

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2014
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NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
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K010000	<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: 11/18/14</p> <p>Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930</p> <p>Surveyors: Brett Overmyer, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Kindred Nursing and Rehabilitation Valley View 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.</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 and in areas open to the</p>	K010000	<p>This Plan of Correction is the center's credible allegation of compliance 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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K010018 SS=E	<p>corridors. Battery operated smoke detectors are provided in all 75 resident rooms. The facility has a capacity of 126 and had a census of 94 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14.</p> <p>The facility was not found in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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</p>			
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K010021 SS=D	<p>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 75 doors protecting corridor openings did not have an impediment to the closing of the door. This deficient practice could affect approximately ten residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 during a tour from 10:15 a.m. to 12:45 p.m. with the Maintenance Director, the door to resident room 108 was blocked open by a wedge pushed under the door. Based on interview during the time of observation with the Maintenance Director, it was acknowledged the door was propped open.</p> <p>3.1-19(b)</p> <p>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</p>	K010018	<p>We respectfully request desk review for this citation. K 018</p> <ol style="list-style-type: none"> <li>Obstructions have been removed from doorway 108 per requirement. Staff will monitor this area to prevent reoccurrence.</li> <li>All other resident room doors have been inspected for impediment to the closing of the door, and none have been found.</li> <li>The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure there are no impediments to the closing of the doors. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance.</li> <li>The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</li> </ol>	12/18/2014	

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	<p>by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as a combustibile storage room over 50 square feet in size, was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect approximately 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 11/18/14 during the tour from 10:15 a.m. and 12:45 p.m. with the maintenance director, the clean utility room which is over 50 sqft in size and has a self closure mechanism on the door, was held open with an apron tied to the handle and then to a hook on wall. This is preventing the door to close and latch into the frame. The maintenance director acknowledged the aforementioned deficiency.</p>	K010021	<p>We respectfully request desk review for this citation.K 021</p> <p>1.The device used to prop open the clean Utility room door has been removed per requirement. Staff will monitor this area to prevent reoccurrence. 2. All other hazardous area doors have been inspected for impediment to the closing of the door, and none have been found. 3. The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure there are no impediments to the closing of the doors. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	12/18/2014

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K010027 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect two of seven smoke compartments.</p> <p>Finding include:</p>	K010027	<p>We respectfully request desk review for this citation. K 027</p> <p>1.The smoke barrier doors located On the 200 hall been repaired and are now closing and latching properly. 2. All other smoke barrier doors have been inspected and are closing and latching properly. 3. The Maintenance Director will inspect all smoke barrier doors for proper operation monthly. These monthly audits are to be reviewed by the Executive Director to ensure proper compliance.</p>	12/18/2014

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K010038 SS=F	<p>Based on observation on 11/18/14 during a tour from 10:15 a.m. to 12:45 p.m. with the Maintenance Director, doors for the smoke barrier in the 200 hall did not operate properly preventing one of the double doors from closing leaving one side completely open. This was confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 15 exit doors with a delayed egress lock initiated an audible signal in the vicinity of the door when activated.</p> <p>LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p>	K010038	<p>4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p> <p>We respectfully request desk review for this citation. K 038</p> <p>1.The delayed egress door on the 200 hallway has been repaired and is now resetting and locking as required.</p> <p>2. All other delayed egress doors have been inspected for proper operation and are resetting and locking as required.</p> <p>3. The Maintenance Director will inspect delayed egress doors weekly and document any issues and make corrections as needed. These weekly audits are to be reviewed by the Executive Director to</p>	12/18/2014			

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	<p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15</p>		<p>ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>				

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K010070 SS=C	<p>SECONDS".</p> <p>This deficient practice could affect any resident, staff or visitor who use the exit near the north laundry room.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 during a tour from 10:15 a.m. to 12:45 p.m. with the Maintenance Director, 1 of 15 delayed egress doors once opened would not reset and lock. Maintenance Director had to physically remove the keypad and remove wires to place the doors back into an alarm mode. Based on interview at the time of observation, the Maintenance Director acknowledged that he had been having problems with several of the delayed egress doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to regulate the use of portable space heaters. This deficient practice could effect anyone visiting the activities director's office on the 500</p>	K010070	<p>We respectfully request desk review for this citation.</p> <p>K 070 1.The portable space heater in the Activity Director's office has been</p>	12/18/2014			

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	<p>Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/18/14 during a tour from 10:15 a.m. and 12:45 p.m. with the maintenance director, a portable space heater was located in the activities director's office. The maintenance director stated at the time of observation the facility had no official policy addressing their use.</p> <p>3.1-19(b)</p>		<p>removed as required.</p> <p>2. All other rooms have been Inspected to ensure no portable space heaters are in use.</p> <p>3. The Maintenance Director will inspect for any sign of portable space heaters weekly and document any issues and make corrections as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance.</p> <p>4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>		