

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 08/15/2012
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NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214
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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/15/12</p> <p>Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Eagle Valley Meadows was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors 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 115 and had a census of 100 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage. The facility was found not in compliance</p>	K0000	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 any violation of regulation. 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 9/1/12.	

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>with the state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services such as a wooden storage shed which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>1. 3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 61 of 61 resident sleeping rooms. This deficient practice could affect 100 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:15 p.m. on 08/15/12, battery operated smoke detectors were installed in 61 of 61 resident sleeping rooms. Based on interview at the time of observation, the Maintenance Director stated documentation of periodic testing and cleaning of battery operated smoke</p>	K9999	<p>It is the practice of this facility to be constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public. The facility will meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-The Maintenance Director completed a preventive maintenance check for smoke detectors in 61/61 resident rooms on 8/16/12. Attachment 1.</p> <p>-The smoke detector in the Dining room was moved away from the ceiling fan on 8/29/12 by the Maintenance Director.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>-All residents have the potential to be affected by this deficient practice.</p>	09/01/2012	

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	<p>detectors in resident sleeping rooms was not available for review and acknowledged a preventive maintenance program for battery operated smoke detectors has not been implemented.</p> <p>3.1-19(a)</p> <p>2. 3.1-19(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date of this rule.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to maintain 1 of 2 Dining Room 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 100 residents, staff or visitors in the Dining Room.</p> <p>Findings include:</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>-The Maintenance Director will test monthly and maintain all battery operated smoke detectors in accordance with the manufacturer's instructions.</p> <p>-The Maintenance Director will complete the Battery-operated Smoke Detector Maintenance Log monthly. Attachment 2.</p> <p>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</p> <p>-The Executive Director will review the Maintenance Log monthly for completion.</p> <p>-Safety Committee to review audit results for compliance. If threshold of 90% not met a plan of action will be completed.</p>		

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	<p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:15 p.m. on 08/15/12, the smoke detector in the Dining Room identified on the detector as # 28 was located on the ceiling within one foot of a ceiling fan. Based on interview at the time of observation, the Maintenance Director acknowledged smoke detector # 28 in the Dining Room was installed within one foot of a ceiling fan.</p> <p>3.1-19(b)</p>			