

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155019	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/02/2015
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NAME OF PROVIDER OR SUPPLIER  GARDEN VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403
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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: 12/02/15</p> <p>Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040</p> <p>At this Life Safety Code survey, Garden Villa-Bloomington 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) and 410 IAC 16.2. The original portion of the facility which was surveyed using Chapter 19, Existing Health Care Occupancies and included everything except the Dining Room/Lounge area on Station 3 and the renovated Sunroom on Station 1.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, all areas open</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 0017 SS=E Bldg. 01	<p>to the corridors, plus all resident sleeping rooms in Units 4, 5 and 6. There are battery operated smoke alarms in resident sleeping rooms 101 through 126, 201 through 216, and 301 through 339. The facility has a capacity of 224 and had a census of 160 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the Station 2 exit vestibule.</p> <p>Quality Review completed 12/08/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 open use areas were separated from the corridor by</p>	K 0017	We respectfully submit this plan of correction as proof of our compliance with State and Federal regulations, and per the	12/17/2015

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	<p>walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above or met an Exception. LSC 19.3.6.1, Exception #1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met:</p> <p>(a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect up to 20 residents, as well as staff and visitors in Station 6.</p> <p>Findings include:</p> <p>Based on observation on 12/02/15 at 1:20 p.m. during a tour of the facility with the</p>		<p>laws that mandate the submission of this plan. We respectfully request a desk review/paper compliance for the plan of correction submitted. Please review the attached documents with this plan of correction, as evidence of completion of this plan of correction and evidence of compliance. 1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; No specific resident was cited however the area this area has had a door reinstalled for fire safety compliance. 2) 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 have the potential to be affected by this deficiency. Area is now protected with a fire rated door. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The area will remain secured with a fire rated door and no changes will be made to this area. 4) 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. Any changes that are requested by staff for any area that involves fire safety will be reviewed in Quality Assurance for</p>	

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K 0048 SS=E Bldg. 01	<p>Maintenance Supervisor, the Station 6 Calm Room (Snuzzle Room) was open to the corridor without a door separating the room from the corridor. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The Calm Room was not protected by an electrically supervised automatic smoke detection system, nor was the entire space arranged and located to allow direct supervision by the facility staff from a nurses' station or similar staffed space. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 70 of 160 residents to accurately address all life safety systems such as staff response to battery operated smoke alarms in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan</p>	K 0048	<p>possible concerns or hazards prior to implementing any structural changes. This review will occur anytime there is a change to the building. The issue current is corrected and will not recur.</p> <p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; Residents in sleeping rooms 101 through 126, 201 through 216, and 301 through 339 have battery operated smoke detectors in their rooms. The fire safety plan has been updated to include specific responses to these alarms. 2) How other residents having the potential to be affected by the same deficient</p>	12/17/2015

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K 0056 SS=E	<p>that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Fire Safety plan on 12/02/15 at 10:30 a.m. with the Maintenance Supervisor present, the Fire Safety plan did not address staff response to battery operated smoke alarms in resident sleeping rooms 101 through 126, 201 through 216, and 301 through 339. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the Fire Safety plan did not include staff response to battery operated smoke alarms in the previously mentioned resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this deficiency. The policy and procedure for battery operated smoke detectors has been updated to include staff response and activation of system. (RACE)</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; This policy correction will address any concerns regarding this deficiency. Garden Villa will put this updated policy and training on an ongoing fire training in addition to the current fire drills we are conducting monthly. 4) 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. Fire drills are conducted monthly, this will increase to 2 drills a month one hardwired system and the other a battery operated smoke detector, this will continue for 6 months and then will alternate units and systems. These drills will be presented in Quality Assurance for review monthly.</p>				

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Bldg. 01	<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>Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 12 smoke compartments. This deficient practice could affect up to 6 residents, as well as staff and any visitors while entering or exiting the Station 2 vestibule.</p> <p>Findings include:</p> <p>Based on observation on 12/02/15 at 12:50 p.m. during a tour of the facility with the Maintenance Supervisor, there was no sprinkler head in the Station 2 entry/exit vestibule. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K 0056	<p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; No specific resident was cited, however a sprinkler will added to this vestibule area. 2) 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 have the potential to be affected by this deficiency in this area. This area will have a sprinkler installed. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur A sprinkler head and system will be added to this vestibule area for fire protection and safety. This area will be inspected by Circle City quarterly. Circle City has been contracted to complete this service and will be at the facility</p>	01/01/2016

