

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/23/13</p> <p>Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Davis Gardens Health Center 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 two story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors were provided in all resident</p>	K010000	<p>K 000 Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Davis Gardens of the truth of the facts alleged in this statement of deficiency and plan of correction is submitted exclusively to comply with state and federal law. Davis Gardens reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Davis Gardens Quality Assurance Performance Improvement Committee.</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:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>rooms. The facility has the capacity for 78 and had a census of 68 at the time of this survey.</p> <p>All areas with resident access were sprinklered. All areas providing facility services were sprinklered except the elevator rooms and the walk-in refrigerator and freezer in the kitchen.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings on 1 of 2 floors could automatically latch into the door frame. This deficient practice affects staff, visitors and 41 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 1:20 p.m., the corridor access door to the first floor locker and crash cart storage room failed to latch when tested three times. The maintenance director acknowledged at the time of observations, the door latch failed to engage to keep the door tightly closed in the door frame.</p>	K010018	<p>K018-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This deficient practice affects staff, visitors and 41 or more residents on the first floor. No one suffered adverse effects as a result of this practice. We are having Crossroads door and hardware come out to correct the issues with the door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. A preventative maintenance schedule will be put in place; no other residents will be affected by this deficient practice. What measures will be put into</p>	10/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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)		place or what systemic changes will be made to ensure that the deficient practice does not recur? Added to the preventative maintenance schedule quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit tool will be created to check that the preventative maintenance is in place and checked quarterly times four quarters. By what date the systematic changes will be completed? October 23, 2013.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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			
K010020 SS=E	<p>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 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 vertical openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect visitors, staff and ten or more residents in the north smoke compartments of the first and second floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 1:40 p.m., the first floor north stairway door leading to the second floor was not</p>	K010020	<p>K020-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This deficient practice could affect visitors, staff and 10 or more residents. In the north smoke compartments on the 1st and 2nd floors. No one suffered adverse effects as a result of this practice. We are having Crossroads door and hardware come out to correct the issues with the door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. A preventative maintenance schedule will be put in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Added to the preventative maintenance schedule quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be</p>	10/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>provided with a working latch to allow the door to close and latch in the door frame. The door was tested three times and the failure to latch was verified by the maintenance supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>put into place. An audit tool will be created to check that the preventative maintenance is in place and checked quarterly times four quarters. By what date the systematic changes will be completed? October 23, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
K010021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 12 doors to hazardous areas, such as a kitchen storage room larger than 50 square feet, were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors and 3 or more kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:20 p.m., the self closing double doors to the kitchen storage room were equipped with kick down door stops which held the doors wide open. The maintenance supervisor acknowledged at the time of observation, the doors would not</p>	K010021	<p>K021-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient practice affects visitors and 3 or more kitchen staff. We removed the door stops. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. Facility removed the door stops. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All plant staff will be in-serviced on this policy. How the corrective action(s) will be</p>	10/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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	
	automatically close.  3.1-19		monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit tool will be created to check that the door is free from door stops quarterly times four quarters. By what date the systematic changes will be completed? October 23, 2013.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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			
K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through smoke barriers on 1 of 2 floors were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 41 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 between 12:20 p.m. and 4:30 p.m.:</p> <p>a. There were two unsealed pipe and</p>	K010025	<p>K025- Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficiency could affect visitor, staff and 41 or more residents on the 1st floor. We have caulked these areas with fire rated material. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. Maintenance Director or designee will complete a house audit of firewall penetrations. Maintenance Director or designee will advise all contractors and maintenance staff on the importance of fire caulk in firewall penetrations. What measures will be put into place or what systemic changes will be made to ensure</p>	10/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>conduit penetrations above the laid in ceiling at the first floor east smoke barrier above the fire doors with one inch annular gaps;</p> <p>b. There were six pipe and conduit penetrations above the laid in ceiling at the first floor north smoke barrier wall above the fire doors which were unsealed leaving one inch annular gaps.</p> <p>The maintenance supervisor agreed at the time of observations the gaps should have been sealed with a fire rated material.</p> <p>3.1-19(b)</p>		<p>that the deficient practice does not recur? Any work above the ceiling near the firewall will need to be inspected by Maintenance Director or designee before the ceiling is closed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Director or designee will check work performed any time work is done around smoke barriers. By what date the systematic changes will be completed? October 23, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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			
