

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2013
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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K010000	<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: 11/19/13</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist & Brett Overmyer, Life Safety Code Specialist Supervisor</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of halls 1, 2, 3, 5 and the main dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in</p>	K010000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements.	

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>corridors and in areas open to the corridors. Battery operated smoke detectors were installed in all resident rooms in the original building. The facility has a capacity of 89 and had a census of 70 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect residents in 1 of 7 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Director of Environmental Services on 11/19/13 at 1:30 p.m., when the set of fire doors separating Hall 5 from Hall F were closed there was a one fourth inch gap between the two doors. Measurements were provided by the Director of</p>	K010027	<p>I. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: No residents have been affected by the deficiency cited. II. IDENTIFYING OTHER RESIDENTS WITH POTENTIAL TO BE AFFECTED: A maximum of 16 residents from Hall 5 could potentially be affected in the case of a fire event. The only resident space affected is their dining room which is further than 50' from the doors. Resident sleeping areas are protected by another set of smoke doors. III. SYSTEMIC CHANGES/CORRECTIONS TO PREVENT REOCCURRENCE: An astragal will be fitted to the doors to cover the gap between them providing a permanent means of preventing the potential passage of smoke. IV. MONITORING: An item will be added to the monthly preventative maintenance (PM) checklist to ensure that the astragal remains fitted to the doors in such a way that it provides for a less than</p>	12/19/2013			

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	Environmental Services at the time of observation. 3.1-19(b)		1/8th inch gap. The checklist will be reviewed monthly by the Director of Environmental Services (DES) and any concerns noted will be brought before the QA Committee.	

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the cinder block enclosure around 1 of 1 Hall 5 mechanical/boiler rooms, a hazardous area, was smoke resistive. This deficient practice could affect 15 residents in Hall 5.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 11/19/13 at 1:51 p.m., there was a 12 inch by 12 inch opening in the cinder block corridor wall above the double doors entering the Hall 5 mechanical/boiler room. Based on an interview with the Director of Environmental Services at the time of observation, he stated the facility recently created the opening to facilitate the movement of air in the mechanical room. He stated there is a fire damper with a</p>	K010029	<p>I. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: No residents have been affected by the deficiency cited. II. IDENTIFYING OTHER RESIDENTS POTENTIALLY AFFECTED: Smoke from a fire in the mechanical room could potentially affect up to 16 residents that could reside on Hall 5. III. SYSTEMIC CHANGES/CORRECTIONS TO PREVENT REOCCURRENCE: The damper has been removed and concrete block has been installed in its place to ensure there is no pathway for smoke to penetrate to the corridor. Make up air to feed equipment in the mechanical room will be drawn in directly from the outdoors through another means. IV. MONITORING: The DES, or his designee, will inspect the wall between the mechanical room and the Hall 5 corridor monthly to ensure that no new penetrations</p>	12/04/2013	

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	<p>fusible link protecting the corridor opening but the opening would not prevent the passage of smoke until the fusible link melted.</p> <p>3.1-19(b)</p>		<p>are made that do not meet the standards set forth in the Life Safety Code. Any instances of non-compliance will be brought before the QA Committee.</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <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 ensure a complete automatic sprinkler system was provided for 1 of 2 canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or combustible canopies exceeding 4 feet in width. This deficient practice could affect 15 residents in Hall 5.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 11/19/13 at 1:32 p.m., there was a unsprinklered combustible overhang at the Hall 5/Hall F</p>	K010056	<p>I. CORRECTIVE ACTION TAKEN FOR AFFECTED RESIDENTS: No residents were affected by the deficiency cited. II. IDENTIFYING OTHER RESIDENTS WITH POTENTIAL TO BE AFFECTED: Up to 16 residents from Hall 5 could potentially be affected in the event of an evacuation, although there are several other exits available to them from their area besides under the canopy identified. III. SYSTEMIC CHANGES/CORRECTIONS TAKEN TO PREVENT REOCCURRENCE: A licensed sprinkler system contractor has installed sprinkler protection under the canopy identified according to NFPA 13 standards. IV. MONITORING: The facility maintains an agreement with the aforementioned sprinkler system</p>	11/21/2013

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	<p>emergency exit door. The overhang extended seven feet from the building and measured thirteen feet wide. Measurements were provided by the Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p>		<p>contractor to perform quarterly inspections and maintenance on the sprinkler system. The DES will inform the QA Committee if the contractor notes any problems with the system or identifies any area in which the system is not in compliance with NFPA 13 standards.</p>		

