STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/29/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/29/14 Facility Number: 000078 Provider Number: 155158 AIM Number: 100289310 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Life Care Center of the Willows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and areas open to the corridors. Resident rooms are equipped with battery operated smoke.	K010000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that adeficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee,agents, or other individuals who draft or may be discussed in the response and Plan of Correction.In addition, preparation and submission of the Plan ofCorrection does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correctionprior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title19 programs. The submission of Plan of Correction within this time frame should in no way be of non-compliance or admission by the facility respectfully requests consideration of paper compliance for the cited deficiencies	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The facility has the capacity for 100 and had a census of 67 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 by Dennis Austill, Life Safety Code Specialist on 01/07/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 8 doors to a	K010021	**What corrective action(s) will be**	01/28/2015

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	hazardous area, such as a laundry larger than 100 square feet was held open only by a device allowing the door to self-close upon activation of the fire alarm. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect visitors, staff and 10 or more residents in the smoke compartment shared with the dining room. Findings include: Based on observation with the maintenance man and Executive Director on 12/29/14 at 11:35 a.m., a service corridor janitor's closet had a back door which opened into the laundry. The door separating the janitor's closet from the corridor lacked a self closer. The janitor's closet back door was equipped with spring hinges which failed to self close the door leaving a one inch gap between the door frame and door. The maintenance man acknowledged at the time of observation, the laundry was not effectively separated from the adjacent exit corridor.		**accomplished for those residents found to have been affected by the deficient practice:** 01/08/2015 The Maintenance assistant replaced the spring hinge on Janitors closet in the service corridor and it now latches properly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** A full facility audit was completed 01/16/2015 to ensure that all spring hinges and door closers are functioning correctly. No further issues identified **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A monthly audit tool was created and it will be documented in the preventative maintenance log to ensure all door closers are functioning properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and	

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	3.1-19(b)		QA for a period of 6 months to ensure 100% compliance.	
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure ceiling smoke barriers in 3 of 4 smoke compartments were maintained to provide the one hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects visitors, staff and 30 or more residents in the east west and north sleeping room smoke compartments.	K010025	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 01/19/2015 Director of Maintenance and the maintenance assistant sealed up the penetrations around the air conditioning units in rooms 26,28,29,32,36,42,46,47,12,17 and 20 with high heat fire and smoke blocking caulk. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** A full facility audit was completed 12/29/2014 to ensure all air conditioning units were properly	01/28/2015

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	Findings include: Based on observation with the maintenance man and Executive Director on 12/29/14 between 10:45 a.m. and 1:00 p.m., one inch annular spaces surrounding two inch conduit for wall mounted heating units in resident rooms 26, 28, 29, 32, 36, 42 46, 47, 12,17,and 20 were unsealed. The maintenance man acknowledged at the time of observation, the gaps were not filled with a material capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device designed for the specific purpose. 3.1-19(b)		sealed with the proper fire rated caulk. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur :** A monthly audit tool was created and it will be documented in the preventative maintenance log to ensure all penetrations are sealed with the proper fire rated caulk. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 10 exits were arranged to minimize tripping hazards. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors staff and 5 or more residents in the physical therapy department.	K010038	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 01/19/2015 The maintenance assistant repaired the explanation joint outside the therapy gym emergency door with concrete to ensure a smooth surface.	01/28/2015

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	Findings include: Based on observation with the maintenance man and Executive director on 12/29/14 at 11:55 a.m., the concrete exit discharge surface immediately outside the physical therapy room emergency exit had a one inch change in grade across the width of the pathway at the meeting edge of the expansion joint with the next section of concrete. The maintenance man said at the time of observation, the uneven surface was weather related due to heaving of the concrete pads. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** A full facility audit will be completed 01/19/2015 to ensure all sidewalks were level with no change in grade. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A monthly audit was created and it will be documented in the preventative maintenance log to ensure all sidewalks are free any tripping hazards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K010051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.			

