STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE	200 W FOURTH ST OAKTOWN, IN 47561

(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	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). Survey Date: 02/03/15 Facility Number: 000517 Provider Number: 155714 AIM Number: 100266770 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Oak Village Inc 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 building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility with a basement was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on both levels including in the corridors, in	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	spaces open to the corridors, and in all resident sleeping rooms. The facility has the capacity for 50 and had a census of 25 at the time of this survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/09/15. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage used for a maintenance shop.			
K010015 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to ensure the interior finish for 2 of 2 rooms had a flame spread rating of Class A, B, or C. This deficient practice affects visitors, staff, and 10 or more residents in the north hall. Findings include:	K010015	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses	03/05/2015

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	Based on observation with the administrator and maintenance director on 02/03/15 between 11:15 a.m. and 11:25 p.m., the entry lounge and administrators office were finished with paneling on the walls. An interview with the administrator at the time of observation, revealed no documentation was available to demonstrate the wallcovering's provided a flame spread rating of Class A, B, or C. 3.1-19(b)		pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15. K 015 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the paneling onthe entry lounge wall and the administrator's office that have the potential toaffect 10 residents, staff and visitors is being treated with a chemical thathas a flame spread rating of Class A, B or C. The facility has the documentation on file to support the flame spreadrating used to treat the paneling. *The corrective action taken for the other residentshaving the potential to be affected by*	

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			the same deficient practice is that a house wide audit has been completed of all areaswith paneling as they have the potential to affect all residents, staff andvisitors. All areas have been treated with achemical that has a flame spread rating of Class A, B or C. The facility has the documentation on file tosupport the flame spread rating used to treat the paneling. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service was providedfor the Maintenance Director on the required flame spread rating of Class A, Bor C for all interior finish surfaces inaccordance with the Life Safety Codes. The Director was also instructed that the facility requireddocumentation in the maintenance files to support the use of the appropriateflame spread	

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			ratings. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to monitor the documentationto support that all interior surface finish products that are used in thefacility have the appropriate flame spread rating of Class A, B or C. This tool will be completed by theAdministrator and/or his designee weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's QualityAssurance meetings to determine if any additional action is warranted.	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 5 exit discharges were arranged to minimize	K010038	By submitting the enclosedmaterial we are not admitting the truth or	03/05/2015

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	tripping hazards. This deficient practice could affect visitors, staff and 6 or more residents on the east wing. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at 1:00 p.m., the exit discharge surface immediately outside the east wing emergency exit was covered with insulation, leaves, fecal matter and other debris. The maintenance director said at the time of observation, the debris had accumulated since a recent repair had been made. 3.1-19(b)		accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15. K 038 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the east wing exitthat has the potential to affect six or more residents as well as staff andvisitors has been cleaned and is free of any tripping hazards. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit	

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			has been completed on all eight facilityexits which have the potential to affect all residents, staff andvisitors. No other exits were found tohave any tripping hazards and are all well maintained. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has added to thepreventative maintenance program the practice of checking all facility exitsweekly to ensure that there are no tripping hazards and that all exits areclear and free of debris. The Directorof Maintenance has been in-serviced on the addition to the facilitypreventative maintenance program. *The corrective action taken to monitor to assure complianceis that* a Quality Assurance tool hasbeen developed and implemented to monitor the facility exits to ensure they arefree of any tripping	

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			hazards. This toolwill be completed by the Administrator and/or his designee weekly for fourweeks, then monthly for three months and then quarterly for threequarters. The outcome of this tool willbe reviewed at the facility's Quality Assurance meetings to determine if anyadditional action is warranted.	
K010048 SS=C	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 include the evacuation of the smoke compartment in the written fire plan for the protection of 25 of 25 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment	K010048	K 048 The corrective action takenfor those residents found to have been affected by the deficient practice isthat all residents havethe potential to be affected by this deficient practice. All residents now are being protected in thatthe facility has revised the Specific Fire Instructions to include theappropriate internal evacuation from one smoke compartment to another. The corrective action takenfor the other residents having the potential to be affected by the samedeficient practice is that all residents have the potential to be affected by this deficientpractice.	03/05/2015

