| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155292 | A. BUILDING -- B. WING | 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| AMERICAN VILLAGE | 2026 EAST 54TH ST INDIANAPOLIS, IN 46220 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Dates: 03/11/25<br><br>Facility Number: 000189<br>Provider Number: 155292<br>AIM Number: 100267330<br><br>At this Emergency Preparedness survey, American Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 150 certified beds. At the time of the survey, the census was 123.<br><br>Quality Review completed on 03/14/25 | E 0000 | This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. American Village respectfully requests consideration for a desk review of this plan of correction. | |
| K 0000<br><br>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).<br><br>Survey Dates: 03/11/25<br><br>Facility Number: 000189<br>Provider Number: 155292<br>AIM Number: 100267330<br><br>At this Life Safety Code survey, American Village was found not in compliance with Requirements | K 0000 | This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. American Village respectfully requests consideration for a desk review of this plan of correction. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Gina Couch | Executive Director | 03/24/2025 |

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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| | 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.<br><br>American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered. The east wing of the second floor of Washington Manor houses the Moving Forward rehabilitation wing. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in 59 of 82 resident sleeping rooms. The facility has smoke detectors hard wired to the facility's electrical system in 23 of 82 resident sleeping rooms. The facility has a capacity of 150 and had a census of 123 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage and repair shed.<br><br>Quality Review completed on 03/14/25 | | | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure 1 of 9 hazardous areas such as a soiled linen or laundry rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect as many as 4 staff. | K 0321 | K321 – Hazardous Areas - Enclosure<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** | 04/04/2025 |

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| | Findings include:<br><br>Based on observations made with the Maintenance Director during a tour of the facility on 03/11/25 at 12:35 p.m., the corridor door to the Laundry room was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to close, the door left approximately a one-inch gap between the door and the door jam on the latching side of the door. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned laundry room, a hazardous area, failed to self-close and fully latch into the door frame.<br><br>This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | The laundry room corridor door has been adjusting and fully closes along with latches.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**<br>No residents were affected by the alleged deficient practice.<br>Laundry staff have the potential to be affected by the alleged deficient practice.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**<br>The Maintenance Director educated on 3/24/25 by the ED/Designee regarding the laundry room corridor door to be separated from other corridor by smoke resistant doors fully closing and latching.<br>A maintenance audit tool will be completed to ensure the laundry room corridor door to fully close and latch.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place**<br>• The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the | |

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| | | | Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>• If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on observation, and interview; the facility failed to ensure 1 of 1 sprinkler heads behind the Laundry room dryers covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical Damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5) Loading<br>(6) Painting unless painted by the sprinkler manufacturer.<br>In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.<br>This deficient practice could affect as many as 4 staff. | K 0353 | **K353 Sprinkler System – Maintenance and Testing**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br>The sprinkler head behind the laundry room dryers has been cleaned and free of lint.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**<br>No residents were affected by the alleged deficient practice.<br>Laundry staff have the potential to be affected by the alleged deficient practice.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**<br>The Maintenance Director has been educated on 3/24/25 by the ED/Designee regarding sprinkler | 04/04/2025 |

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| | Findings include:<br><br>Based on observations made with the Maintenance Director during a tour of the facility on 03/11/25 at 12:35 p.m., the sprinkler head located behind the Laundry room dryers was completely covered with lint. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was loaded with lint adding that he would have one of his team clean the area behind the dryers and blow off the sprinkler head immediately.<br><br>This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | heads being inspected and free of lint.<br>A maintenance audit tool will be completed monthly to ensure the sprinkler heads are inspected and free of lint and debris.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place**<br>The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 42 residents, 6 staff and 2 visitors.<br><br>Findings include: | K 0374 | K374 Subdivision of Building Spaces – Smoke Barrier Doors<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br>The smoke barrier doors nearest to resident room #101 has been cleared of a moveable food cart.<br>**How other residents having the potential to be affected by the same deficient practice will be** | 04/04/2025 |

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| | Based on observations made with the Maintenance Director during a tour of the facility on 03/11/25 at 12:35 p.m., the set of smoke barrier doors nearest to resident room # 101 on Harrison hall was obstructed by a food cart. Based on interview at the time of observation, the Maintenance Director acknowledged these smoke barrier doors as being obstructed from fully closing and added that staff knew better than to leave items obstructing the barrier doors.<br><br>This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **identified and what corrective action(s) will be taken**<br>No residents were affected by the alleged deficient practice.<br>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**<br>The Maintenance Director educated on 3/24/25 by ED/Designee regarding smoke barrier doors not to be obstructed and to be able to fully close.<br>A maintenance audit tool will be completed to ensure the smoke barrier doors are clear of obstruction and able to fully close.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place**<br>The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. | |

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| K 0712 SS=C Bldg. 01 | NFPA 101<br>Fire Drills<br><br>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.<br><br>Findings include:<br><br>Based on review of the facilities fire drill documentation entitled "Direct Supply - TELS - Conduct a Fire Drill" documentation with the Maintenance Director during record review at 9:56 a.m. on 03/11/25, the third shift (11:00 p.m. to 7:00 a.m.) fire drills conducted on 03/31/24, 05/01/24 and 08/31/24 and 11/11/24 were conducted at, respectively, 5:37 a.m., 5:03 a.m., 5:00 a.m. and 5:30 p.m.: were all conducted within a 37 minute window, and were not at varied times. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.<br><br>This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | K 0712 | **K712 – Fire Drills**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br>The fire drill schedule has been modified so that the fire drills will be at varied times and under varying conditions.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**<br>No residents were affected by the alleged deficient practice.<br>All residents, visitors and staff have the potential to be affected by the alleged deficient practice.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**<br>The Maintenance Director has been educated on 3/24/25 by the ED/Designee in ensuring the fire drills are conducted at varied times and under varying conditions.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality** | 04/04/2025 |

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| | | | **assurance program will be put into place**<br>The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. | |
| K 0754<br>SS=E<br>Bldg. 01 | NFPA 101<br>Soiled Linen and Trash Containers<br><br>Based on observation and interview, the facility failed to ensure 4 of 4 soiled linen or trash receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect as many as 42 residents, 6 staff and 4 visitors in the smoke compartment.<br><br>Findings include:<br><br>Based on observations made with the Maintenance Director during a tour of the facility on 03/11/25 between the hours of 12:15 p.m. and 2:15 p.m., the following was noted:<br>a) there was a large 40-gallon soiled linen cart and a large 40-gallon trash container being stored in the corridor outside resident room #414.<br>b) there was a large 40-gallon soiled linen cart and a large 40-gallon trash container being stored in the corridor outside resident room #213.<br>Based on interview at the time of each observation, the Maintenance Director confirmed the capacity of the receptacles and the fact that | K 0754 | K754 – Soiled linen and Trash Containers<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br>The soiled linen carts have been placed in a room protected as a hazardous area.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**<br>No residents were affected by the alleged deficient practice.<br>All residents, visitors and staff have the potential to be affected by the alleged deficient practice<br><br>**What measures will be put into place or what systemic** | 04/04/2025 |

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| | they were all being stored within a 64 square foot area.<br><br>This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **changes will be made to ensure that the deficient practice does not recur**<br>Maintenance Director, housekeeping and nursing staff have been educated on 3/19/25 by ED regarding facilities practice of not using trash or soiled linen containers larger than 32 gallons in a 64 foot area.<br>A maintenance audit tool will be completed to ensure there are no trash or soiled linen containers larger than 32 gallons in a 64 foot area.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place**<br>The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |