

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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	<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: 10/06/15</p> <p>Facility Number: 000054 Provider Number: 155126 AIM Number: 100287850</p> <p>At this Life Safety Code survey, Springs Valley Meadows 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>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 67 at the time of this</p>	K 0000	<p>"This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited, This submission of this Plan of Correction is not an admission or agreement with the deficiencies or conclusions contained in the Department's inspection report" We would like to request a desk review, please feel free to contact, Stacy Burton, Executive Director, should you need any further additional information to support the desk review @812-936-9991 Thank You for your consideration to this request</p>	
------------------------	---	--------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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 0062 SS=F Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached laundry building, as well as two small detached wooden sheds used for facility storage and bio hazard storage.</p> <p>Quality Review completed 10/08/15 - DA</p> <p>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</p> <p>1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of</p>	K 0062	<p>Maintenance Director was in-serviced on ensuring timely written quarterly inspections Vanguard was @ facility on 10/08/15 and completed the missing 3rd quarter sprinkler system inspection with written report obtained Quarterly Auditing to be completed to ensure appropriate timing of sprinkler system inspections Extra spare quick response pendent type heads with green glass tubes were ordered on 10/07/15 and received on 10/12/15 and placed in the cabinet Facility will ensure that extra spares will be ordered at the time of usage if needed</p>	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspection; flow, drain, and pump tests; trip tests of dry pipe, deluge and preaction valves. NFPA 25, 2-2.6 requires that alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 2-3.3 requires waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the quarterly sprinkler system inspection records on 10/06/15 at 11:00 a.m. with the Maintenance Supervisor present, there was no quarterly sprinkler system inspection report available for the third quarter (July, August, and September) of 2015. During an interview at the time of record review, the Maintenance Supervisor acknowledged there was no written documentation or other evidence the sprinkler system had been inspected</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>during the third quarter of 2015.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler head storage cabinets were provided with at least two of each type of sprinkler heads used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect one staff as well as visitors while using the Mechanical Room where the fire alarm panel is located.</p> <p>Findings include:</p> <p>Based on observation on 10/06/15 at 12:20 p.m. during a tour of the facility with the Maintenance Supervisor, the spare sprinkler head cabinets in the sprinkler riser room had over ten spare sprinkler heads, however, there were no spare quick response pendent type heads with green glass tubes. Quick response pendent type sprinkler heads with green glass tubes were observed in the Mechanical Room where the fire alarm panel was located. This was acknowledged by the Maintenance</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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 0144 SS=C Bldg. 01	<p>Supervisor at the time of observation, furthermore, the Maintenance Supervisor said there were no other spare sprinkler heads in the facility that he was aware of.</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>1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be</p>	K 0144	<p>Facility received documentation from Vanguard on 10/12/15 that the current Generator does meet the required 30% load EPS nameplate rating for a minimum of 30minutes.Maintenance Director in-serviced by Vanguard on the proper way to figure the load with the appropriate formula. Generator documentation to include a cool down time following the load test. Generator Documentation to be reviewed monthly to ensure appropriate completeness.</p>	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log on 10/06/15 at 10:15 p.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested monthly under load, however, the documentation did not show the generator was exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past three months and was under the 30 percent requirement. The generator log form indicated the generator was a 63 KW generator that required 18.9 KW to meet at least the 30 percent requirement. The column for load had the answer 10.5 KW during each of the past three months. This was acknowledged by the Maintenance Supervisor at the time of record review. Furthermore, the Maintenance Supervisor said the generator was fueled by natural gas with an LP back up.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015	
NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected and exercised in accordance with NFPA 99. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log on 10/06/15 at 10:15 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested monthly for 35 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include documentation of a cool down time being recorded.</p> <p>3.1-19(b)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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 0154 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 67 of 67 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors at the time of this survey.</p>	K 0154	The facilities Fire Watch Procedure written policy was updated to include the phone numbers of the Local Fire Department, Insurance Carrier and the Indiana State Department of Health.	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(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 0155 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on review of the emergency Fire Watch Procedure with the Maintenance Supervisor present on 10/06/15 at 10:55 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch procedure did not include phone numbers for the local fire department, insurance carrier, and the Indiana State Department of Health. The lack of this documentation was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 67 of 67 residents containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8.</p>	K 0155	The facilities Fire Watch Procedure written policy was updated to include the phone numbers of the Local Fire Department, Insurance Carrier and the Indiana State Department of Health.	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility including residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the emergency Fire Watch Procedure with the Maintenance Supervisor present on 10/06/15 at 10:55 a.m., the facility did have a written policy and procedure for an impaired fire protection system, however, the fire watch procedure did not include phone numbers for the local fire department and the Indiana State Department of Health. The lack of this documentation was acknowledged by the Maintenance Supervisor at the time of record review.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432		
(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	
	3.1-19(b)				