

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 12/04/2012
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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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K0000	<p>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).</p> <p>Survey Date: 12/04/12</p> <p>Facility Number: 000224 Provider Number: 155331 AIM Number: 100267700</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>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</p>	K0000	<p>I respectfully request consideration for paper compliance. I have forwarded a signed copy of the first sheet of the 2567 by fax today (12-21-12) to 1-317-233-7494. Please reference the attached 2567 as "Credible Allegation of Compliance" for our Life Safety Code survey conducted on 12-4-12. 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</p>	

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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	<p>and 410 IAC 16.2.</p> <p>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 smoke detection in the corridors, hard wired smoke detectors in the fifty nine resident sleeping rooms and areas open to the corridors. The facility has a capacity of 110 and had a census of 96 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the two mini barns and one garage located on the west side of the facility which were used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</p>			
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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 5 sets of double corridor doors would latch automatically into the door frame. This deficient practice could affect 10 of 96 residents.</p> <p>Findings include:</p> <p>Based on observation on 12/04/12 with the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., the set of therapy room corridor doors would not latch automatically into the door frame. One of the therapy room doors was provided with a lever that needed to be manually flipped in order to latch the door into the frame and the other door latched into this door. Based on interview at the</p>	K0018	<p>K018 1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 12-14-12, Larry Miller Door and Glass installed a positive latching hardware on the set of Dutch doors in the Therapy room. 2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice.</u> The Maintenance Supervisor or designee will inspect all facility doors weekly to ensure the doors latch 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</p>	12/14/2012			

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	time of observation, the Maintenance Director acknowledged the set of therapy room double doors was not provided with positive latching hardware which automatically latched each door into the door frame. 3.1-19(b)		add to his weekly facility rounds checklist the monitoring of doors to ensure they are latching properly. <u>4. 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 QA/QI 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. DATE CERTAIN 12/14/12		

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K0051 SS=F	<p>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. 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</p> <p>1. Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include: Based on observation on 12/04/12 with</p>	K0051	<p>K051 1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 12-17-12, Martin Securities installed a new dialer for 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. Martin securities will monitor the Fire Alarm dialer daily and conduct a test nightly to ensure that both lines are functioning properly.</p>	12/17/2012			

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	<p>the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., the dialer for the fire alarm control panel (FACP) was located in the maintenance/electrical room, an area remote from any area where continuous on site monitoring could occur, such as the nurses' station. After testing the dialer for simulated phone line failure, a trouble signal was not annunciated to the FACP and the Maintenance Director confirmed with the fire alarm monitoring company that a trouble signal was not received.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 dialers located in an area that was not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p>		<p><u>3. 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 alarm dialer to insure that there is no problem with the device and or line. <u>4. 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 QA/QI 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. DATE CERTAIN 12-17-12</p>		

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	<p>Based on observation on 12/04/12 with the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., the dialer for the fire alarm control panel (FACP) was located in the maintenance/electrical room, and the room was not provided with a smoke detector. Based on interview at the time of observation, the Maintenance Director acknowledged that the maintenance/electrical lacked automatic smoke detection.</p> <p>3.1-19(b)</p>			

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K0052 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>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 the maintenance staff.</p> <p>Findings include:</p> <p>Based on observation on 12/04/12 with the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., the fire alarm system circuit breaker located in the emergency power breaker box in the maintenance/electrical room lacked identification. The Maintenance Director stated at the time of observation, he was not aware the fire alarm circuit breaker was to be identified.</p> <p>3.1-19(b)</p>	K0052	<p>K052 1. <u>Corrective action accomplished for resident affected by the alleged deficient practice:</u> On 12-4-12, the Maintenance Supervisor labeled the Fire Alarm circuit breaker with a red dot and wrote the letters F.P. next to each breaker for the Fire Alarm.</p> <p>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.</p> <p>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 or designee will monitor the Fire Alarm circuit monthly to ensure the red label is visible. The Maintenance Supervisor will add to his monthly maintenance spreadsheet to monitor that both Fire Alarm Circuits are labeled per regulations.</p> <p>4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will</u></p>	12/04/2012			

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			<p>not recur: 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 QA/QI 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.</p> <p>DATE CERTAIN 12-4-12</p>	

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K0062 SS=C	<p>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</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for 1 of 1 automatic sprinkler systems in accordance with NFPA 25, 1998 Edition, and the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 12/04/12 with the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., there was</p>	K0062	<p>K062</p> <p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 12-7-12, State Line Sprinkler dropped off some spare side wall sprinkler heads.</p> <p>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.</p> <p>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 or designee will monitor the spare sprinkler head box located in the main sprinkler room weekly to ensure that there are at least 2 spare sprinkler heads for each type in the facility. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure the appropriate quantity of spare sprinkler heads stored in the Sprinkler room. A list will be developed to identify the types</p>	12/07/2012			

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	only one side wall sprinkler in the spare sprinkler cabinet. There were side wall sprinkler heads observed during the tour throughout the facility. The lack of spare sidewall sprinklers was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)		of sprinkler heads and the number of spares for each type. This list will be used by maintenance to track when sprinkler heads are removed and when replacement sprinkler heads are needed. <u>4. 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. DATE CERTAIN 12-7-12		

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K0073 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 59 facility resident rooms remains free of combustible decorations. This deficient practice affects at least 10 residents on the 100 wing hallway in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 12/04/12 with the Maintenance Director during the tour from 9:00 a.m. to 12:45 p.m., there were two scented candles with unlit wicks and one wrapped candle in resident room 108. In an interview with the Maintenance Director, he acknowledged the facility policy does not allow candles in the resident rooms and he removed the wicks.</p> <p>3.1-19(b)</p>	K0073	<p>K073</p> <p>1. <u>Corrective action accomplished for residents affected by the alleged deficient practice:</u> On 12-4-12, the Maintenance Supervisor removed the candles from the patient room</p> <p>2. <u>How the facility will identify other residents potentially affected by the same alleged deficient practice.</u> The Maintenance Supervisor conducted a facility wide audit to ensure there are no more candles in the facility.</p> <p>3. <u>What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur:</u> The Admission Coordinator added to the Admission Packet that "No candles are allowed in the facility". The Housekeeping Supervisor will add to the Housekeeping checklist to check all rooms daily for candles and remove any candles if found.</p> <p>4. <u>How corrective actions will be monitored to ensure the alleged deficient practice will not recur:</u> The Maintenance Supervisor or designee will</p>	12/21/2012	

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