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K 0062 SS=E Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 8 of over 1000 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect 4 residents, as well as staff while in the Pool Room and Station 3 south shower room.</p>	K 0062	<p>the week of December 21st to get measurements for the special order sprinkler heads. 4) 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. This sprinkler once installed will be added to the preventative maintenance with the other sprinklers and fire safety program at Garden Villa. The results of inspection will be presented in Quality Assurance monthly.</p> <p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were cited. The cited sprinkler heads will be changed. 2) 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 have the potential to be affected by this deficiency in this area. New non corrosive heads will be installed to replace the current heads. 3) What measures will be put into place or what systemic changes will be made to ensure that the</p>	01/01/2016	

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K 0130 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observations on 12/02/15 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with Maintenance Supervisor, the following was noted:</p> <p>a. 4 of 6 sprinkler heads in the Pool Room were covered with corrosion b. 4 of 4 sprinkler heads in the Station 3 south shower room were covered with corrosion.</p> <p>This was acknowledged by Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding</p>			K 0130	<p>deficient practice does not recur; This should not ever recur due to the new type of head in this humidity filled area. However, the sprinklers will be checked for corrosion as part of an on-going preventative maintenance program on a monthly basis. Circle City has been contracted to complete this service and will be at the facility the week of December 21st to get measurements for the special order sprinkler heads. 4) 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. Preventative maintenance will check monthly and report back to Quality Assurance monthly.</p> <p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; The batteries for all 81 battery operated smoke detectors have been changed and this action documented for resident sleeping rooms 101 through 126, 201 through 216, and 301 through 339 The rolling metal door has since been inspected and a new inspection tag is in place. 2) How other residents having the potential to be affected by the same deficient practice will be</p>		12/17/2015

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	<p>and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect over 25 residents, as well as staff and visitors while in the main Dining Room and kitchen staff.</p> <p>Findings include:</p> <p>Based on observation on 12/02/15 at 12:00 p.m. during a tour of the facility with the Maintenance Supervisor, the metal rolling fire door was without a current inspection tag protecting the opening from the kitchen to the main Dining Room. The most recent tag/sticker on the metal rolling fire door was dated 08/14 from Koorsen. Based on interview at the time of observation, this was confirmed by the Maintenance Supervisor, furthermore, the Maintenance Supervisor stated there was no additional documentation of an annual inspection or test for the kitchen rolling fire door to check for proper operation and full closure of the metal curtain since the 08/14 inspection tag/sticker.</p>		<p>identified and what corrective action(s) will be taken? All residents have the potential to be affected by this deficiency. All battery operated smoke detectors will have batteries changed annually and this has been added to the preventative maintenance program. Metal door inspection completed and has been added to the on-going list for Koorsen to inspect annually. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Preventative maintenance programs have been added to ensure proper function of all alarms at all times. Battery changes will be done annually and if needed and this action documented when completed. Metal door inspection completed and has been added to the on-going list for Koorsen to inspect annually. 4) 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. All preventative maintenance programs regarding checks, function and replacement of batteries for all battery operated smoke alarms has been added to be reviewed in Quality Assurance on a monthly basis. Also the metal door inspection was added to the Preventative Maintenance to ensure that if Koorsen misses it on their</p>	

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	<p>3.1-19(b)</p> <p>2. Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 81 of 81 battery operated smoke alarms in resident rooms to ensure the smoke alarms are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect 70 residents.</p> <p>Findings include:</p> <p>Based on review of the Monthly Preventative Maintenance form for resident room smoke alarm testing on 12/02/15 at 11:25 p.m. with the Maintenance Supervisor present, there was no documentation to show all 81 resident room battery operated smoke alarms have had batteries replaced during the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation to show all 81 resident room battery operated smoke alarms have had batteries replaced within the past twelve months. Based on observations between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the</p>		<p>inspection we will be alerted to ensure that it gets done. This will also be included in the Preventative Maintenance to be presented to Quality Assurance monthly.</p>	

