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	10/24/2024

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: 10/24/24 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 62 at the time of this survey. Quality Review completed on 10/25/24	E 0000	Allegation of Compliance Please accept the following plan of correction for the Life Safety survey completed on October 24, 2024. Preparation and/or execution of this plan of correction does not constitute admission of 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 Surveyors; 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 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: 10/24/24 Facility Number: 000549 Provider Number: 155510	K 0000	Allegation of Compliance Please accept the following plan of correction for the Life Safety survey completed on October 24, 2024. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth facts alleged or conclusion	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Gerig	Executive Director	11/07/2024

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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	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 is partially protected by a 60 Kw type II EES liquid propane generator. The facility has a capacity of 84 and had a census of 62 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/25/24		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 Surveyors; 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 and paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 1 cooler doors in the kitchen were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect staff in the kitchen. Findings include:	K 0211	K 211 1.No residents were found to be affected by the alleged deficient practice. 2. Dietary staff and other staff using in cooler could be affected by turn release latch handle not working correctly.	11/07/2024

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	Based on observation with the Maintenance Director and the Administrator on 10/24/24 at 12:18 p.m., the walk-in cooler door could be locked with a padlock from the outside, but the turn release handle for the lock on the inside did not work when tested. This condition could trap a person inside the cooler if locked from the outside. Based on an interview at the time of observation, the Maintenance Director agreed the cooler release handle did not work when tested. This finding was reviewed with the Administrator, Maintenance Director, and the Environmental Director during the exit conference. 3.1-19(b)		3. The maintenance staff replaced the turn release latch with a new one for safety measures. 4. By putting release latch in place, a safe ingress/egress from cooler can take place at any time. The completion of this task will be done by 11-7-24 and noted in QAPI and the lock will be checked quarterly for correct operation.	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Based on observation and interview, the facility failed to ensure that 2 of 3 smoke doors in the service hall smoke barrier were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the	K 0223	K-223 No residents were found to be affected by kitchen dish room door being held open with wedge. All residents have the potential to be affected by the alleged deficient practice. The door to kitchen was closed by Director, and removed. Director or will do daily for 2 weeks, starting 11-25-24, at different times to the door is being used properly in room and no wedge is holding open. Then monthly, then quarterly to that the practice of keeping door shut is observed properly, results will be brought to QAPI .	11/07/2024

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	door leaf becomes self-closing. This deficient practice could affect any residents using the dining room. Findings include: Based on observations with the Maintenance Director on 10/24/24 between 11:00 a.m. and 1:00 p.m., the service hall smoke wall contained three separate smoke doors. The kitchen dish room and the serving line smoke doors were self-closing but were held open with a door wedge from the front of the door. Based on an interview at the time of observation, the Maintenance Director agreed the two doors were in a smoke wall, were held open with a device that did not release with the fire alarm, and removed the door wedges. This finding was reviewed with the Administrator, Maintenance Director, and the Environmental Director during the exit conference. 3.1-19(b)			
K 0224 SS=F Bldg. 01	NFPA 101 Horizontal Sliding Doors Based on observation and interview, the facility failed to maintain the means of egress through 1 of 2 horizontal sliding door exit egresses in accordance with LSC section 7.2.1.14 Horizontal-Sliding Door Assemblies which states, horizontal-sliding door assemblies shall be permitted in means of egress, provided that all of the following criteria are met: (1) The door leaf is readily operable from either side without special knowledge or effort. (2) The force that, when applied to the operating device in the direction of egress, is required to operate the door leaf is not more than 15 lbf (67	K 0224	K224 No residents were found to be affected per front door releasing correctly when power is could affect residents and staff. All residents have the potential to be affected by alleged deficient practice. The maintenance staff scheduled door vendor in, to repair door release in the event power goes out and door release is engaged. This to be completed on or before 11-7-24. 4. Maintenance	11/07/2024

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	N). (3) The force required to operate the door leaf in the direction of travel is not more than 30 lbf (133 N) to set the leaf in motion and is not more than 15 lbf (67 N) to close the leaf or open it to the minimum required width. (4) The door leaf is operable using a force of not more than 50 lbf (222 N) when a force of 250 lbf (1100 N) is applied perpendicularly to the leaf adjacent to the operating device, unless the door opening is an existing horizontal-sliding exit access door assembly (5) The door assembly complies with the fire protection rating, if required, and, where rated, is self-closing or automatic closing by means of smoke detection in accordance with 7.2.1.8 and is installed in accordance with NFPA80. This deficient practice could affect all residents using the main entrance. Findings include: Based on observation with the Maintenance Director on 10/24/24 at 11:45 a.m., the main entrance was provided with an exterior and an interior horizontal-sliding door. The breakaway feature for the exterior door functioned correctly when tested but the breakaway feature for the interior door did not open when tested. Based on an interview at the time of observation, the Maintenance Director agreed the interior door did not function correctly and would not swing open. This finding was reviewed with the Administrator, Maintenance Director, and the Environmental Director during the exit conference. 3.1-19(b)		staff will functionality quarterly and the results will be reported to Assurance Performance Improvement committee.	

