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	10/18/2022

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

(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: 10/18/22 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 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. The facility has 150 certified beds. At the time of the survey, the census was 113. Quality Review completed on 10/21/22	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 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: 10/18/22 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 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	11/04/2022

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. 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 rehab 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 113 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage and repair shed. Quality Review completed on 10/21/22			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting 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 observation and interview, the facility failed to ensure 14 of 14 battery backup lights were tested monthly for 30 seconds over the past	K 0291	K291 Emergency Lighting **What corrective action(s) will be accomplished for those**	11/11/2022

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	year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) 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 in the facility. Findings include: Based on record review of the document entitled "Battery-operated emergency light inspection report - 2022" with the facility outgoing Maintenance Director, on 10/19/22 at 12:35 p.m., the report had a slash through January 2022 through August of 2022 with no documented inspections being noted. Based on interview at the time of record review, the outgoing Maintenance Director acknowledged that he understood the battery-operated emergency lights needed monthly testing but added that the facility was without a Maintenance person for that period of time, so he began to document the checks as soon as he took over the Maintenance Director position. Based on observations made during a tour of the facility from 12:40 p.m. to 2:40 p.m. it was noted that the facility did indeed have battery-operated emergency lights at various locations throughout the facility. This finding was reviewed with the facility Administrator, the outgoing Maintenance Director, and the incoming Maintenance Director		**residents found to have been affected by the deficient practice** All 14 of 14 Battery-operated emergency lights were tested and recorded. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance Director has been educated on required monthly 30 second battery-operated emergency lighting testing along with recording A maintenance audit tool will be completed to ensure the battery operated lights are being tested. **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** · The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	

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	at the exit conference held on 10/18/22 at 2:45 p.m. 3.1-19(b)		with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	K300 - Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 59 of 59 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review of the document entitled "Battery-operated smoke detector inspection	K 0300	K300 Protection - Other **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All 59 of 59 smoke alarms were tested and recorded. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	11/11/2022

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	report - 2022" with the facility outgoing Maintenance Director, on 10/19/22 at 12:02 p.m., there was no itemized list of resident room battery operated smoke alarms testing for January 1st 2022 through August 14th of 2022. Based on interview at the time of record review, the outgoing Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for monthly testing but added that the facility was without a Maintenance person for that period of time, so he began to document the checks as soon as he took over the Maintenance Director position. Based on observations made during a tour of the facility from 12:40 p.m. to 2:40 p.m., 59 of 82 resident sleeping rooms surveyed within the facility did indeed have battery operated smoke detectors within them. This finding was reviewed with the facility Administrator, the outgoing Maintenance Director and the incoming Maintenance Director at the exit conference held on 10/18/22 at 2:45 p.m. 3.1-19(b)		**practice does not recur** Maintenance Director has been educated on testing and recording battery operated smoke alarms. A maintenance audit tool will be completed to ensure all battery operated smoke alarms are tested in accordance with the manufacturer's guidelines.. **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** · 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 · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
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 failed to ensure 1 of 1 portable fire extinguishers in the lobby area was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers,	K 0355	K355 Portable Fire Extinguishers **What corrective actions will be accomplished for those residents found to have been**	11/11/2022

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	2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect as many as 2 residents, 2 staff and 1 visitor. Findings include: Based on observations made upon entering the facility on 10/18/22 at 9:03 a.m., the portable fire extinguisher located in the lobby of the facility was obstructed by a walker and a well as a relocation chair. Based on interview during a tour of the facility at 12:40 p.m. with the facility Administrator, the outgoing Maintenance Director, and the incoming Maintenance Director it was noted that the portable fire extinguisher was still obstructed. When asked if items were normally kept in the area, the Administrator stated that they were not supposed to be kept there and immediately moved the walked and the relocation chair to another area removing the obstructions. This deficiency was removed prior to my exiting of the facility but again discussed at the exit conference with the facility Administrator, the outgoing Maintenance Director and the incoming Maintenance Director at the exit conference held on 10/18/22 at 2:45 p.m. 3.1-19(b)		**affected by the deficient practice** The walker and wheelchair were immediately removed from in front of the portable fire extinguisher located in the lobby. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur** Maintenance Director has been educated on that all portable ABC fire extinguishers are readily accessible without any obstruction. A maintenance audit tool will be completed to ensure that portable fire extinguishers are checked and maintained. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put in place** · The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year	

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			with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure 7 of 7 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire	K 0521	K521HVAC **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All fire dampers were inspected on July 29, 2022. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance Director has been	11/11/2022

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	damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review of the document entitled "Fire / Smoke Damper Maintenance Record" dated 07/05/18 with the facility outgoing Maintenance Director, on 10/19/22 at 11:31 a.m., it was noted that this inspection was completed more than four years ago. When asked if a more recent copy of the inspection could be provided, it could not be readily located. The lack of a current four-year maintenance conducted on the fire dampers throughout the facility was verified by the outgoing Maintenance Director at the aforementioned time of the record review. 3.1-19(b)		educated on record keeping and on regulations of testing/inspecting fire dampers. A maintenance audit tool will be completed annually to ensure fire dampers are working properly and inspected by certified company. **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** · 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 · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failure to ensure 1 of 1 portable space heater was not used within the facility. This deficient practice would affect as many as 2 residents, 2 staff and 1 visitor in the	K 0781	K781 Portable Space Heaters **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/11/2022

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	main lobby- entrance area. Findings include: Based on observations made upon entering the facility on 10/18/22 at 9:03 a.m., a portable space heater was in use by the staff at the front desk. Manufacturer's documentation affixed to the portable space heater did not state the maximum temperature achieved by the unit. Based on interview at the beginning of the tour of the facility at 12:40 p.m. it was noted that the portable space heater had been removed and was no longer in use. When the facility Administrator was asked about a policy on the use portable space heaters, she advised that she would try to locate one. Later it was determined that although the facility Administrator could not the specific policy on the use of portable space heaters, she stated that she was sure they were prohibited to be used anywhere within the facility. This deficiency was removed prior to my exiting of the facility but again discussed at the exit conference with the facility Administrator, the outgoing Maintenance Director and the incoming Maintenance Director at the exit conference held on 10/18/22 at 2:45 p.m. 3.1-19(b)		**practice** The space heater in the front lobby was immediately removed. **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** No residents were affected by the alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** Maintenance Director has been educated on facilities practice of not using space heaters. A maintenance audit tool will be completed to ensure the portable space heater has been removed. **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** · 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	

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			· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	