rating that self-close and latch. Based on observation on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the fire door set at the Administration Hall to the Station #6 Hall and the fire door set at the Managers Hall each had a three quarter inch gap where the fire door sets came together and latched in the closed position. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the		administration hall to Unit 6 and the fire doors at the managers hallwill be repaired in order to reduce the gap between doors to a permissible gapof 1/8". The work is scheduled to begin on August 15-19, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Once the doors have been repaired there will be no potentialto be affected by this deficient practice. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: During monthly preventative maintenance rounds fire doorswill be observed for gaps. How the corrective action will be monitored to ensure the deficientpractice will not recur: The monthly preventative maintenance will be monitored and the results will be brought to the monthlyQAPI meeting. By what date the systemic changes will be completed 8/19/16	

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	administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on observation and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the	K 0046	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: Both the batteryback-up lights at the generator and in the generator transfer room are on acurrent monthly checklist and are tested monthly The annual 90 minute test ofboth of these lights were not documented correctly but will be from this pointforward. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: No residents were affected by the lack of documentation forboth the lights in question. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur:	07/23/2016

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	facility. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the first floor emergency generator transfer switch room and the outside generator set each had a battery backup light. Based on a review of the Monthly Battery Light Log on 06/23/16 at 12:50 p.m. with the maintenance supervisor, the Monthly Battery Light Log indicated a monthly test of the battery backup light at the emergency generator set but lacked a monthly test of the first floor transfer switch room battery backup light. Furthermore, there was no annual ninety minute tests conducted on the two battery backup lights. The lack of monthly testing of the first floor transfer switch room battery backup light and annual ninety minute testing of both the emergency generator set battery backup light and the first floor transfer switch battery backup light was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		To ensure that these lights are tested annually, we willprovide education to maintenance staff to implement the proper annual testingand documentation. The testing of these lights has been added to thepreventative maintenance log. How the corrective action will be monitored to ensure the deficientpractice will not recur The preventative maintenance log will be brought to themonthly QAPI meeting By what date the systemic changes will be completed 7/23/16	

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K 0047 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 4 of 27 exit signs were continuously illuminated. This deficient practice affects 23 residents who reside on the Station #1 South Hall and 40 residents who reside on the Station #3 Hall. Findings include: Based on observations on 06/23/16 during a tour of the facility with the maintenance supervisor and assistant maintenance supervisor, the activity room exit sign, the Station #1 South Hall exit sign, the Station #1 South Hall exit sign by the dining room, and the Administration Hall exit sign at the fire door set leading to Station #3 were each not illuminated. Based on an interview with the assistant maintenance supervisor on 06/23/16 at the time of observations, it was stated the exit sign light bulbs are burned out. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of	K 0047	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The 4 exit lightshave been updated and new bulbs installed. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents have the potential to be affected by exitsigns that are not illuminated. Exits signs will be checked during weeklypreventative maintenance rounds What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: Maintenance staff will be educated to include the check ofexit signs being illuminated during the weekly preventative maintenance rounds How the corrective action will be monitored to ensure the deficientpractice will not recur The illumination ofexit signs will be	07/23/2016

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	observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		monitored during the weekly preventative maintenance rounds andbrought to the monthly QAPI meetings By what date the systemic changes will be completed 7/23/16	
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to ensure 4 of 4 second shift fire drills were held at varying times over the past year to protect 136 of 136 resident. This deficient practice could affect all residents in the facility. Findings include: Based on a review of the Fire Drill Reports with the maintenance supervisor on 06/23/16 at 8:45 a.m., the Fire Drill Reports for second shift were held at the following similar times over the past year; 02/28/26 at 3:00 p.m., 05/31/16 at	K 0050	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: Fire drills for 2ndshift from now on will be given at a more random time schedule and spacedfarther apart to meet the guidelines dictated by state regulations. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents have the potential to be affected by thispractice. Second shift fire drills will be done at a more	07/23/2016