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	(7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the Oak Village Department Specific Fire Instructions and First Responder to a Fire Situation with the administrator and maintenance director on 02/03/15 at 2:35 p.m., the evacuation plan did not address internal evacuation from one smoke compartment to another. Internal evacuation in the evacuation plan refers to evacuation to "another part of the building" rather than another smoke compartment separated by smoke barrier doors. The administrator acknowledged at the time of record review, the plan did not address the evacuation of resident from one smoke compartment to another. 3.1-19(b)		All residents now are beingprotected in that the facility has revised the Specific Fire Instructions toinclude the appropriate internal evacuation from one smoke compartment toanother. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has reviewed andrevised the Specific Fire Instructions to include the internal evacuation fromone some compartment to another. Amandatory in-service has been provided for all facility staff on the revisionsof the Specific Fire Instructions. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to monitor the staff'sknowledge of the facility Specific Fire Instructions which include the internalevacuation from one smoke compartment to another. This tool will be completed by the Directorof Maintenance and/or his designee. Thistool will be completed weekly for four weeks, then monthly for three months andthen quarterly for three quarters. Theoutcome of this tool will be reviewed at the facility's Quality Assurancemeetings to determine if any additional action is warranted.	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are			

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	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 1. Based on record review, observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler system gauges were replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at 1:10 p.m., two sprinkler riser gauges were marked with a date of 7/09, usually the date the gauges were last calibrated or replaced. A review of sprinkler system maintenance and test reports with the maintenance director and administrator on 02/03/14 at 2:30 p.m., noted the two sprinkler system gauges were replaced in July of 2009. The status of the sprinkler gauges was noted on the 07/11/14 and 01/20/15 sprinkler Reports	K010062	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15.K 062 1. The corrective action taken for those residents foundto have been affected by the deficient practice is that the two automatic sprinkler systemgauges that have the potential to affect all	03/05/2015

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	of Inspection. The administrator said at the time of record review he had not know the replacement or calibration test for sprinkler system pressure gauges was due. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads protecting occupants in 2 of 4 first floor smoke compartments were free of foreign materials, such as debris. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in east and west wings. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at between 11:15 a.m. and 2:00 p.m., sprinkler heads under the east wing and west wing exit discharge roof overhangs were each covered with grass and twigs. The administrator acknowledged at the time of observations, the sprinkler heads should have been free of the foreign materials. 3.1-19(b)		occupants have been replaced. 2. The corrective action taken for those residents foundto have been affected by the deficient practice is that the sprinkler heads under the east and west exit dischargeroof overhangs, which have the potential to affect 10 or more residents on theeast and west wings, as well as visitors and staff have been cleaned and arefree of any debris including grass and twigs. 3. The corrective action taken for those residents foundto have been affected by the deficient practice is that the identified ceiling fan in the MDS office which has thepotential to affect 10 or more residents, staff and visitors has been removedand the sprinkler head is now free of obstructions in its	

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	3. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 4 first floor smoke compartments was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and 10 or more residents in the north smoke compartment. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at 11:45 a.m., a ceiling fan in the MDS office was located four inches below the single sprinkler head protecting the space. The administrator acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstruction. 3.1-19(b)		spray pattern. 1. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of the facility automatic sprinkler system gauges have been checkedand are in compliance with the required calibrations and/or replacementrequirements of every five years. Thishas the potential to affect all occupants. 2. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of all sprinkler heads was conducted, which has the potential toaffect all residents, staff and visitors. All sprinkler heads were found to be cleanand free of any type	

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			of debris. 3. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of all sprinkler heads which has the potential to affect all residents,staff and visitors has been completed. All sprinkler heads were found to be free of obstructions to their spraypatterns. *The measures that have been put into place to ensurethat the deficient practice does not recur is* that the facility has added the checking of the facility automaticsprinkler system gauges to the annual preventative maintenance program toensure that scheduled calibrations and/or replacement are completed in a timelymanner. The	