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K 0144 SS=C Bldg. 01	<p>Maintenance Supervisor, battery operated smoke alarms were observed in resident sleeping rooms 101 through 126, 201 through 216, and 301 through 339.</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>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. This deficient practice could affect all</p>	K 0144	<p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were cited, however the deficiency was a documentation only issue and is corrected. The facility generator has an automatic cool down period. This portion of the generator testing was not documented but was taking place and has since been corrected to include the documentation. 2) 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 have the potential to be affected by this deficiency. The generator test log has been updated to include the cool down time period. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p>	12/17/2015

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K 0147 SS=E Bldg. 01	<p>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 12/02/15 at 11:15 a.m. with the Maintenance Supervisor present, the monthly generator log form documented the generator was tested monthly for 60 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> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure power strips and extension cords were not used as a substitute for fixed wiring in 3 of 112 resident sleeping rooms. LSC 19.5.1</p>	K 0147	<p>Generator log updated. Use of this updated log will ensure this deficient practice does not recur on paper however the cool down period has been occurring as required per our system. 4) 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. Generator log is part of Preventative Maintenance and will be presented in Quality Assurance monthly for review.</p> <p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #103, #110, and #118 have had extension cords removed and all medical</p>	01/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155019	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/02/2015
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NAME OF PROVIDER OR SUPPLIER  GARDEN VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403
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	<p>requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 5 residents in resident sleeping rooms 103, 110, and 118.</p> <p>Findings include:</p> <p>Based on observations on 12/02/15 between 12:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:</p> <p>a. Resident room 103 had two power strips plugged into each other, plus a bed, oxygen concentrator, and lift chair plugged into one of the power strips.</p> <p>b. Resident room 110 was using an extension cord for a clock and lamp.</p> <p>c. Resident room 118 was using an extension plugged into a power strip which also had a bed plugged in. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>equipment plugged directly into the direct wall outlet. 2) 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 have the potential to be affected by this deficiency. All rooms have been inspected and cords removed if found. Signs have been placed throughout the facility which reads Use of any extension cords must be approved prior to use by Maintenance. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Memos to reeducated the staff as well as the family about medical equipment being plugged directly into outlets has been hung on all stations. Preventative Maintenance includes an all room inspection weekly to ensure medical equipment is plugged into direct wall outlets. An audit of all rooms has been completed and some rooms identified as needing additional outlets are getting surface mount outlets installed. 4) 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. Preventative Maintenance includes an all room inspection weekly to ensure medical equipment is</p>	

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NAME OF PROVIDER OR SUPPLIER  GARDEN VILLA - BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403		
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K 0000  Bldg. 03	<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: 12/02/15</p> <p>Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040</p> <p>At this Life Safety Code survey, Garden Villa-Bloomington 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) and 410 IAC 16.2. The new portion of the facility which was surveyed using Chapter 18, New Health Care Occupancies and included the Dining Room/Lounge area on Station 3 and the renovated Sunroom on Station 1.</p>	K 0000	<p>plugged into direct wall outlets. When a room is identified as needing additional outlets maintenance will address. The PM inspections will be done weekly and presented monthly in Quality Assurance for review.</p>		

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K 0144 SS=C Bldg. 03	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, all areas open to the corridors, plus all resident sleeping rooms in Units 4, 5 and 6. There are battery operated smoke alarms in resident sleeping rooms 101 through 126, 201 through 216, and 301 through 339. The facility has a capacity of 224 and had a census of 160 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the Station 2 exit vestibule.</p> <p>Quality Review completed 12/08/15 - DA</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>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires</p>	K 0144	<p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were cited, however the deficiency was a documentation only issue and is corrected. The facility generator</p>	12/17/2015

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	<p>generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. 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 12/02/15 at 11:15 a.m. with the Maintenance Supervisor present, the monthly generator log form documented the generator was tested monthly for 60 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</p>		<p>has an automatic cool down period. This portion of the generator testing was not documented but was taking place and has since been corrected to include the documentation. 2) 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 have the potential to be affected by this deficiency. The generator test log has been updated to include the cool down time period. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Generator log updated. Use of this updated log will ensure this deficient practice does not recur on paper however the cool down period has been occurring as required per our system. 4) 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. Generator log is part of Preventative Maintenance and will be presented in Quality Assurance monthly for review.</p>				

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	documentation of a cool down time being recorded.  3.1-19(b)				