K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 5 of 12 doors to hazardous areas such as a storage rooms larger than 50 square feet closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors staff and 41 or more residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 1:30 p.m., the self closing door to the 80 square foot activities supply storage room failed to self close into the door frame when tested three times. The maintenance supervisor acknowledged at the time of observation, the closer was</p>	K010029	<p>K029-1-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient practice affects visitors, staff and 41 or more residents on the 1st floor. We are having Crossroads door and hardware come out to correct the issues with all of the deficient doors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. A preventative maintenance schedule will be put in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality</p>	10/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>malfunctioning.</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 1:35 p.m., the self closing door to the 176 square foot medical supply had no means to self close. When opened the door remained open until it was manually closed. The maintenance supervisor acknowledged at the time of observation, the door was not equipped with the means to self close.</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:00 p.m., the self closing door to the clean side of the laundry failed to self close and latch when tested three times. When opened the door swung closed but hit the door frame and the latch did not engage. The maintenance supervisor acknowledged at the time of observation, the door closer was not operating effectively.</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:15 p.m., the self closing door between the kitchen and adjacent facility supply receiving storage room would not close completely and gapped six inches. The door failed to close any tighter when tested three times. The maintenance supervisor acknowledged at the time of</p>		<p>assurance program will be put into place? Added to the preventative maintenance schedule quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit tool will be created to check that the preventative maintenance is in place and checked quarterly times four quarters. By what date the systematic changes will be completed? October 23, 2013.</p> <p>K029-2 Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficiency could affect visitors and 10 or more staff in the service areas and break room, and 1 or more residents transported through the ambulance entrance of the service corridor. We have caulked these areas with fire rated material. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. Maintenance Director or designee will complete a house audit of firewall penetrations. Maintenance Director or designee will advise all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>observation, the door closer was not operating effectively.</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:30 p.m., the self closing door between the kitchen and service corridor did not close and latch. When opened and allowed to close, the door hit the door frame and the latch failed to engage. The maintenance director acknowledged at the time of observation the door closer was malfunctioning.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 service corridor hazardous area wall smoke barriers were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors and 10 or more staff in the service areas and break room, and 1 or more residents transported through the ambulance entrance of the</p>		<p>contractors and maintenance staff on the importance of fire caulk in firewall penetrations. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? Any work above the ceiling near the firewall will need to be inspected by Maintenance Director or designee before the ceiling is closed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Director or designee will check work performed any time work is done around smoke barriers. By what date the systematic changes will be completed? October 23, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:20 p.m., the smoke barrier above the laid in ceiling between the service corridor and facility supply receiving storage room had two unsealed pipe penetrations which left one inch annular gaps. The maintenance supervisor agreed at the time of observations, the gaps around the penetrations should have been sealed.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire alarm panels in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. LSC 9.6.2.10.1 requires smoke alarms shall be in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants.</p>	K010051	<p>K051-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. We are having Simplexgrinnell install the smoke detector in this location. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. We are having Simplexgrinnell install the smoke detector in this location. What measures will be put into place or</p>	10/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 12:25 p.m., an adjunct fire alarm control panel (FACP) was located in the entry foyer, an area not continuously occupied. The area was not electrically supervised by a smoke detector. The maintenance supervisor acknowledged at the time of observation, the panel could be incapacitated by fire before an alarm could be annunciated in the area.</p> <p>3.1-19(b)</p>		<p>what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? The smoke detector will be monitored by the fire panel. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? It will be checked during the inspections by Simplexgrinnell. By what date the systematic changes will be completed? October 23, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
K010056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 first floor elevator equipment rooms were provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect visitors, staff and 41 or more residents who make use of the elevators.</p> <p>Findings include:</p>	K010056	<p>K056-Life Safety Code Standard</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient practice could affect visitors, staff and 41 or more residents who make use of the elevators. We are having Simplexgrinnell install sprinkler heads in the elevator equipment rooms and in the walk in cooler and freezer. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. We are having Simplexgrinnell install sprinkler heads in the elevator equipment rooms and in the walk in cooler</p>	10/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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>Based on observations with the maintenance supervisor on 09/23/13 between 12:20 p.m. and 3:00 p.m., the north and south elevator equipment rooms were not provided with sprinkler coverage. The maintenance supervisor confirmed no sprinklers protected these areas at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 1 kitchens. This deficient practice affects visitors and 3 or more kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:40 p.m., sprinkler protection was not provided for the walk-in refrigerator and freezer in the kitchen. The maintenance director acknowledged at the time of observation, the area was not protected by the sprinkler system.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>and freezer. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? The smoke detector will be monitored by the fire panel. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? It will be checked during the inspections by Simplexgrinnell. By what date the systematic changes will be completed? October 23, 2013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
--------------------	--	---------------	---	----------------------

