STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE	4600 E JACKSON ST MUNCIE, IN 47303

(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
K0000	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: 01/16/13 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Liberty Village 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 smoke detection in the corridors, spaces open to the corridors and all resident sleeping rooms. The facility has 52 resident rooms with 13 resident	K0000		

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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	rooms on Rosewood having hard wired smoke detectors and the other 39 resident rooms having battery powered smoke detection. The facility has a capacity of 104 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered except for the one detached garage for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 2 doors leading to hazardous areas such as rooms where soiled linen is stored were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents on 100 hall north and 18 residents on 200 north as well as visitors and staff. Findings include: Based on observation on 01/16/13 during the tour between 12:55 p.m. and 1:15 p.m. with the Maintenance Supervisor, the east and west shower rooms located on 100 hall north and 200 hall north respectively were used to store soiled linen. The rooms which were greater than fifty square feet in size did not have self closing devices on the corridor doors.	K0029	Deficiency ID K 029Issue: Facility failed to ensure 2 of 2 doors leading to hazardous areas such as rooms where soiled linen is stored were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents on 100 hall north and 18 residents 200 north as well as visitors and staff. Plan of correction:1. No residents were affected by the alleged deficient practice.2. This deficient practice affects 20 residents on 100 hall north and 18 residents on 200 north as well as visitors and staff.3. Correction was made on 1/29/2013. Soiled Linens were removed from shower rooms. Other storage area has been created for soiled linens. The new area, has self closing devices. Nursing and laundry staff have been re-educated in	02/15/2013

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	Based on interview on 01/16/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned doors leading into the east and west shower rooms which contained soiled linen were not equipped with self closing devices on either door. 3.1-19(b)		the proper placement and storage of soiled linens. (See Attached A) 4. Dirty linen storage placement will be monitored on working days for 2 weeks. Then weekly for 2 months. Followed with monthly checks for 6 months. (See Attached)5. Monitored monthly per the administrator until ongoing compliance is assured.	

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K0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of Fire Drill Reports on 01/16/13 at 2:04 p.m. with Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months from 12/11 to 12/12 indicated the fire alarm system had been	K0050	Deficiency ID K 050 Issue: Failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted. Plan of correction: 1. No residents were affected by the alleged deficient practice. 2. The deficient practice affects all occupants in the facility including staff, visitors and residents. 3. Fire exit drills in health care occupancies shall include d the transmission of a fire alarm signal and simulation of emergency fire conditions. Verification of the transmission of the signal has to be documented. Maintenance Supervisor re-education on proper procedure of documenting the verification of transmission. 4. Form created to track the verification of the transmission after each fire drill. (See Attached B) 5. Monitored monthly per administrator until ongoing	02/15/2013

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	activated, but the verification of the transmission of the signal was not documented. Based on interview on 01/16/13 at 2:05 p.m. it was acknowledged by Maintenance Supervisor, none of the fire drill reports documented the transmission of the signal was received by the monitoring station. 3.1-19(b) 3.1-51(ac)		compliance is assured.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure the pressure gauge readings on 1 of 2 portable ABC class fire extinguishers on 200 hall west was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 16 residents on 200 hall west as well as visitors and staff. Findings include: Based on observation on 01/16/13 at 2:45 p.m. with the Maintenance Supervisor, the gauge on the ABC Class portable fire extinguisher located on 200 west hall showed the extinguisher was overcharged. Based on interview on 01/16/13 at 2:46 p.m. with the Maintenance Supervisor, the gauge reading was not in the normal operating range and he did not know if it would affect the operation of the fire extinguisher.	K0064	Deficiency ID 064 Issue: The gauge on the ABC Class portable fire extinguisher located on 200 west hall showed the extinguisher was overcharged. Plan of Correction: 1. No residents were affected by the alleged deficient practice. 2. The deficient practice could affect 16 residents on 200 hall west as well as visitors and staff. 3. Fire Safety Provider in building on 1/17/2013 to inspect and correct issues with fire extinguishers. (See Attachment C) 4. Maintenance supervisor will monitor monthly all fire extinguishers to ensure they are not overcharged as well as the Fire Safety Provider during quarterly inspections. (See Attachment C) 5. Monitored monthly per the administrator until ongoing compliance is assured.	02/15/2013

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	3.1-19(b)			

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K0070 SS=D	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 Based on observation and interview, the facility failed to provide a portable space heater policy to regulate the use of 1 of 1 portable space heaters in nonresident rooms. This deficient practice could affect anyone visiting the Front Reception office as well as visitors and staff. Findings include: Based on observation on 01/16/13 at 1:15 p.m. with the Maintenance Supervisor and Administrator, a portable space heater was plugged in for use in the Reception office adjacent to the front entrance. Based on interview on 01/16/13 at 1:20 p.m., it was acknowledged by the Maintenance Supervisor and the Administrator, space heaters were not allowed, however, there was no written policy for portable space heaters addressing their use in the facility. 3.1-19(b)	K0070	Deficiency ID 070 Issue: Portable space heater was plugged in for use in the reception office adjacent to the front entrance. Plan of Correction: 1. No residents were affected by the alleged deficient practice 2. The deficient practice could affect anyone visiting the front office as well as visitors and staff. 3. Space heater was removed and staff has been re-educated that space heaters are not allowed per facility policy. 4. Administrator will monitor for space heater usage.	02/15/2013

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents	K0144	Deficiency ID 144 Issue: No documentation which verifies the amperage or the percentage of load capacity for the past 12 months.Plan of correction:1. No residents were affected by the alleged deficient practice.2. The deficient practice could affect all residents as well as staff and visitors.3. Monthly documentation of amperage testing will be done by Maintenance Supervisor. (See Attachment D)4. Monitored by administrator to ensure testing documentation is being done until ongoing compliance is assured.	02/15/2013

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	as well as staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 01/16/13 at 4:38 p.m. with the Maintenance Supervisor, there was no documentation which verified the the amperage or the percentage of load capacity for the past twelve months. Based on interview on 01/16/13 at 4:40 p.m. with the Maintenance Supervisor, it was acknowledged the facility had no documentation to verify amperage or percentage of load capacity for the past twelve months. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the generator was capable of automatically connecting to load within 10 seconds of the loss of normal electrical power for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate			

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	source of power will automatically connect to load within 10 seconds. This deficient practice could affect all residents in the facility as well as visitors and staff if it could not be assured all residents were safeguarded by the facility with a generator which would operate under load conditions when needed during a power failure. Findings include: Based on review of Generator Log records on 01/16/13 at 4:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer the load was not documented. Based on interview on 01/16/13 at 4:33 p.m. with the Maintenance Supervisor, it was acknowledged the information on time of load transfer had not been recorded for the past twelve months and the Maintenance Supervisor was unaware it needed to be documented. 3.1-19(b)			