

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/11/2015
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NAME OF PROVIDER OR SUPPLIER  ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
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K 000  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: 05/11/15</p> <p>Facility Number: 000305 Provider Number: 155625 AIM Number: 100287200</p> <p>At this Life Safety Code survey, Arbor Grove Village 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 83 and had a census of 65 at the time of this visit.</p>	K 000		
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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 025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden storage shed which was not sprinkled.</p> <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 observations and interview, the facility failed to ensure the smoke barriers in 2 of 7 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device</p>	K 025	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a desk review in lieu of a Post Survey Review on or after 5/22/2015</p> <p>K 025 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in</p>	05/25/2015

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	<p>designed for the specific purpose. This deficient practice could affect 29 residents who reside on the 400 Hall and 12 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 05/11/15 from 1:00 p.m. to 1:40 p.m., the following attic smoke barrier walls had penetrations not firestopped;</p> <ol style="list-style-type: none"> <li>The 400/300 Hall attic smoke barrier wall had two, two inch circular gaps around electrical wiring penetrations and two, three inch gaps around electrical conduit with no fire stopping material used to seal the gaps.</li> <li>The 200 Hall attic smoke barrier wall had two, two inch circular areas of drywall missing in the center of the smoke barrier wall. The 400/300 Hall and 200 Hall attic smoke barrier wall penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/11/15 at 2:15 p.m.</li> </ol> <p>3.1-19(b)</p>		<p>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>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected. The two, two inch circular gaps around the electrical wiring penetrations and the two, three inch gaps around the electrical conduit was sealed with the proper fire sealing material in accordance with K 025 NFPA 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 LIFE SAFETY CODE STANDARD on 5/22/2015. The 200 Hall attic smoke barrier wall that had two, two inch circular areas of drywall missing was repaired in accordance with K 025 NFPA 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 LIFE SAFETY CODE STANDARD on</p>	

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			<p>5/22/2015</p> <p>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. All smoke barriers were corrected so that each area identified is now fire stopped. All smoke barriers were inspected by the maintenance director with no other areas identified.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Inspections will be conducted by the maintenance Director/designee to ensure that all smoke barriers are properly fire stopped when any new wiring or construction occurs.</p> <p>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? The Maintenance Director/designee will monitor all smoke barriers through the environmental CQI on a monthly basis for 6 months. All areas identified on the CQI will be addressed timely by the maintenance supervisor/designee and be reviewed by the Quality Assurance Committee. An action</p>	

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K 144 SS=F Bldg. 01	<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 document monthly load tests for 7 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all</p>	K 144	<p>plan will be developed for any area with a threshold lower than 100%.</p> <p>K 144 SS=F 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. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected. In accordance with K 144 NFPA 99. 3.4.4.1 LIFE SAFETY CODE STANDARD, the generator was tested on 5/19/2015 by Vanguard Alarm Services and is operating properly. See attachment A 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? There were no residents affected. In accordance with K 144 NFPA 99. 3.4.4.1 LIFE SAFETY CODE STANDARD, the generator was tested on 5/19/2015 by Vanguard Alarm Services and was found to be exceeding 30% capacity. See attachment A 3. What measures will be put into place or what</p>	05/25/2015

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Monthly Generator Load Test Log with the maintenance supervisor on 05/11/15 at 9:45 a.m., the monthly load tests from November 2014 to May 2015 indicated the following results; 5/4/15 load test was 60.5 kilowatts, 4/6/15 load test was 60.5 kilowatts, 3/16/15 load test was 61.1 kilowatts, 2/2/15 load test was 61.2 kilowatts, 01/12/15 load test was 60.1 kilowatts, 12/8/14 load test was 60.1 kilowatts, 11/17/14 load test was 59.9 kilowatts. Based on an interview with the maintenance supervisor on 05/11/15 at 9:50 a.m., the maintenance supervisor stated the new diesel emergency generator set was initially installed in October 2014 and the new diesel emergency generator set is a two hundred seventy five kilowatt powered machine. When load tests are conducted monthly, the transfer switch is engaged and the emergency generator runs under load for 30 minutes and the kilowatt output is recorded from the meter during the tests. Furthermore, when asked what thirty percent of the emergency generators' rated capacity is, the maintenance supervisor indicated 82.5 kilowatts and an annual load bank test is not conducted.</p>		<p>systematic changes will be made to ensure that the deficient practice does not recur? Vanguard Alarm Services visited ArborGrove on May 19, 2015 to in service the maintenance director on proper instruction of reading power usage of the generator. See attachment A 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? The maintenance director will monitor load tests monthly using the environmental CQI tool. All issues identified through monitoring will be addressed by the maintenance supervisor/designee. This will be reviewed monthly by the Quality Assurance Committee and action plans will be developed accordingly.</p>	

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	<p>Based on a review of the pat seven monthly load tests, the emergency generator runs at less than thirty percent of the rated capacity. The lack of the emergency generator meeting at least thirty percent of its rated capacity during monthly load tests over the past seven months was verified by the maintenance supervisor at the time of interview and record review and acknowledged by the administrator at the exit conference on 05/11/15 at 2:15 p.m.</p> <p>3.1-19(b)</p>				