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	3:30 p.m., 08/12/15 at 5:00 p.m., 11/04/15 at 2:30 p.m. Based on an interview with the maintenance supervisor and written on each Fire Drill Report, the second shift time runs from 2:00 p.m. to 10:00 p.m. The similar timed fire drill records were acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		random time scheduleand spaced farther apart. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The facility will be following the guidelines for 2ndshift fire drills and they will be on a random basis. How the corrective action will be monitored to ensure the deficientpractice will not recur Fire drills will bereviewed monthly and the monitored through the monthly QAPI meeting. By what date the systemic changes will be completed 7/23/16	
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on observation and interview, the facility failed to ensure 4 of 77 smoke detectors were not located where airflow would prevent the operation of the detectors. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be	K 0052	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: All smoke detectorslocated between six inches and two feet from a return or supply air duct willbe moved to a suitable location. Work to relocate these smoke detectors isscheduled	08/01/2016

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	located where airflow prevents operation of the detectors. This deficient practice affect 38 residents who use the basement Station #5 activity room, 12 residents who use the basement physical therapy room, 33 residents who use the first floor activity room, and 32 residents who reside on the first floor Station #4 Hall. Findings include: Based on observations on 06/23/16 during a tour of the facility with the maintenance supervisor and assistant maintenance supervisor from 8:40 a.m. to 1:05 p.m., the smoke detector located in the basement corridor outside the medical records room, the smoke detector located in the basement laundry wash machine room, the smoke detector located in the first floor Activity Room South Hall near the exit door, and the smoke detector located in the first floor Station #4 Hall near resident room 410 were between six inches and two feet from a return or supply air duct. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		to begin on August 1, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents affected by the improper location of smokedetectors will be not be affected after the completion of the relocationscheduled to begin on August 1, 2016. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: Once the relocation of the smoke detectors is completed onAugust 1, 2016 there will be no further recurrence. How the corrective action will be monitored to ensure the deficientpractice will not recur: Once the relocation of the smoke detectors is completed onAugust 1, 2016 there will be no further reocurrence By what date the systemic changes will be completed 8/1/16	

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K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinkler types stored in a cabinet and a sprinkler wrench for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. 2-4.1.6 requires a special sprinkler wrench to be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed. This deficient practice could affect all residents in the facility if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.	K 0062	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: A sprinkler cabinet,including two spare sprinkler heads of each type in the building and a wrenchfor each type of head will be obtained and mounted in the sprinkler room. Allmissing or improperly installed sprinkler escutcheons have be installed ormounted properly. Room 305 that had two nonmatching sprinkler heads will bechanged to ensure both heads are the same type. The Unit 3 stairwell side wallsprinkler head has been cleaned. The work to do these corrections is scheduledto begin on 7/26/16. How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action will be taken: A sprinkler cabinet,including two spare sprinkler heads of each type in the building and a wrenchfor each type of head will be obtained and mounted in the sprinkler room. Allmissing or improperly installed sprinkler escutcheons have be installed ormounted properly. Room	07/26/2016

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	Findings include: Based on observation on 06/23/16 at 1:00 p.m. with the maintenance supervisor and assistant maintenance supervisor, the first floor riser room, located in the first floor activity room closet, lacked two spare sprinklers of four different types observed throughout the facility, a cabinet, and a sprinkler wrench. Based on an interview with the maintenance supervisor at the time of observation, the facility has a couple spares in the basement repair shop but does not have two spares of each of the four types of sprinklers in the facility identified during the facility tour as sidewall sprinklers, upright intermediate sprinklers, and ordinary upright and pendant sprinklers, does not have a sprinkler cabinet or a sprinkler wrench. The lack of spare sprinklers, a sprinkler cabinet and a sprinkler wrench was verified by the maintenance supervisor at the time of observation of the sprinkler riser room and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 9 of over 300		305 that had two nonmatching sprinkler heads will bechanged to ensure both heads are the same type. The Unit 3 stairwell side wallsprinkler head has been cleaned. The work to do these corrections is scheduledto begin on 7/26/16. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: The monthly preventative maintenance log will be updated toinclude the observation of the spare sprinkler heads of each type and wrenchfor each type is located in the sprinkler room, and escutcheons are in placewith proper installment, and sprinkle heads will be observed for debris. How the corrective action will be monitored to ensure the deficientpractice will not recur The preventative monthly maintenance log will be review andbrought to the monthly QAPI meeting. By what date the systemic changes will be completed 7/26/16	

