STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/08/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALPARAISO		STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385	

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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: 04/08/14 Facility Number: 000224 Provider Number: 155331 AIM Number: 100267700 Surveyors Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Life Care Center of Valparaiso 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in corridors, in resident rooms and in areas open to the corridor. The facility has a capacity of 110 and had a	K010000	I respectfully request consideration for paper compliance. I have forwarded a signed copy of the first sheet of the 2567 by fax today (4-21-14) to 1-317-233-7322. Please reference the attached 2567 as "Credible Allegation of Compliance" for our Life Safety Code survey conducted on 4-8-14. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the 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 Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director	

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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	census of 91 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached mini barns and a garage used for equipment storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010021 SS=F	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 4 of 4 smoke barrier door sets would remain self closing until the fire alarm system was returned to normal operations after activation. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 04/08/14 at 1:35 p.m., magnets holding open all smoke barrier doors released the doors to self close upon activation of the fire alarm. When the fire alarm system was placed in the silence mode, the doors were opened and the magnetic devices designed to hold the doors open reengaged to hold the fire doors open instead of allowing them	K010021	K0021 **1. <u>Corrective action accomplished for residents affected by the alleged deficient practice</u>: On 4-9-14, Phil and Sons came out and reprogrammed the door holder circuit on the fire panel at the main nursing station.** **2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice.</u> All facility residents had the potential to be affected. The Maintenance Supervisor or designee will monitor the fire doors monthly during each fire**	04/09/2014

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	to self close until the fire alarm was reset. The maintenance director acknowledged the condition at the time of observations. He called his fire system contractor immediately to report the problem. 3.1-19(b)		**drill to ensure all fire doors are functioning properly.** **3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> The Maintenance Supervisor will add to his monthly fire drill checklist to monitor the fire doors to ensure the doors function properly.** **4<u>. How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6**	

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			months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. **DATE CERTAIN 4/9/14**	

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K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure sprinkler heads in 3 of 5 smoke compartments were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff, and 20 or more residents in the east, west, and northwest smoke compartments. Findings include: Based on observation with the maintenance director on 04/08/14 between 12:30 p.m. and 1:50 p.m., ceiling fan blades were located four to ten inches below the only sprinkler protecting the ADON's office, the DON's office, the Physical Therapy office and the Payroll office. Fan blades for four ceiling fans in the assisted dining room were located ten inches from four of five sprinkler heads protecting the room. The maintenance	K010062	K0062 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-11-14, the Maintenance Supervisor removed/relocated ceiling fans throughout the facility. **2. How the facility will identify other residents potentially affected by the same alleged deficient practice: All facility residents had the potential to be affected.** **3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will monitor all current and future ceiling fan installations throughout the facility to ensure that all fans are at least 18 inches from the sprinkler heads. The Maintenance Supervisor**	04/11/2014

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	director acknowledged at the time of observations, the sprinkler heads were less than the minimum distance allowed between a sprinkler head and obstruction. 3.1-19(b)		**will develop a checklist identifying all rooms with ceiling fans installed and monitor monthly to ensure all fans are installed properly.** **4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.**	

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			DATE CERTAIN 4/11/14 **THIS IS OUR CREDIBLE** ALLEGATION	