K010062 SS=F	<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 observation and interview, the facility failed to ensure sprinkler piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 3:00 p.m., a sprinkler pipe above the laid in ceiling at the second floor smoke barrier near G211 was used as a hanger for wires zip tied to the pipe. The maintenance supervisor agreed at the time of observation, the sprinkler pipes should not be used to support other equipment installations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 6</p>	K010062	<p>K062-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. We have removed the zip ties that were attached to the sprinkler pipe outside G211. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. We are creating a policy and in-servicing all plant staff. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? Any work that is being done around the sprinkler system has to be inspected by the Maintenance Director or designee upon completion. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Director or designee will check</p>	10/23/2013
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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>sprinkler heads in the laundry were free of foreign materials such as lint. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects visitors and 1 or more laundry staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at 2:10 p.m., two sprinkler heads protecting the enclosed area behind the gas fueled commercial dryers in the laundry were covered with a thick white fuzzy material. The maintenance supervisor identified the material as lint at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 5 first floor smoke compartments were maintained. This deficient practice could affect visitors, 10 or more staff and 1 or more residents accessing the ambulance entrance in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/23/13 at</p>		<p>work performed any time work is done around the sprinkler systems. By what date the systematic changes will be completed? October 23, 2013.</p> <p>K062-2 Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient practice affects visitors and 1 or more laundry staff. We are cleaning the sprinkler heads behind the driers and we are issuing a preventative maintenance schedule to clean these sprinkler heads monthly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. A preventative maintenance schedule will be put in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? All plant staff will be in-serviced on this policy. A preventative maintenance schedule has been created monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>2:25 p.m., two sprinkler heads in the facility supply receiving storage room were missing sprinkler head escutcheons. The maintenance supervisor acknowledged at the time of observations, the escutcheons were part of the sprinkler assembly.</p> <p>3.1-19(b)</p>		<p>assurance program will be put into place? An audit tool will be created to check that the preventative maintenance is in place and checked monthly times twelve months. By what date the systematic changes will be completed? October 23, 2013.</p> <p>K062-3-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient could affect visitors, 10 or more staff and 1 or more residents accessing ambulance entrance in the service corridor. Simplexgrinnell is installing appropriate escutcheons to the locations. We are putting this on preventative maintenance schedule for every 6 months to be checked. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. Simplexgrinnell is installing appropriate escutcheons to the locations. We are putting this on preventative maintenance schedule for every 6 months to be checked. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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
			quality assurance program will be put into place? All plant staff will be in-serviced on this policy. A preventative maintenance schedule has been created for every 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit tool will be created to check that the preventative maintenance is in place and checked every 6 months times for a year. By what date the systematic changes will be completed? October 23, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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			
K010067 SS=F	<p>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</p> <p>Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 2 of 2 floors were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork 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 all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor between 12:30 p.m. and 3:00 p.m., smoke dampers were installed in center smoke compartment</p>	K010067	<p>K067- Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. We are getting the smoke dampers inspected by Simplexgrinnell. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. We are adding this to our contract with Simplexgrinnell to ensure this is being done; we will be able to provide the proper documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? We are putting this on a preventative maintenance schedule to be checked once a year. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Director or designee</p>	10/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
---	---

(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>ducts above the north and south smoke barrier doors on the second floor, one damper was located on F hall on the first floor. A review of contractor Fire Safety Inspection and Test Reports with the maintenance supervisor on 09/23/13 at 3:50 p.m. did not include damper inspections for three dampers in ducts on the first and second floor. The maintenance supervisor said at the time of record review the dampers had been inspected and immediately called the contractor, but was unable to provide documentation of the testing.</p> <p>3.1-19(b)</p>		<p>will check that Simplexgrinnell has completed their inspection every 4 years by having a preventative maintenance schedule created for Simplexgrinnell to come to the facility and inspect. By what date the systematic changes will be completed? October 23, 2013.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2013	
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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			
K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect visitors and 3 or more kitchen staff.</p> <p>Findings include:  Based on a review of contracted Range Hood Systems Report inspection records with the maintenance supervisor on 09/23/13 at 3:40 p.m., inspection and</p>	K010069	<p>K069-Life Safety Code Standard What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents suffered adverse effects as a result of this practice. This deficient practice could affect visitors and 3 or more kitchen staff. We are adding this to our preventative maintenance schedule every 6 months to ensure this gets completed on time. We were in compliance as of 9/18/2013. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by this practice. We are adding this to our preventative maintenance schedule every 6 months to ensure this gets completed on time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur, i.e. what quality assurance program will be put into place? Added to the preventative maintenance schedule every 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be</p>	10/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/23/2013
NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802		
(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>service records for the commercial range hood fire equipment extinguishing system were dated 02/25/13 and 09/18/13, a seven month lapse between inspections required at least every six months. The maintenance supervisor said at the time of record review, he was unaware the time between inspections had exceeded the six months allowed.</p> <p>3.1-19(b)</p>		<p>put into place? An audit tool will be created to check that the preventative maintenance is in place and checked every 6 months times for a year. By what date the systematic changes will be completed? October 23, 2013.</p>		