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	sprinkler heads in the facility were maintained. This deficient practice could affect 22 residents who use the Station #3 dining room, 38 residents who reside on the Station #6 Hall and 12 residents who reside in resident room #319, #505, #620, #608, #301, and #305. Findings include: Based on observations on 06/23/16 during a tour of the facility with the maintenance supervisor and assistant maintenance supervisor from 8:40 a.m. to 1:05 p.m., the following sprinklers were either missing the escutcheon or were not tight fitting to the ceiling; a. The first floor Station #3 dining room sprinkler by the television had a one inch gap where the escutcheon was not tight fitting to the ceiling. b. The first floor Station #3 soiled linen room sprinkler had a two inch gap where the escutcheon was not tight fitting to the ceiling. c. The first floor resident room #319 bed 1 sprinkler had a one inch gap where the escutcheon was not tight fitting to the ceiling. d. The first floor resident room #505 sprinkler was missing the escutcheon. e. The first floor resident room #620 was missing the escutcheon. f. The first floor Station #6 Hall			

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	sprinkler in the corridor by resident room #611 was missing the escutcheon. g. The first floor resident room #608 sprinkler was missing the escutcheon. h. The first floor resident room #301 sprinkler was missing the escutcheon. i. The first floor resident room #305 sprinkler was missing the escutcheon. The above listed sprinklers not tight fitting to the ceiling or missing the escutcheons was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 20 Station #3 Hall resident rooms was provided with sprinklers with similar temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. NFPA 13, Table			

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	5-2.5.1 describes Ordinary sprinklers as having a temperature rating of 135 to 170 degrees Fahrenheit (F) and Intermediate sprinklers as having a temperature rating of 175 to 225 degrees F. This deficient practice could affect 2 residents who reside in resident room 305. Findings include: Based on observation on 06/23/16 at 11:50 a.m. with the maintenance supervisor, resident room #305 had one ordinary sprinkler with a temperature rating of one hundred fifty five degrees and one intermediate sprinkler with a temperature rating of two hundred twelve degrees in the same room. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b) 4. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.			

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(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
	NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect any staff who use the basement maintenance repair shop stairway exit during an emergency. Findings include: Based on observation on 06/23/16 at 9:35 a.m. with the maintenance supervisor and assistant maintenance supervisor, the basement maintenance repair shop stairway sidewall sprinkler was completely covered in white paint. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0066 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.			

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	(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review, and interview, the facility failed to ensure 3 of 4 areas where smoking was permitted used a noncombustible ashtray and metal self-closing containers for discarded smoking material. This deficient practice could affect all residents if a fire occurred at the outside locations where smoking is permitted. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the Activity outside smoking location and the Administration Hall two outside smoking locations each had over one hundred discarded cigarette butts on the ground surface in the wooden mulch. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and	K 0066	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: Garden Villa has adesignated smoking area on the property, behind the building in the backparking lot. Staff have been educated on the location of the only designatedsmoking area. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Garden Villa has adesignated smoking area on the property, behind the building in the backparking lot. Staff have been educated on the location of the only designatedsmoking area. What measure will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Staff will be monitored for compliance with smoking in thedesignated smoking area only.	07/23/2016

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	acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		Staff found to be smoking outside this area willreceive disciplinary action. How the corrective action will be monitored to ensure the deficientpractice will not recur Staff monitoring will be brought to the monthly QAPImeeting. By what date the systemic changes will be completed 7/23/16	
K 0067 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire damper was inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 12 residents who use the	K 0067	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The fire damper inthe basement elevator #1 is scheduled for inspection and routine maintenance onAugust 1, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any resident using elevator #1 has thepotential to be affected. The fire damper in the basement elevator #1 is scheduledfor inspection and routine maintenance on August 1, 2016. What measure will be put into place or what systemic changeswill be	08/01/2016

