STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING -- B. WING	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/23/23 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 At this Emergency Preparedness survey, Century Villa Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 84 and had a census of 60 at the time of this survey. Quality Review completed on 08/31/23	E 0000	Deficiency ID: E and K_0000 Completion Date 9/11/23 12:00:00 AM Plan of Correction Text: Allegation of Compliance Please accept the following plan of correction for the Life Safety survey completed on August , 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws. This facility appreciated the time and dedication of the surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Gerig	ED	09/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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			and paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/23/2023 Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470 At this Life Safety Code survey, Century Villa Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and smoke detection in the resident sleeping rooms. The facility has a capacity of 84 and had a census of 60 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.	K 0000	Deficiency ID: E and K_0000 Completion Date 9/11/23 12:00:00 AM Plan of Correction Text: Allegation of Compliance Please accept the following plan of correction for the Life Safety survey completed on August , 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws. This facility appreciated the time and dedication of the surveyor; the facility will accept the survey as a tool for our facility to use in	

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	Quality Review completed on 08/31/23		continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 exit doors in the facility were readily accessible	K 0222	K-222 The corrective action that will take place for egress on main door, will	09/11/2023

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	for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20 residents. Findings include: Based on observation with the Maintenance Director on 08/23/23 at 1:20 p.m., the exit door at the Main Entrance was marked as a facility exit and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director stated the code to open the exit door was not posted on the access control pad because the facility has dementia residents mixed in with residents without dementia and they did not want to risk an elopement. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		be the display of the 4-digit code for those that need to use it to come and go, and in emergency. There could be up to 20 people affected by of correct display notification. The display of the 4-digit code will be put in a visible area by electronic exit pad. This will be inspected weekly to the 4-digit code is on display and recorded by maintenance staff. This will be implemented by Sept 11,2023 and checked weekly moving forward.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility	K 0355	K-355 Portable Fire Extinguisher	09/11/2023

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	failed to inspect 4 of 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 10 residents. Findings include:		Check Monthly The monthly check for Fire Extinguishers can affect up to 10 people in the facility. Other residents could be affected if this isn't done correctly on a monthly basis. The extinguisher tag audit will be and a spreadsheet will be added for quick doublecheck of duty by Maintenance Director. This added audit sheet will be checked at the first of every month by Director to that all extinguisher checks are done on time and notated accurately. Compliance date 9-11-23	

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	Based on observation during a tour of the facility with the Maintenance Director (MD) on 08/23/23 between 01:20 p.m. and 02:30 p.m., the monthly inspection tag on the two fire extinguishers located in the maintenance shop, one lacked documentation of a monthly inspection for July 2023 and one had been inspected in November and December of 2022 but no other month thereafter. The fire extinguisher by room 415 lacked documentation of a monthly inspection for July 2023 and the fire extinguisher in the second kitchen lacked documentation of a monthly inspection for June and July 2023 Based on interview at the time of observation, the MD confirmed the fire extinguishers aforementioned were missing monthly visual inspections as noted. These findings were reviewed with the Administrator and MD at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 2 of 10 corridor doors. This deficient practice could affect 20 residents in the Community room. Findings include: Based on observation with the Maintenance Director on 08/23/23 at 02:00 p.m., the two corridor doors to the Community room were held open with a door kick stop on the front of each door, and the doors would not close by just pulling or pushing them. Based on interview at the time of	K 0363	K-363 The deficiency to have door stop on Community Room could affect the safety of 20 residents. Other residents and staff could be affected by having doorstop in place for egress. The door stop was removed and there no longer is anything to impede the doors from swinging freely at all times. The photos attached are proof that it is gone. Compliance date 9-11-23.	09/11/2023

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	observation, the Maintenance Director agreed kick stops were holding the doors open and could not close the doors unless the stop was kicked up first. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of over 50 ground fault circuit interrupter (GFCI) were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 10 residents in the vicinity of resident rooms 200, 212, and 303. Findings include: Based on observation with the Maintenance Director on 08/23/23 between 01:35 p.m.and 02:40 p.m., when the GFCI electric receptacle in the restroom of resident rooms 200, 212, and 303 were tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical	K 0511	K-511 The deficiency to have 3 GFCI electrical receptacles fail to trip in 3 residents rooms. This could affect the 6 residents of these 3 rooms and any staff working for and with said residents. The 3 GFCI's in question were replaced with hospital grade receptacles. Photographic evidence is included with this survey to prove this work was completed. Compliance date 9-11-23.	09/11/2023

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	circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacles identified did not properly work when tested. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			