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K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed ensure 1 of 1 cooktops open to the corridor meet the requirements of LSC 19.3.2.5.3 which states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: LCS TIA 12-2 19.3.2.5.3 states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: (1) The portion of the health care facility served by the cooking facility is limited to 30 beds and is separated from other portions of the health care facility by a smoke barrier constructed in accordance with 19.3.7.3, 19.3.7.6, and 19.3.7.8. (2) The cooktop or range is equipped with a range hood of a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and clean-out capability. (3)* The hood systems have a minimum airflow of 500 cfm (14,000 L/min). (4) The hood systems that are not ducted to the exterior additionally have a charcoal filter to remove smoke and odor. (5) The cooktop or range complies with all of the following: (a) The cooktop or range is protected with a fire suppression system listed in accordance with UL 300, or is tested and meets all requirements of UL 300A, in accordance with the applicable testing document's scope. (b) A manual release of the extinguishing system	K 0324	K-324 No residents were found to be affected by in area as it was not on and in use. ·All residents that use the Activity room could be affected by the alleged deficient practice with stove. ·The stove will have a 120 times put on it, so that it meets code and will shut off automatically, so as to not create a fire hazard. ·Director is contracting to have the correct timer installed, per regulation, for safety and use. Invoice and photo of will be part of this POC.	11/07/2024

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	is provided in accordance with NFPA 96, Section 10.5. (c) An interlock is provided to turn off all sources of fuel and electrical power to the cooktop or range when the suppression system is activated. (6)* The use of solid fuel for cooking is prohibited. (7)* Deep-fat frying is prohibited (8) Portable fire extinguishers in accordance with NFPA 96 are located in all kitchen areas. (9)* A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop or range, independent of staff action. (10) Procedures for the use, inspection, testing, and maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the manufacturer's instructions and are followed. (11)* Not less than two AC-powered photoelectric smoke alarms with battery backup, interconnected in accordance with 9.6.2.10.3, and equipped with a silence feature are located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (12)* The smoke alarms required by 19.3.2.5.3(11) are permitted to be located outside the kitchen area where such placement is necessary for compliance with the 20- ft (7.6-m) minimum distance criterion. (13)* A single system smoke detector is permitted to be installed in lieu of the smoke alarms required in 19.3.2.5.3(11) provided the following criteria are met:			

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	(a) The detector is located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (b) The detector is permitted to initiate a local audible alarm signal only. (c) The detector is not required to initiate a building-wide occupant notification signal. (d) The detector is not required to notify the emergency forces. (e) The local audible signal initiated by the detector is permitted to be silenced and reset by a button on the detector or by a switch installed within 10 ft (3.0 m) of the system smoke detector. (14) System smoke detectors that are required to be installed in corridors or spaces open to the corridor by other sections of this chapter are not used to meet the requirements of 19.3.2.5.3(11) and are located not closer than 25 ft (7.6 m) to the cooktop or range. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 10/24/24 at 1:10 p.m., the activity's cooktop stove was open to the corridor and did not contain the following: a) An extinguishing system with a manual release. b) A locked switch on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop. c) A portable K-class fire extinguisher. Based on an interview at the time of observation, the Maintenance Director agreed the cooktop was open to the corridor and was missing the aforementioned items. The finding was reviewed with the Maintenance Director, the Facilities Maintenance Supervisor,			

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	and the Administrator during the exit conference. 3.1-19(b)			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and the Environmental Director on 10/24/24 at 11:00 a.m., the provided fire watch plan did not indicate staff conducting fire watches were trained on fire watch procedures. Also, the plan only listed a phone number for IDOH and failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.health.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on an interview during the record review, the Maintenance Director agreed the fire watch documentation provided was missing training for staff and did not contain the complete IDOH Gateway link or the e-mail address listed above. This finding was reviewed with the Administrator, Maintenance Director, and the Environmental Director during the exit conference.	K 0346	K-346 1.No residents were found to be affected by alarm system out-of- service training and notification procedures. 2 residents have the potential to be affected by the alleged deficient practice. 3 correct on fire watch when fire alarm is not functioning and notification for IDOH will be done to correct facility Maintenance and EOP manuals. 4 for the correct individuals and appropriate notification information will be by 11-7-24.	11/07/2024

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K 0354 SS=C Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and the Environmental Director on 10/24/24 at 11:00 a.m., the provided fire watch plan did not indicate staff conducting fire watches were trained on fire watch procedures. Also, the plan only listed a phone number for IDOH and failed to include contacting the Indiana Department of Health via the IDOH Gateway link	K 0354	K-354 No residents were found to be affected by sprinkler system out-of- service training and notification procedures. All residents have the potential to be affected by the alleged deficient practice. The correct inservice on fire watch when sprinkler is not functioning and notification for IDOH will be done to correct facility Maintenance and EOP manuals. The inservice for the correct individuals and appropriate notification information will be complete by 11-7-24.	11/07/2024

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	at https://gateway.health.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on an interview during the record review, the Maintenance Director agreed the fire watch documentation provided was missing training for staff and did not contain the complete IDOH Gateway link or the e-mail address listed above. This finding was reviewed with the Administrator, Maintenance Director, and the Environmental Director during the exit conference. 3.1-19(b)			