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	basement physical therapy room and 38 residents who use the basement Station #5 Hall activity room. Findings include: Based on observations on 06/23/16 at 9:50 a.m. with the maintenance supervisor, the basement elevator #1 mechanical room door had a fire damper installed in the door opening. Based on an interview with the maintenance supervisor on 06/23/16 at 10:00 a.m., the maintenance supervisor indicated the basement elevator #1 room fire damper has not had a four year inspection conducted and no records were available for review. The lack of a four year fire damper inspection on the basement elevator #1 fire damper was acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		made to ensure that the deficient practice does not recur: The fire damper will be placed on routine inspectionsKoorsen Fire and Security. How the corrective action will be monitored to ensure the deficientpractice will not recur The fire damper will be placed on routine inspectionsKoorsen Fire and Security and inspections will be verified and brought to themonthly QAPI meeting. By what date the systemic changes will be completed 8/1/16	
K 0068 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 6 boiler rooms were provided with outside air.	K 0068	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice:	07/23/2016

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	This deficient practice could affect 38 residents who use the basement Station #5 Hall activity room, located adjacent to the basement main boiler room, and any number of residents who use the first floor Activity Hall located near the first floor main electric/boiler room. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the basement main boiler room, which had three natural gas hot water heaters in use, and the first floor main electric/boiler room, which had two natural gas hot water heaters in use, each lacked a fresh air intake supplied from the outside. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		Both mechanical roomshave had fresh air intake completed on July 7, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: No residents have the potential to be affected as the freshair intake has been completed to both mechanical rooms on July 7, 2016. What measure will be putinto place or what systemic changes will be made to ensure that the deficientpractice does not recur: Both mechanical room have fresh air intake as of July 7,2016 and this is a permanent fix so the deficient practice can not recur. How the corrective action will be monitored to ensure the deficientpractice will not recur Both mechanical room have fresh air intake as of July 7,2016 and this is a permanent fix so the deficient practice cannot recur. By what date the systemic changes will be completed 7/23/16	
K 0069 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			

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	Based on observation, review and interview, the facility failed to ensure 1 of 1 fire extinguishing systems for commercial cooking operations was maintained in accordance with the applicable requirements of NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation. NFPA 96, Section 7-5.1 requires a readily accessible means for manual activation located in the path of exit or egress. This deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 06/23/16 at 12:10 p.m. with the maintenance supervisor and assistant maintenance supervisor, the kitchen overhead range hood suppression system manual pull station box was located on the south wall at the end of the kitchen corridor and not in a path of egress from the range. Furthermore, to activate the pull station box in the event of a fire, the activation would require a twenty foot distance in the opposite direction of the exit door from the range. The lack of the range hood suppression system manual pull station box not located in the path of travel from the range was verified by the	K 0069	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The manual pullstation for the range hood suppression system in the kitchen will be relocatedto a suitable location in the path of egress from the range. The work tocorrect this issue is to begin on August 1, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: The corrective action for the range hood suppression systemin the kitchen will be done on August 1, 2016. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: This will be a permanent fix for the range hood suppressionsystem and will not recur after August 1, 2016. How the corrective action will be monitored to ensure the deficientpractice will not recur This will be a permanent fix for the range hood suppressionsystem and will not recur after August 1, 2016. By what date the systemic changes will be completed 8/1/16	08/01/2016

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	maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0070 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 portable space heating devices was permitted in 1 of 12 basement staff offices where the heating element did not exceed 212 degrees F. This deficient practice could affect 38 residents who use the Station #5 Hall basement activity room and 12 residents who use the basement physical therapy room. Findings include: Based on observation on 06/23/16 at 8:50 a.m. with the maintenance supervisor, the basement dietician office had an electric space heater in use. Based on observation of the space heater and	K 0070	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: Space heaters of anytype are not permitted to be used anywhere in the building. Employees in thedietician office have been instructed to discontinue use of any space heatersand the space heater has been removed from the building. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any resident near anoffice with a space heater has the potential to be affected. Staff educationwas provided on no space heaters	07/23/2016

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	interview with the maintenance supervisor at the time of observation, there was no indication on the space heater of the heating elements temperature rating. Furthermore, the maintenance supervisor indicated at the time of observation the facility does not allow staff to use space heaters. This was verified by the maintenance supervisor at the time of observation and interview and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		permitted to be used in the building. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: During the monthly preventative maintenance rounds officeswill be observed for the use of space heaters. How the corrective action will be monitored to ensure the deficientpractice will not recur The monthly preventativemaintenance rounds will be brought to the monthly QAPI meeting By what date the systemic changes will be completed 7/23/16	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure 6 of 13 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 38 residents who reside on the Station #5 Hall, and 56 residents who reside on the Station #1 Hall. Findings include:	K 0072	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The hallways havebeen cleared of items. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken:	07/23/2016

