

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER  GARDEN VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN47421
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<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: 1/06/12</p> <p>Facility Number: 000040 Provider Number: 155100 AIM Number: 100274460</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Garden Villa was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 190 and had a census of</p>	K0000		

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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K0029 SS=E	<p>141 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 metal rolling doors separating the kitchen, a hazardous area, from the corridor would close automatically with the fire alarm system to maintain a smoke resistant barrier. This deficient practice could affect residents on 300 hall north as well as visitors and staff.</p> <p>Findings include:</p>	K0029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Based on the new interpretation of these rules the existing rolling window will be replaced with a new rolling window to meet the new interpretation of the K029 tag.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.Residents and visitors on the 300 hallway</p>	02/14/2012	

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K0064 SS=B	<p>Based on observation on 1/06/12 at 11:40 a.m. with the Maintenance Supervisor, the metal rolling door in the north kitchen wall which was open to the corridor was inspected annually, but did not release upon activation of the fire alarm system leaving a hazardous area open to the escape route corridor. Based on interview on 1/06/12 at 11:45 a.m. with the Maintenance Supervisor, it was acknowledged by the Maintenance Supervisor the rolling metal door does not close automatically upon activation of the fire alarm system and would leave the escape route corridor unprotected.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be</p>	K0064	<p>had the potential to be affected and a new rolling window has been ordered and will be installed on February 14, 2012. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The rolling window has been ordered and will be replaced on February 14, 2012. The new window will also be included with our yearly alarm test and maintenance that is contracted with Esco Communications. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The new rolling window has been added to the Plant Operations Yearly Preventative Maintenance Program. By what date the systemic changes will be completed. February 14, 2012</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A K class fire extinguisher placard was purchased and displayed beside the extinguisher. 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? Residents and visitors located in the dining room</p>	01/19/2012	

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	<p>listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 1/06/12 at 2:08 p.m. with the Maintenance Supervisor, there was a K class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 1/06/12 at 02:10 p.m. with the Maintenance Supervisor, it was acknowledged the K class portable fire extinguisher was not provided with a placard.</p> <p>3.1-19(b)</p>		<p>adjacent to the kitchen had the potential to be affected. Placard was placed beside the extinguisher on January 19, 2012. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Supervisor or designee will be responsible to monitor all fire extinguishers and placards monthly to ensure compliance. All audit results will be submitted to the QA&amp;A Committee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Supervisor or designee will be responsible to monitor all fire extinguishers and placards monthly to ensure compliance. All audit results will be forwarded to the QA&amp;A Committee. By what date systemic changes will be completed? January 19, 2012</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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