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			facility has also added the checking of all sprinkler heads monthlyto ensure that they are free of debris and have no obstructions to their spraypatterns. The maintenance director hasbeen provided a mandatory in-service by the administrator on the revisedpreventative maintenance program which includes the checking of the automaticsprinkler system gauges annually and the checking of all sprinkler headsmonthly. K 062(continued) *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to monitor thecalibration/replaceme nt of the automatic	

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			sprinkler system gauges every fiveyears, and the monitoring of sprinkler heads to ensure they are free of anydebris and free of obstruction of their spray patterns. This tool will be completed by theAdministrator and/or his designee weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's QualityAssurance meetings to determine if any additional action is warrante	
K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation, the facility failed to ensure 3 of 12 portable fire extinguishers were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers	K010064	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations	03/05/2015

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	weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects 10 or more residents, staff and visitors in north smoke compartment and anyone in the basement with access limited to visitors and staff. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 between 11:15 a.m. and 2:00 p.m., portable fire extinguishers were measured at 68 inches above the finished floor: adjacent to the entry door, under the entrance canopy, and at the basement exit door. The administrator said at the time of observations, he was unaware there was a maximum height requirement for mounting the fire extinguishers. 3.1-19(b)		as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15. K 064 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the threeidentified portable fire extinguishers which were located adjacent to the entrydoor, under the entrance canopy and at the basement exit door which have thepotential to affect ten or more residents, staff and visitors on the northsmoke compartment, have been moved and are now no more than five feet above thefloor surface. *The corrective action taken for the other*	

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			residentshaving the potential to be affected by the same deficient practice is that a house wide audit of all portable fire extinguishers,which has the potential to affect all residents, staff and visitors, has beencompleted. All fire extinguishers arenow located in accordance with NFPA 20, the Standard for Portable FireExtinguishers Chapter 1, 1-6.10. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has been providedby the Administrator for the Maintenance Director of the proper placement ofportable fire extinguishers in accordance with NFPA 20, the Standard forPortable Fire Extinguishers Chapter 1, 1-6.10. *The corrective action taken*	

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			to monitor to assurecompliance is that a QualityAssurance tool has been developed and implemented to monitor the properplacement of all portable fire extinguishers. This tool will be completed bythe Administrator and/or his designee weekly for four weeks, then monthly forthree months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility's Quality Assurance meetings to determine if any additional actionis warranted.	
K010071 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic			

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	extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was provided with a self closing fire rated door assembly. LSC 9.5 requires compliance with LSC 8.2. LSC 8.2.3.2.1(b) requires fire doors shall be self closing. This deficient practice could affect visitors, staff, and 10 or more residents in the north smoke compartment. Findings include: Based on observation with the maintenance director and administrator on 02/03/15 at 1:05 p.m., a laundry chute was located in the soiled utility room and emptied into the laundry in the basement below. At the basement level the laundry chute was protected by a rolling fire door assembly. The door was closed manually by the laundry staff. The laundry supervisor said at the time of observation, the door had never self closed. A review of fire system inspection and test records with the administrator and maintenance	K010071	Oak Village, Inc. would like to exercise our right to request a temporary waiver as we are having trouble finding a Fire/Safety service provider to fix or replace our laundry chute door so that it is hooked up to our fire system and will close automatically when alarm sounds. Our current door is fire rated and remains shut at all times except when retrieving laundry from chute. Our fire door is on a chain system and is equipped with two links that melt when extreme heat is applied forcing the door to shut when a fire is present. The laundry chute also has a sprinkler. We will continue to reach out to vendors in an attempt to get corrected. Please accept our request and extend our deadline of March 5, 2015. By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our	03/05/2015