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K010062 SS=D	<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>1. Based on observation and interview, the facility failed to replace the corroded sprinkler head in 1 of 1 laundry rooms washing machine area. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect laundry staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 11/19/13 at 2:06 p.m., the two sprinkler heads above the washing machines in the laundry room were corroded with a green substance. This was acknowledged by the Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p>	K010062	<p>I. CORRECTIVE ACTION TAKEN FOR AFFECTED RESIDENTS: No residents were identified to have been affected by the deficiency cited. II. IDENTIFYING OTHER RESIDENTS WITH POTENTIAL TO BE AFFECTED: Any residents or staff on Hall 5 could have potentially been affected in the event of a fire that would activate a sprinkler head. III. SYSTEMIC CHANGES/CORRECTIONS MADE TO PREVENT REOCCURRENCE: The two sprinkler heads in the laundry room showing signs of corrosion were replaced. The two gauges identified as not indicating their last date of testing or replacement were replaced with a single new gauge. Both of these jobs were completed by a licensed sprinkler system contractor. IV. MONITORING: The sprinkler system is inspected quarterly by a licensed sprinkler system contractor. If any corroded sprinkler heads or outdated gauges are encountered during those inspections, the contractor is to replace them while onsite and will notify the DES of that work. The DES will</p>	11/21/2013			

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	<p>2. Based on observation and interview, the facility failed to ensure 2 of 7 sprinkler gauges were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five 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 could affect any number of occupants in the existing portion of the building.</p> <p>Findings include:</p> <p>Based on an observation with Director of Environmental Services on 11/19/13 at 2:06 p.m., one of the sprinkler gauges in the Hall 5 sprinkler riser room, in the existing portion of the building had a date of 1996 and the other gauge had a date of 2000. Based on an interview with Director of Environmental Services at the time of observation, he was unable to verify if the sprinkler gauges had been calibrated.</p> <p>3.1-19(b)</p>		report the findings of the contractor to the QA Committee.		

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K010076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 21 oxygen cylinders in the oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice was not in a resident care area but could affect any facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 11/19/13 at 12:06 p.m., there was an unsupported "E" cylinder of compressed oxygen in the oxygen storage room. This was acknowledged by the Director of Environmental Services at the time of observation.</p>	K010076	<p>I. CORRECTIVE ACTION TAKEN FOR AFFECTED RESIDENTS: No residents were identified to have been affected by the deficiency cited. The tank identified to be unrestrained was removed from the room and placed in an appropriate holder. II. IDENTIFYING RESIDENTS WITH POTENTIAL TO BE AFFECTED: No residents reside in the vicinity of the oxygen storage room. Any nursing staff who utilize the room could be affected. III. SYSTEMIC CHANGES/CORRECTIONS MADE TO PREVENT REOCCURRENCE: Facility nurses and the drivers who deliver the oxygen tanks will be in-serviced on the requirement that all freestanding tanks be restrained. A larger rack will be acquired to accommodate the occasion on which a larger number of tanks is needed at any one time. IV. MONITORING: The Director of Nursing (DON), or</p>	12/19/2013			

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	3.1-19(b)		her designee will inspect the oxygen room at least one day per week for the next 30 days and at least one day per month for the following 6 months to ensure no tanks are present without proper restraints. The results of the monitoring will be presented to the QA Committee, which will determine if the efforts to prevent reoccurrence are adequate. If non-compliance is found, the monitoring process will start over.	

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K030000	<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: 11/19/13</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist, Brett Overmyer, Life Safety Code Specialist Supervisor</p> <p>At this Life Safety Code survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The Rehabilitation addition to the facility completed in 2007 was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in corridors</p>	K030000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated in the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements.		

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	<p>and in areas open to the corridors. The new Rehabilitation Unit had hard wired smoke detectors in resident rooms. The facility has a capacity of 89 and had a census of 70 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a fire pump room that was sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K030067 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 dampers was inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be opened to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects any number of occupants in the Rehabilitation hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services on 11/19/13 at 11:57 p.m., a damper was observed in the ventilation system in the Rehabilitation hall mechanical room. Based on interview with the Director of</p>	K030067	<p>I. CORRECTIVE ACTION TAKEN FOR AFFECTED RESIDENTS: No residents were identified to have been affected by the deficiency cited. II. IDENTIFYING OTHER RESIDENTS WITH POTENTIAL TO BE AFFECTED: There are a maximum of 12 residents whose sleeping rooms would be in the vicinity of this damper. Several other exits exist such that it would not be necessary for any resident of the facility to exit past this damper in the event of a fire. III. SYSTEMIC CHANGES/CORRECTIONS TO PREVENT REOCCURRENCE: Facility maintenance personnel have completed servicing of the identified damper. Inspection and servicing of dampers has been added to the PM schedule to ensure that it is done according to the timeframe specified in NFPA 90A. IV. MONITORING: The DES will review the PM logs monthly to ensure that all required inspection/servicing has been done. He will report to the QA Committee the results of his monitoring.</p>	11/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2013
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	<p>Environmental Services at the time of observation, the damper did not receive an inspection.</p> <p>3.1-19(b)</p>			