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	Based on an observations with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m., the following corridors were obstructed with storage: a. The basement Station #5 activity corridor exit door was blocked by two tables, six chairs and two six foot long rubber mats. b. The basement Station #5 west corridor exit door was blocked by six empty soiled linen containers. c. The first floor Service Hall corridor had three plastic clean linen carts stored in the corridor near the exit door. d. The Kitchen Hall had six, six foot tall metal hot food carts and three metal food carts stored in the corridor outside the kitchen door. e. The Station #1 South Hall had two chairs stored in the corridor near the exit door. f. The Station #1 North Hall had three chairs and two Hoyer lifts stored in the corridor. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		All residents havethe potential to be affected by the storage of items in hallways. Staff havebeen educated on location for storage of items, and not leave them in thehallways. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: Daily preventative maintenance rounds will be done withnotification to staff of any items in hallways. Ongoing staff education will beprovided as needed. How the corrective action will be monitored to ensure the deficientpractice will not recur The dailypreventative maintenance rounds will be brought to the monthly QAPI meeting. By what date the systemic changes will be completed 7/23/16	

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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 103 of 103 resident rooms for 8 of the past 12 months. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility. Findings include: Based on record review on 06/23/16 at 8:45 a.m. with the maintenance supervisor, the Monthly Room Smoke Detector Checks log was reviewed and failed to list monthly tests of the one hundred three resident room battery operated smoke detectors for the months of June, July, August, September, October, December for the year 2015, and the months of January and February for the year 2016. The lack of resident room battery operated smoke detector monthly testing for eight of the past twelve months was verified by the maintenance supervisor at the time of	K 0130	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: All the 103 batteryoperated smoke detector have been checked. The water heaters in the buildinghave been inspected on 6/23/16. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All residents have the potential to be affected due to everyroom having a battery operated smoke detector. What measure will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur: The battery operated smoke detectors have been placed on themonthly preventative maintenance log to be checked. The heater/boiler inspectorcompleted the inspection of the water heaters on 6/23/16, and will be inspectedevery 2 years. How the corrective action will be monitored to ensure the deficientpractice will not recur The monthly preventative maintenance logs will be reviewedand brought to the	07/23/2016

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	record review and interview and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 7 of 7 hot water heaters/boilers had an inspection certificate that were current to ensure the boilers were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 38 residents who use the basement Station #5 activity room, 12 residents who use the basement physical therapy room, which are both located near the two basement boiler rooms, and any number of residents who use the first floor Activity Hall located near the first floor main electric/boiler room. Findings include: Based on review of the boiler/hot water heater inspection certificates with the maintenance supervisor on 06/23/16 at 8:55 a.m., the inspection certificates for boiler/hot water heater #218494, #228088, #261755, #261753, #280503, #291209, and #291210 all had an		monthly QAPI meeting By what date the systemic changes will be completed 7/23/16	

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	expiration date of 06/12/14. Based on an interview with the maintenance supervisor on 06/23/16 at 8:55 p.m., it was stated there is no current two year inspection certificate for the seven boiler/hot water heaters and it has not had or is scheduled for the two year inspection. The lack of current inspection certificate for the seven boiler/hot water heaters was verified by the maintenance supervisor at the time of interview and record review and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0143 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (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; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and			

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	Compressed Gas Association. 8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with 1 hour fire resistive construction. This deficient practice affect staff only who work in the first floor Manager Hall. Findings include: Based on observation with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 at 1:00 p.m., the first floor Manager Hall liquid oxygen storage room, where six full liquid oxygen containers were stored, had a ceiling fan located in the center of the ceiling. Furthermore, the ceiling fan cover was taken off and exposed one layer of five eighth inch drywall, which only gives the ceiling a one half hour rating. Furthermore, the charge nurse on the Manager Hall indicated during an interview on 06/23/15 at 1:00 p.m., the liquid oxygen storage room is used to transfer liquid oxygen from large containers to small portable containers for resident use. The lack of a one hour rated ceiling in the liquid oxygen storage room was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and	K 0143	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The first floormanagers hall liquid oxygen storage room ceiling has been updated and anadditional layer of 5/8" dry wall was added to the ceiling. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any resident near the liquid oxygen storage room had thepotential to be affected and an additional layer of 5/8" dry wall was added tothe ceiling What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: This was a permanent fix to the ceiling in the liquid oxygenstorage room and will not recur. How the corrective action will be monitored to ensure the deficientpractice will not recur This was a permanent fix to the ceiling in the liquid oxygenstorage room and will not recur. By what date the systemic changes will be completed 7/23/16	07/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155100		06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BEDFORD	2111 NORTON LN BEDFORD, IN 47421

