

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G384	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2015
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NAME OF PROVIDER OR SUPPLIER BETHESDA LUTHERAN COMMUNITIES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 STURDY RD VALPARAISO, IN 46383
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 10/09/15</p> <p>Facility Number: 000898 Provider Number: 15G384 AIM Number: 100235150</p> <p>At this Life Safety Code survey, Bethesda Lutheran Communities Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p>	K 0000		
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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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K 0130 Bldg. 01	<p>Calculation of the Evacuation Difficulty Score E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.0.</p> <p>Quality Review completed 10/13/15 - DA.</p> <p>1. Based on record review and interview, the facility failed to ensure 4 of 4 interior emergency lights were tested and the records of the testing maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could</p>	K 0130	The maintenance man will be retrained on the importance of checking each of the four emergency lights for 30 seconds each month and 90 minutes annually. This will be documented on the Life Safety QA Checklist. A section has been added for the annual 90 minute test The Program Manager will be responsible for ensuring that the documentation is completed by the 10th of each month and that the forms are properly filed for easy retrieval. Results will be discussed at the monthly Risk Management Meeting. Portable oxygen cylinders have been removed from the home as they are no longer in use. Staff will be retrained on the importance of proper storage of portable oxygen cylinders. The Program Manager will be responsible for ensuring	11/08/2015

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	<p>affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on record review with the Program Manager on 10/09/15 at 1:52 p.m., all four of the facility's battery-powered emergency lights was missing documentation for the monthly thirty second testing on December 2014, January 2015, February 2015, March 2015, and June 2015. Additionally, no documentation was available for the annual ninety minute test. Based on interview at the time of record review, the Program Manager acknowledged the lack of documentation and acknowledged the aforementioned condition.</p> <p>2. Based on observation and interview, the facility failed to ensure 6 of 6 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder</p>		that any oxygen cylinders used in the future are properly stored per guidelines.				

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K S017 Bldg. 01	<p>stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Program Manager on 10/09/15 at 1:58 p.m., six oxygen cylinders were standing in the Office without support. Based on interview at the time of observation, the Program Manager acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¼ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke</p>						

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	<p>partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 clients slept in a room provided with a door which would close and latch securely in the door frame. This deficient practice could affect one client.</p> <p>Findings include:</p> <p>Based on observation with the Program Manager on 10/09/15 at 2:10 p.m., the</p>	K S017	<p>The maintenance man and staff will be retrained on the importance of all bedroom doors shutting and latching when closed. This will be tested at least monthly by the maintenance man and documented on the Life Safety QA Check list.</p> <p>The Program Manager will ensure that this done by the 10th of each month and that any issues are corrected immediately.</p>	11/08/2015	

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	East Bedroom door failed to latch when tested. Based on interview at the time of observation, the Program Manager acknowledged the aforementioned condition.				