STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(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
K 0000 Bldg. 01	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: 05/05/16 Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310 At this Life Safety Code survey, Eagle Valley Meadows 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. 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 and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 107	K 0000	Thecreation and submission of this Plan of Correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the Letter of Credible Allegation andrequests a Desk Review in lieu of a Post Survey Review on or after 06/1/16.	

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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	at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached storage sheds providing facility services which were not sprinklered. Quality Review completed on 05/10/16 - DA			
K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 13 of 13 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr. duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.	K 0046	What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? All13 of the identified battery powered lights were tested for duration of 1.5hours on May 12, 2016. All lightingfunctioned correctly. Howwill you identify other residents having the potential to be affected by thesame alleged deficient practice and what corrective action will be taken Allresidents that would need to utilize the areas illuminated by the batterypowered lights would have the potential to be affected by the same allegeddeficient practice. Whatmeasures will be put into place or what systematic changes will be made toensure the deficient practice does not recur?	06/01/2016

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	Findings include: Based on review of "Battery Operated Emergency Lights-Test Log for 2015 and 2016" documentation with the Maintenance Director during record review from 9:00 a.m. to 11:10 a.m. on 05/05/16, documentation of an annual test for 13 of 13 battery powered emergency lights for not less than 1 ½ -hr. duration for the most recent twelve month period was not available for review. A review of Vanguard Alarm Services "Emergency Light Detail Report" indicated each of 13 battery powered emergency lights most recent annual testing occurred on 03/17/15. Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:20 p.m. on 05/05/16, a total of thirteen battery operated emergency lights were located in the facility and each battery operated emergency light operated when their respective test button was pushed. Based on interview at the time of record review and of the observations, the Maintenance Director stated the facility changed annual battery powered emergency light testing contractors in 2016 and acknowledged documentation of annual ninety minute testing for all battery operated emergency lights in the facility		Facilityrecently switched to a new vendor to conduct emergency inspections. New vendor will have lighting test scheduledfor every May going forward. TheMaintenance Director will conduct weekly inspections to ensure properfunctioning of the battery powered lights. Corrective action will be immediately implemented for any concerns notedduring the inspections. Howthe corrective actions will be monitored to ensure the deficient practice willnot recur and what quality assurance program will be put into place? TheMaintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthlythereafter. The results of these auditswill be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, anaction plan will be developed to ensure compliance.	

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	for the most recent twelve month period was not available for review. 3.1-19(b)			
K 0048 SS=C Bldg. 01	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 document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (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 affects all residents, staff and visitors in the event of an emergency. Findings include: Based on review of "Disaster Preparedness Plan" documentation with	K 0048	What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? AllDisaster Manuals were updated to include a color coded map of the facility thatdesignates all smoke barrier doors and fire compartments. Howwill you identify other residents having the potential to be affected by thesame alleged deficient practice and what corrective action will be taken Allresidents within the facility would have the potential to be affected by thealleged deficient practice. Whatmeasures will be put into place or what systematic changes will be made toensure the deficient practice does not recur? Allcopies of the facility Disaster Manual were updated to include a color codedmap of the facility that designates all smoke barrier doors and firecompartments. All staff will bere-educated on the location of fire barrier doors, and the designated firecompartments. The fire emergency policywill be	06/01/2016

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	the Maintenance Director during record review from 9:00 a.m. to 11:10 a.m. on 05/05/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors, fire doors and fire compartments in the facility for the evacuation of smoke compartments. Item 1.a of "Section E Specific Hazards" states "Keep all smoke/fire doors closed." Item 1.b states "Continue past fire door with evacuated persons" and "Continue removing in sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors. Move residents to an area away from the fire to an adjacent fire compartment." Based on interview at the time of record review, the Maintenance Director acknowledged the location of smoke barrier doors, fire doors and fire compartments are not identified in the written fire safety plan for the facility for evacuation purposes. 3.1-19(b)		reviewed during new employee orientation, which will also include thelocation of fire doors Howthe corrective actions will be monitored to ensure the deficient practice willnot recur and what quality assurance program will be put into place? TheMaintenance Director will review all Disaster Manuals monthly to ensure allcopies are up to date and accurate. TheMaintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthlythereafter. The results of these auditswill be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, anaction plan will be developed to ensure compliance.	
K 0052 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric			

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	Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, 1. Based on record review and interview, the facility failed to ensure documentation of annual functional testing for all facility smoke detectors and duct detectors was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system initiating devices such as smoke detectors and duct detectors are tested annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:00 a.m. to 11:10 a.m. on 05/05/16, it could not be assured all facility smoke detectors and duct detectors were documented as being functional tested annually. A review of Vanguard Alarm Services "Inspection and Testing Certificate" documentation dated 03/16/15, indicated the facility has 39 smoke detectors and two duct detectors hard wired to the fire alarm system which were each functional tested on 03/16/15. A review of Vanguard Alarm Services "Inspection and Testing	K 0052	What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? Acomplete inspection of all smoke detectors, including sensitivity test has beencompleted. Corrective action was implemented for any noted findings from theinspection. The smoke detector outsideof room 124 was relocated to ensure it is more than 3 feet away from an airsupply diffuser or return air opening. Howwill you identify other residents having the potential to be affected by thesame alleged deficient practice and what corrective action will be taken Allresidents within the facility would have the potential to be affected by thealleged deficient practice. Whatmeasures will be put into place or what systematic changes will be made to ensurethe deficient practice does not recur? Thefacility has recently obtained the services of a new fire inspectionvendor. The new vendor has scheduled thefacility for routine inspections that meet the guidelines set forth by LifeSafety Code. An audit of all smokedetectors was completed to ensure proper placement and distance from airdiffusers and	06/01/2016