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	acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 133 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 57 residents who use the beauty shop. Findings include:	K 0147	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The first floorbeauty shop receptacle was changed to a GFCI receptacle. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any resident usingthe beauty shop had the potential to be affected by this practice before thereceptacle was changed to a GFCI receptacle. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: This was apermanent fix as the receptacle was replacement to GFCI. How the corrective action will be monitored to ensure the deficientpractice will not recur This was a permanentfix as the receptacle was replacement to GFCI. By what date the systemic changes	07/23/2016

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	155100		06/23/2016

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	Based on observation with the maintenance supervisor and assistant maintenance supervisor on 06/23/16 at 11:50 a.m., the first floor beauty shop had an electric receptacle on the west wall within two feet of the hair wash basin with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor and assistant maintenance supervisor at the time of observation, the circuit breakers for the electric outlet was not provided with GFCI protection at the breaker panel. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		will be completed 7/23/16	
K 0160 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2,			

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	9.4.3, 19.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) Based on observation and interview, the facility failed to ensure 2 of 4 elevator lobby areas were provided with smoke detection. This deficient practice could affect 38 residents who use the basement Station #5 Hall activity room, 12 residents who use the basement physical therapy room, and 32 residents who reside on the first floor Station #4 Hall. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the first floor Station #4 Hall elevator lobby room and the basement Maintenance Hall elevator lobby room each lacked smoke detection. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)	K 0160	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: The first floorStation 4 elevator lobby will have smoke detection added on August 1, 2016. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: Any residentutilizing the State 4 elevator lobby had the potential to be affected by thelack of smoke detection. Smoke detection is scheduled to begin on August 1,2016. What measure will be put into place or what systemic changeswill be made to ensure that the deficient practice does not recur: This will be a permanent fix as the smoke detection isscheduled to begin on August 1, 2016. How the corrective action will be monitored to ensure the deficientpractice will not recur This will be apermanent fix as the smoke detection is scheduled to begin on August 1, 2016 By what date the systemic changes	08/01/2016

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			will be completed 8/1/16	
K 0211 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623			
	Based on observation and interview, the facility failed to ensure 2 of 10 first floor corridor area alcohol based hand rub dispensers did not exceed 1.2 liters in capacity. This deficient practice could affect 80 residents who reside on the Station #1 Hall and Station #2 Hall. Findings include: Based on observations on 06/23/16 during a tour of the facility from 8:40 a.m. to 1:05 p.m. with the maintenance supervisor and assistant maintenance supervisor, the Station #1 Hall nurses' station and the Station #2 Hall nurses' station each had a two liter container of	K 0211	What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice: All Alcohol basedhand rubs exceeding 1.2 liters have been removed from the building. How other residents having the potential to be affected bythe same deficient practice will be identified and what corrective action willbe taken: All Alcohol based hand rubs exceeding 1.2liters have been removed from the building. What measure will be put into place or what systemic changeswill be made to ensure that the deficient	07/23/2016

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	alcohol based hand rub in use. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/23/16 at 1:05 p.m. 3.1-19(b)		practice does not recur: Staff education provided to the staff who order supplies onnever to order alcohol based hand rubs in containers larger than 1.2 liters.During the monthly preventative maintenance rounds the nursing units will beobserved for containers of alcohol based hand rubs larger than 1.2 liters. How the corrective action will be monitored to ensure the deficientpractice will not recur The monthlypreventative maintenance rounds will be brought to the monthly QAPI meeting. By what date the systemic changes will be completed 7/23/16	