

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2011
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403	
(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: 02/14/11</p> <p>Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040</p> <p>Surveyors: 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 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, spaces open to the corridors and resident rooms on Unit 4 and rooms 501 to 508 on Unit 6. The facility has a capacity of 224 and had a census of 202 at</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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	<p>the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/18/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0027	<p>Based on observations and interview, the facility failed to ensure 3 of 5 sets of smoke barrier doors which swing in the same direction were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 51 residents on 300 hall north and south, and 27 residents on station 4 including staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 02/14/11 during the tour between 12:30 p.m. and 03:00 p.m. with the Maintenance Supervisor, the 300 hall north and south set of smoke barrier doors, and the smoke barrier doors leading into station four which all swing in the same direction and were equipped with a metal astragal, lacked a coordinator to allow the astragal side of the door to close first. Based on interview on 02/14/11 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke</p>	K0027	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Gravity door coordinators have been ordered and will be installed on appropriate doors ensuring the safety for all identified residents. II. 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 could be affected by this practice. The entire facility has been checked for other door openings that could be in need of door coordinators. No additional coordinators were needed. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Anytime doors are replaced or new doors are installed the Physical Plant Operations staff will insure the appropriate hardware is in place. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? Interior door coordinator check has been added to our annual Preventive Maintenance schedule. V. Systemic changes will be completed by: March 16, 2011</p>	03/16/2011	

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	barrier doors lacked a coordinator to ensure the door with the metal astragal closed first. 3.1-19(b)				

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K0054	<p>Based on observation and interview, the facility failed to ensure 1 of 3 smoke detectors in station 1 dining room was installed in a location which would allow the smoke detector to function to its fullest capability. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 4 residents observed in the dining room including visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 02/14/11 at 1:33 p.m. with the Maintenance Supervisor, there was one smoke detector installed directly above a ceiling fan in the dining room of station one which was turned on at the time of observation. Based on interview on 02/14/11 at 1:35 p.m., it was acknowledged by the Maintenance Supervisor the single smoke detector was installed within one foot to an operating ceiling fan which would not allow the smoke detector to detect smoke to its fullest capability.</p>	K0054	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Any staff, visitors or residents on Station 1 could be affected. The single smoke detector was moved away from the ceiling fan to allow for improved smoke detector function. II. 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. The identified smoke detector was moved to ensure optimal functioning. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All smoke detectors have been checked to ensure placement is appropriate for function. No other concerns noted. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? Prior to any smoke detector installation the Physical Plant Director must verify placement and agree. V. Systemic changes will be completed by: February 21, 2011</p>	02/21/2011	

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K0130	<p>Based on observation, interview and record review; 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 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 5 residents present in the lounge room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/14/11 at 12:45 p.m. with the Maintenance Supervisor, there was a rolling fire door protecting the opening from the kitchen to the lounge room without an attached</p>	K0130	<p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Any resident, staff, or visitor that was in the indicated lounge area had the potential to be affected. ESCO Alarm and Communication has been contacted and will perform an annual inspection of the rolling door.II. 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 the practice.The facility has been inspected and this is the only rolling door in the building, no further action needed.III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?This inspection has been added to ESCO's yearly inspection along with our fire alarm system.IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?The alarm test and inspection is on our annual Preventive Maintenance schedule.V. Systemic changes will be completed by:March 16, 2011</p>	03/16/2011			

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	<p>inspection tag. The lounge room was open to the corridor. Based on interview on 02/14/11 and subsequent Fire Safety record review at 12:46 p.m. and 3:08 p.m. respectively with the Maintenance Supervisor, it was acknowledged there was no additional documentation of an annual inspection or test to check for proper operation and full closure of the vertical rolling fire door.</p> <p>3.1-19(b)</p>				