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	Certificate" and "Facility Equipment Inspection" documentation dated 06/11/15, 09/10/15 and 12/12/15 indicated not all facility smoke detectors and duct detectors were listed as being functionally tested in any of the aforementioned three quarterly fire alarm inspections conducted within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director stated the facility changed fire alarm system inspection contractors in 2016, the new contractor indicated smoke detector and duct detector annual functional testing was not yet due to be performed but the Maintenance Director acknowledged documentation of functional testing of all facility smoke detectors and duct detectors within the most recent twelve month period was not available for review. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required		returns. Any notedconcerns were immediately corrected. Howthe corrective actions will be monitored to ensure the deficient practice willnot recur and what quality assurance program will be put into place? TheMaintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthlythereafter. The results of these auditswill be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, anaction plan will be developed to ensure compliance.	

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	calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or			

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	be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:00 a.m. to 11:10 a.m. on 05/05/16, documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sensitivity testing documentation for all facility fire alarm system smoke detectors within the most recent two year period was not available for review. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 39 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 18 residents, staff and visitors in the vicinity of Room 124.			

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:20 p.m. on 05/05/16, the smoke detector in the corridor outside Room 124 was located on the ceiling within ten inches of an air supply vent. Based on interview at the time of observation, the Maintenance Director acknowledged the smoke detector in the corridor outside Room 124 was located on the ceiling less than three feet from an air supply vent. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. 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 10 residents, staff and visitors in the vicinity of the Salon.	K 0147	What corrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? Thepower strips were immediately removed from the Beauty Salon. The hair dryer is currently plugged directlyinto the wall outlet. Howwill you identify other residents having the potential to be affected by thesame alleged deficient practice and what corrective action will be taken Allresidents within the vicinity of	06/01/2016

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:20 p.m. on 05/05/16, the hair dryer for the Salon was plugged into a power strip which was plugged into a second power strip in the Salon. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were being used as a substitute for fixed wiring in the Salon. 3.1-19(b)		the salon have the potential to be affected bythe alleged deficient practice. Whatmeasures will be put into place or what systematic changes will be made toensure the deficient practice does not recur? TheMaintenance Director audited all resident rooms, common areas, and officespaces to ensure that no other power strips/extension cords were in use. No other findings noted. Education was provided to the beauticianregarding the use of power strips/extension cords. The prohibiting of utilization of powerstrips/extension cords will be reviewed with all new staff members as a part ofgeneral orientation and with all current staff a minimum of annually. Howthe corrective actions will be monitored to ensure the deficient practice willnot recur and what quality assurance program will be put into place? TheMaintenance Director/designee with be responsible to complete the Life SafetyReview CQI weekly for four weeks, bi-weekly for two months and monthlythereafter. The results of these auditswill be reviewed by the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, anaction plan will be developed to ensure compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR)			

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	dispensers are installed: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623			
	Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol based hand sanitizers were not installed above or adjacent to an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 12 residents, staff and visitors in the vicinity of Room 141. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:20 p.m. on 05/05/16, an alcohol based hand sanitizer was installed directly above an electrical outlet in the restroom for Room 141. The	K 0211	Whatcorrective actions will be accomplished for those found to have been affectedby the alleged deficient practice? ABHRdispenser that was located in the restroom of Resident Room #141 has beenrelocated to ensure that it is not located over or adjacent to an ignitionsource Howwill you identify other residents having the potential to be affected by thesame alleged deficient practice and what corrective action will be taken Allresidents within the vicinity of room 141 have the potential to be affected bythe alleged deficient practice. Whatmeasures will be put into place or what systematic changes will be	06/01/2016

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	aforementioned hand sanitizer contained alcohol as an ingredient as stated on its packaging. Based on interview at the time of observation, the Maintenance Director acknowledged the hand sanitizer in the restroom for Room 141 was alcohol based and was installed directly above an ignition source. 3.1-19(b)		made toensure the deficient practice does not recur? TheMaintenance Director audited all resident rooms, common areas, and officespaces to ensure that all ABHR dispensers were installed per Life Safety CodeGuidelines. No other findings noted. Howthe corrective actions will be monitored to ensure the deficient practice willnot recur and what quality assurance program will be put into place? Properplacement and installation of ABHR dispensers will be added to the Life SafetyReview CQI tool. The MaintenanceDirector/designee with be responsible to complete the Life Safety Review CQIweekly for four weeks, bi-weekly for two months and monthly thereafter. The results of these audits will be reviewedby the CQI committee overseen by the Executive Director. If threshold of 95% is not achieved, anaction plan will be developed to ensure compliance.	