

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2015
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NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150
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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: 12/31/15</p> <p>Facility Number: 012619 Provider Number: 155813 AIM Number: 201238590</p> <p>At this Life Safety Code Recertification and State Licensure Survey, The Villages at Historic Silvercrest 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This five story facility with a basement was determined to be of Type II (222) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 54</p>	K 0000		

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

TITLE

(X6) DATE

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

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K 0025 SS=E Bldg. 01	<p>and had a census of 52 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the first floor beauty shop and all areas providing facility services were sprinkled except the basement elevator equipment room.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 basement ceiling smoke barrier was constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or</p>	K 0025	The penetrations in the ceilings of the basement sprinkler control room and the basement boiler room have been fire stopped. No other areas were identified during the inspection and an additional inspection was conducted by Plant Operations Support and the Director of Plant Operations with no additional concerns identified. The Director of Plant Operations and Plant Ops Assistant will be re-inserviced to ensure know to firestop any penetrations made by them or and inspect the work	01/30/2016

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K 0029	<p>be protected by an approved device designed for the specific purpose. This deficient practice affects all staff who work in the basement and 14 healthcare residents who use the first floor main dining room, first floor swimming pool, and first floor beauty.</p> <p>Findings include:</p> <p>Based on observations with the assistant director of plant operations during a tour of the basement on 12/31/15 from 9:35 a.m. to 10:45 a.m., the following locations had ceiling penetrations not firestopped;</p> <ol style="list-style-type: none"> 1. The basement sprinkler control valve room ceiling had two, one half inch gaps around sprinkler pipe penetrations not fire stopped. 2. The basement boiler room ceiling had twelve, one half inch circular holes in the concrete ceiling not fire stopped. <p>The basement control valve room ceiling and basement boiler room ceiling gaps and holes not fire stopped was verified by the assistant director of plant operations at the time of observations and acknowledged at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b) NFPA 101</p>				<p>area if using outside contractors. Plant Operations Support will conduct an inspection of ceilings for penetrations during monthly rounds. Results of these inspections will be shared with the ED and QA Committee monthly and will continue until 100% compliance is reached for 3 consecutive months.</p>		

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SS=B Bldg. 01	<p>LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered basement kitchen storage room over 100 square feet was separated from the Service Hall by smoke resistant doors. This deficient practice affects all staff who work in the basement Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 12/31/15 at 10:10 a.m. with the assistant director of plant operations, the basement kitchen storage room, which measured two hundred square feet and stored six combustible wooden chairs, four cloth lounge chairs, and twelve plastic mattresses, had a three quarter inch gap on the door set where the doors came together in the closed position. This was verified by the assistant director of plant operations at the time of observation and acknowledged at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b)</p>	K 0029	A door sweep was installed to fill the gap between the doors identified. During inspection, no other doors were identified. After the inspection, Plant Operations Support and the Director of Plant Ops also inspected and found no additional concerns with gaps between fire doors. All fire doors will be checked monthly by the Director of Plant Operations or designee to ensure no gaps. This will continue monthly and will be permanently added to our preventive maintenance schedule in order address any gaps that may develop. Results of these inspections will be shared with the ED and QA Committee for review.	01/30/2016

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K 0038 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 first floor swimming pool room corridor doors was readily accessible for staff egress. This deficient practice affects maintenance staff that uses the swimming pool room pump room.</p> <p>Findings include:</p> <p>Based on observations on 12/31/15 at 12:20 p.m. with the assistant director of plant operations, the first floor swimming pool pump room door failed to open after the door was closed and latched from the inside of the room. This was acknowledged by the assistant director of plant operations at the time of observation and at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b)</p>	K 0038	The locking door knob was replaced on the swimming pool pump room to a lock that will allow exit at all times. All other locking doors throughout the campus were checked with no other concerns noted. This door will be checked by the Director of Plant Operations or designee a minimum of monthly to ensure the new locking mechanism is functioning properly. Results of these inspections will be shared with the ED and QA Committee monthly and will continue until 100% compliance for 3 consecutive months.	01/30/2016			
K 0039 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at</p>						