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	Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance man and Executive Director on 12/29/14 at 11:50 a.m., the fire alarm system circuit breaker box identified by the Maintenance Director had three different circuit breakers with a red marking. The maintenance man said at the time of observation, one of these	K010051	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The maintenance assistant on 12/29/2014 labeled the fire alarm circuit breaker with a red mark on the breaker and placed label next fire panel breaker. Also a legend was created for that breaker box on 01/15/2015 and placed on the inside of the door of the breaker box. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** A full facility audit was completed on 01/15/2015 of all other breaker boxes to ensure legends were accurate and in place.	01/28/2015

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	served the fire alarm control panel (FACP) but he did not know which one, additionally the legend for the circuit breakers did not identify the equipment each circuit served. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A monthly audit tool was created to ensure all legends are in place in each breaker box, and it will be documented in the preventative maintenance log. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K010068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an	K010068	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The maintenance assistant on 01/14/2015 met with Dodrill Mechanical to give facility a BID on installing a dedicated fresh air intake in facility laundry area.	01/28/2015

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	individual family living environment." This deficient practice could affect visitors, staff, and 10 or more residents in the same smoke compartment. Findings include: Based on observation with the maintenance man and Executive Director on 12/29/14 at 11:40 a.m., the laundry had two, gas fueled dryers with no fresh air intake. Fresh air was limited to that provided if a window was opened. The maintenance man acknowledged at the time of observation, the two gas fueled dryers did not have a dedicated fresh air intake. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Audit was completed to ensure all other natural gas fired appliances had adequate air supply. We will be installing a levered air intake vent in the laundry area behind the gas dryers to ensure adequate fresh air supply into the laundry area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee will monitor weekly to ensure fresh air intake is working properly and not obstructed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K010130 SS=F	NFPA 101 MISCELLANEOUS			

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	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to properly install smoke detectors on walls in 48 of 48 resident sleeping rooms in accordance with LSC Section 9.6.1.4 and 19.3.4 and NFPA 72, 1999 Edition. NFPA 72, 2-3.5.11 and 2-3.5.1 requires the installation of wall mounted smoke detectors to be located four to 12 inches below the ceiling. This deficient practice could affect visitors staff and all residents if a smoke detector did not function properly due to improper installation. Findings include: Based on observations with the maintenance man and Executive Director on 12/29/14 between 10:45 a.m. and 1:00 p.m., smoke detectors in every resident sleeping room was mounted on the wall two and one half or three inches below the point where the ceiling met the wall. The maintenance man acknowledged the smoke detectors were not mounted within the minimum of four inches and maximum of 12 inches below the meeting edge of the ceiling and wall, he had no manufacturer's documentation to evidence the required installation for the smoke detectors.	K010130	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The maintenance assistant on 01/14/2015 moved all of the smoke detectors in all of the residents sleeping rooms on the east wing of the facility to four and half inches from the edge of the ceiling or wall. On 01/15/2015 the maintenance assistant moved all of the smoke detectors in the residents sleeping rooms on the west wing of the facility to four and half inches from the edge of the ceiling or the wall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** The maintenance assistant on 12/29/2014 did a full facility audit of the location of all of the smoke detectors and their measurements to ensure they were all at least the minimum of four inches from the edge of the ceiling or wall. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director or	01/28/2015

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			designee will add to the monthly check list to monitor smoke detectors to ensure they are properly located per regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 3 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents, staff, and visitors in the central smoke compartment where the nurses station and dining room with 10 residents were located.	K010147	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The maintenance assistant on 12/29/2014 removed extension cords from room 14 and room 40. Also on 12/29/2014 the two piggy backed power strip extension cords were removed in the therapy room powering the exercise equipment and the piggy back power strip in the staff coordinators office was removed.	01/28/2015

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	Findings include: Based on observation with the maintenance man and Executive Director on 12/29/14 between 10:40 a.m. and 12:45 p.m., two power strip extension cords were piggybacked to supply power to exercise machines in the physical therapy room and office equipment in the Staff Development Coordinator's office. An extension cord supplied power to lighting in resident rooms 14 and 40. The maintenance man acknowledged the cords in use at the time of observations. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Full facility audit was conducted on 12/30/2014 to ensure no extension cords or piggyback powers strips were being used in the facility. No further issues were identified. New outlets will be installed in the therapy room and the staff development coordinators office to ensure the appropriate amount of outlets for the equipment is there. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The maintenance director or designee will add to the monthly check list to monitor for use of extension cords and power strips to ensure they are proper used per regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	

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