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	director on 02/03/15 at 2:00 p.m., did not include an annual inspection for the rolling fire door. The administrator and maintenance director acknowledged at the time of record review, there was no evidence the fire door had been inspected. They said they did not think it was connected to the fire alarm system. 3.1-19(b)		regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 (If Possible) or extended deadline to the state findings ofthe Life Safety Code survey conducted on 02-03-15. K 071 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the identifiedlaundry chute at the basement level, which has the potential to affect ten ormore residents, staff and visitors in the north smoke compartment, has beenreplaced or fixed with a self-closing fire rated door assembly. In additionthis device has been added to the annual preventative maintenance program toensure annual inspection of its proper functioning. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit of all laundry chutes have beencompleted and no other chutes were identified in the facility. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has added the checkingof all laundry chutes for proper functioning to the annual preventativemaintenance program. A mandatoryin-service has been provided by the Administrator for the Maintenance	

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			Directoron the revisions of the preventative maintenance program which includes theannual inspection of all laundry chutes. *The corrective actiontaken to monitor to assure compliance is that* a Quality Assurance tool has been developed andimplemented to monitor the facility laundry chutes to ensure they are all self-closingfire rated assemblies and that they are functioning properly. This tool will becompleted by the Administrator and/or his designee weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility's Quality Assurance meetings to determine if any additional actionis warranted	
K010147 SS=D	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 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 3 staff, and visitors in basement laundry with no access to	K010147	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility	03/05/2015

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	residents. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at 1:05 p.m., the automatic chemical dispensing equipment in the basement level was supplied with power from a power strip extension cord. The administrator acknowledged at the time of observation, the power strip was in use. 3.1-19(b)		request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15. K 147 The corrective action takenfor those residents found to have been affected by the deficient practice isthat a new fixed wiringreceptacle has been added to the laundry room and the identified automatic chemicaldispensing equipment, which had the potential to affect three staff members andvisitors, is now plugged into that fixed wiring receptacle. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* a house wide audit has been conducted related to theinappropriate use of flexible cords, which could	

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			have the potential to affectall residents, staff and visitors. Noother inappropriate flexible cords were identified. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service was providedby the Administrator for the Maintenance Director on the NFPA 70 NationalElectrical Code 1999 Edition Article 400 – 8 as it relates to the use offlexible cords as a substitute for fixed wiring of a structure. *The corrective actiontaken to monitor to assure compliance is that* a Quality Assurance tool has been developed andimplemented to monitor the improper use of flexible cords as a substitute forfixed wiring. This tool will be completed by the Administrator and/or hisdesignee weekly for four weeks, then monthly for three months and	

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			thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the facility's Quality Assurancemeetings to determine if any additional action is warranted	
K030000	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). Survey Date: 02/03/15 Facility Number: 000517 Provider Number: 155714 AIM Number: 100266770 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Oak Village Inc. was found in compliance with Requirements for Participation in Medicare, 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 2012 Dining Room addition with two attached egress corridors was surveyed with Chapter 18, New Health Care	K030000		

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	Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The addition has a fire alarm system with hard wired smoke detectors in the dining room and two attached corridors. The facility has the capacity for 50 and had a census of 24 at the time of this survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 02/0915/. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except, a detached garage used for a maintenance shop.			
K030048 SS=C	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. 18.7.1.1 Based on record review and interview, the facility failed to include the evacuation of the smoke compartment in the written fire plan for the protection of 25 of 25 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:	K030048	K 048 The corrective action takenfor those residents found to have been affected by the deficient practice isthat all residents havethe potential to be affected by this deficient practice. All residents now are being protected in thatthe facility has revised the Specific Fire Instructions to include theappropriate internal	03/05/2015