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K 0050 SS=C Bldg. 01	<p>least 6 feet. 18.2.3.3, 18.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 4 third floor corridors was at least 8 feet in width. This deficient practice could affect 23 residents who reside on the third floor.</p> <p>Findings include:</p> <p>Based on observation on 12/31/15 at 12:25 p.m. with the assistant director of plant operations, the third floor forty two foot long dining room corridor measured five feet six inches wide. This was verified by the assistant director of plant operations at the time of observation and measurement and acknowledged at the time of observations and at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p>			K 0039	We are requesting a waiver regarding the corridor width cited. Please see the attached document for details from Gary Joy, VP of Construction of Developmen with Trilogy Health Services.		04/30/2016
	<p>Based on record review and interview, the facility failed to ensure 2 of 3 shift</p>			K 0050	The timing of the fire drills has now been planned for the entire		01/30/2016

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	<p>fire drills were held at varying times over the past year to protect 52 of 52 healthcare residents. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Record of Fire Drill reports with the assistant director of plant operations on 12/31/15 at 8:50 a.m., the Record of Fire Drill reports for first shift and second shift over the past year were held at the following similar times; First Shift on 01/29/15 at 11:50 a.m., 04/30/15 at 10:33 a.m., 07/27/15 at 11:44 a.m., Second Shift on 02/28/15 at 2:46 p.m., 06/30/15 at 3:11 p.m., 09/28/15 at 3:10 p.m. Based on an interview with the assistant director of plant operations at the time of record review, first shift time runs from 6:00 a.m. to 2:30 p.m., and second shift time runs from 2:30 p.m. to 10:00 p.m. The similar timed fire drill records for first and second shift was verified by the assistant director of plant operations at the time of record review and acknowledged at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b)</p>		<p>year. This schedule has been outlined on a document and is maintained for the Director of Plant Operations to follow when initiating fire drills. The Director of Plant Operations and Plant Ops Assistant will be re-inserviced on the fire drill timing schedule, to include the importance of adhering to the times identified. The schedule for 2016 includes 1st shift drills at 8am, 11am, & 1:30pm. 2nd shift drills at 3pm, 6:00pm, & 9:30pm. 3rd shift drills at 11pm, 2am, & 5am. The fire drill times will be reviewed monthly during monthly QA Committee meetings to ensure compliance to include recommending an additional fire drill at the scheduled time if times aren't within 30 mintues of the schedule. This will ensure the fire drill times are spaced out sufficiently to meet the regulatory requirement.</p>	

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K 0056 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to ensure 1 of 1 basement elevator equipment rooms and 1 of 1 first floor beauty shops was fully sprinklered. This deficient practice affects 14 healthcare residents who use the first floor beauty shop.</p> <p>Findings include:</p> <p>Based on observation on 12/31/15 during a tour of the facility from 9:25 a.m. to 1:00 p.m. with the assistant director of plant operations, the basement elevator equipment room lacked sprinkler coverage. Furthermore, the first floor beauty shop had one sprinkler on the west side of the room and lacked sprinkler coverage on the east side of the room. This was verified by the assistant director</p>	K 0056	A sprinkler line and head will be installed in the basement elevator equipment room and an additional head in the beauty shop on the east side of the room. No additional needs for sprinklers was identified during the inspection.	01/30/2016

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K 0062 SS=E Bldg. 01	<p>of plant operations at the time of observations and acknowledged at the exit conference on 12/31/15 at 1:10 p.m.</p> <p>3.1-19(b)</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in corrosion. 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. 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 14 healthcare residents who use the first floor swimming pool.</p> <p>Findings include:</p> <p>Based on observation on 12/31/15 at 12:25 p.m. with the assistant director of plant operations, the swimming pool</p>	K 0062	<p>A wax-coated sprinkler head will be installed that is less likely to corrode in this location. During inspection, no other sprinkler heads were noted as a concern. Plant Operations Support and the Director of Plant Ops conducted an additional inspection of all sprinkler heads and noted no additional concerns. An inspection of all sprinkler heads will be implemented and added to the preventive maintenance schedule so all sprinkler heads are checked a minimum of quarterly for corrosion. Results of these inspections will be shared with the ED and QA Committee monthly and will continue until 100% compliance for 3 consecutive quarters.</p> <p>Addendum: The Director of Plant Ops verified with our electrician that shunt trips for elevators are already existing and installed. Vanguard Alarm Systems is scheduled to connect to the Fire</p>	01/30/2016

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	pump room sprinkler was completely covered in green corrosion. This was verified by the assistant director of plant operations at the time of observation and acknowledged at the exit conference on 12/31/15 at 1:10 p.m. 3.1-19(b)		Panel/Fire Alarm on 1/25/16.		