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	(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the Oak Village Department Specific Fire Instructions and First Responder to a Fire Situation with the administrator and maintenance director on 02/03/15 at 2:35 p.m., the evacuation plan did not address internal evacuation from one smoke compartment to another. Internal evacuation in the evacuation plan refers to evacuation to "another part of the building" rather than another smoke compartment separated by smoke barrier doors. The administrator acknowledged at the time of record review, the plan did not address the evacuation of resident from one smoke compartment to another. 3.1-19(b)		evacuation from one smoke compartment to another. The corrective action takenfor the other residents having the potential to be affected by the samedeficient practice is that all residents have the potential to be affected by this deficientpractice. All residents now are beingprotected in that the facility has revised the Specific Fire Instructions toinclude the appropriate internal evacuation from one smoke compartment toanother. The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has reviewed andrevised the Specific Fire Instructions to include the internal evacuation fromone some compartment to another. Amandatory in-service has been provided for all facility staff on the revisionsof the Specific Fire Instructions. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to monitor the staff'sknowledge of the facility Specific Fire Instructions which include the internalevacuation from one smoke compartment to another. This tool will be completed by the Directorof Maintenance and/or his designee. Thistool will be completed weekly for four weeks, then monthly for three months andthen quarterly for three quarters. Theoutcome of this tool	

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			will be reviewed at the facility's Quality Assurancemeetings to determine if any additional action is warranted.	
K030062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and interview, the facility failed to ensure 2 of 2 automatic sprinkler system gauges were replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants. Findings include: Based on observation with the administrator and maintenance director on 02/03/15 at 1:10 p.m., two sprinkler riser gauges were marked with a date of 7/09, usually the date the gauges were last calibrated or replaced. A review of	K030062	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 03-05-15 to the state findings ofthe Life Safety Code survey conducted on 02-03-15.K 062 1. The corrective action taken for those residents	03/05/2015

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	sprinkler system maintenance and test reports with the maintenance director and administrator on 02/03/14 at 2:30 p.m., noted the two sprinkler system gauges were replaced in July of 2009. The status of the sprinkler gauges was noted on the 07/11/14 and 01/20/15 sprinkler Reports of Inspection. The administrator said at the time of record review he had not know the replacement or calibration test for sprinkler system pressure gauges was due. 3.1-19(b)		foundto have been affected by the deficient practice is that the two automatic sprinkler systemgauges that have the potential to affect all occupants have been replaced. 2. The corrective action taken for those residents foundto have been affected by the deficient practice is that the sprinkler heads under the east and west exit dischargeroof overhangs, which have the potential to affect 10 or more residents on theeast and west wings, as well as visitors and staff have been cleaned and arefree of any debris including grass and twigs. 3. The corrective action taken for those residents foundto have been affected by the deficient practice is that the identified ceiling fan in the MDS office which	

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			has thepotential to affect 10 or more residents, staff and visitors has been removedand the sprinkler head is now free of obstructions in its spray pattern. 1. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of the facility automatic sprinkler system gauges have been checkedand are in compliance with the required calibrations and/or replacementrequirements of every five years. Thishas the potential to affect all occupants. 2. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of all sprinkler heads was	

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			conducted, which has the potential toaffect all residents, staff and visitors. All sprinkler heads were found to be cleanand free of any type of debris. 3. *The corrective action taken for the other residents having thepotential to be affected by the same deficient practice is that* a housewide audit of all sprinkler heads which has the potential to affect all residents,staff and visitors has been completed. All sprinkler heads were found to be free of obstructions to their spraypatterns. *The measures that have been put into place to ensurethat the deficient practice does not recur is* that the facility has added the checking of the facility automaticsprinkler system gauges to the annual preventative	

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			maintenance program toensure that scheduled calibrations and/or replacement are completed in a timelymanner. The facility has also added the checking of all sprinkler heads monthlyto ensure that they are free of debris and have no obstructions to their spraypatterns. The maintenance director hasbeen provided a mandatory in-service by the administrator on the revisedpreventative maintenance program which includes the checking of the automaticsprinkler system gauges annually and the checking of all sprinkler headsmonthly. K 062(continued) *The corrective action taken to monitor to assurecompliance is*	

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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561	

(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
			that a QualityAssurance tool has been developed and implemented to monitor thecalibration/replacement of the automatic sprinkler system gauges every fiveyears, and the monitoring of sprinkler heads to ensure they are free of anydebris and free of obstruction of their spray patterns. This tool will be completed by theAdministrator and/or his designee weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's QualityAssurance meetings to determine if any additional action is warrante	