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 09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION VALLEY VIEW	333 W MISHAWAKA RD ELKHART, IN 46517

(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, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/18/12 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Valley View Health Center 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, areas open to the corridors and a hard wired smoke detector in one resident room. Battery operated smoke detectors have been installed in the remaining resident rooms. The facility has a capacity of 126 and had a census of 87 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas providing customary access to the residents 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. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/20/12. The facility was not found in compliance with the aforementioned regulatory requirements as	K0000	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.	

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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	evidenced by the following:			

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K0021 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 8 of 9 sets of smoke barrier doors would remain self closing once the fire alarm system is activated until the fire alarm system is returned to normal operations. This deficient practice could affect 68 residents. Finding include: Based on observations with the Maintenance Director on 09/18/12 from 2:30 p.m. to 2:48 p.m., eight sets of smoke barrier doors released initially with the fire alarm system test but when the system was placed in silence mode and the doors were opened,	K0021	K021 1.The eight smoke barrier doors have been re-programmed to release initially with the fire alarm system activation and to remain released completely during the time the fire alarm system is activated, including when in silent mode. 2.No other residents would be affected by this practice. 3.The fire safety provider who programs the system has been made aware of the need for corrective action and the understanding to keep the system in compliance. This will be part of their quarterly and annual fire safety system audits and testing. 4.The Environmental Services Director or designee will manually test the system weekly. The results of these tests will be forwarded to the monthly facility Performance Improvement	10/18/2012

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	the magnetic devices reengaged causing the smoke barrier doors to remain open instead of self closing as required. The set of smoke barrier doors in the Reflections unit is always in the closed position. This was acknowledged by the Maintenance Director at the time of observations. 3.1-19(b)		Committee for follow up as needed. The PI Committee will review monthly for 6 months.	

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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 1 of 1 roll down doors at the openings in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect all residents in the north lounge. Findings include: Based on observation with Maintenance Director on 09/18/12 at 2:05 p.m., the north lounge was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the north lounge is therefore, considered to be the corridor wall.	K0029	K029 1.The rolling door protecting the open space between the north lounge and the kitchen is being repaired to now close automatically upon activation of the fire alarm system. 2.No other residents would be affected by this practice. 3.The rolling door protecting the open space between the north lounge and the kitchen is now being electronically attached to the fire alarm system to operate consistently to close upon activation of the fire alarm system. 4.The Environmental Services Director or designee will manually test the system weekly for 4 weeks and monthly thereafter to ensure the rolling door closes automatically upon activation of the fire alarm system as required. The results of these tests will be forwarded to the monthly facility Performance Improvement	10/18/2012

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	There was a pass through opening in the corridor wall between the north lounge and the kitchen. The opening was protected with a rolling door. Based on interview with Maintenance Director at the time of observation, the rolling door does not close upon activation of the fire alarm. 3.1-19(b)		Committee for follow up as needed. The PI committee will review for 6 months.	

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K0038 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 14 of 16 doors in the path of egress, equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect 68 residents. Findings include: Based on an observation with the Maintenance Director on 09/18/12 from 2:30 p.m. to 2:48 p.m., fourteen exit doors, which were equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence	K0038	K038 1.The fourteen exit doors have been re-programmed to release initially with the fire alarm system activation and to remain released completely during the time the fire alarm system is activated, including when in silent mode. 2.No other residents would be affected by this practice. 3.The fire safety provider who programs the system has been made aware of the need for corrective action and the understanding to keep the system in compliance. This will be part of their quarterly and annual fire safety system audits and testing. 4.The Environmental Services Director or designee will manually test the system weekly for 4 weeks and monthly thereafter to ensure the exit doors are releasing and closing as required. The results of these tests will be forwarded to the monthly facility Performance Improvement Committee for follow up as needed. The PI committee will review for 6 months.	10/18/2012

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	mode. Only the two Reflection hall exit doors, also equipped with a magnetic locking system, remained unlocked when the fire alarm system was placed in silence mode. Additionally, the set of smoke barrier doors entering/exiting the Reflection hall, which were equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence mode. Based on an interview with the Maintenance Director at the time of observation, he stated the system had been set up this way and he was not aware of this requirement. 3.1-19(b)			

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K0074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3			
	Based on observation and interview, the facility failed to ensure 2 of 2 privacy curtains in resident room 108 were flame retardant. This deficient practice could affect 2 of 87 residents. Findings include: Based on observations with the Maintenance Director on 09/18/12 at 1:45 p.m., the privacy curtains in resident room 108 were a solid curtain suspended from the ceiling by hooks and extenders in order to achieve the eighteen inches	K0074	K074 1.The two privacy curtains in room 108 have been replaced with curtains which are documented to be flame retardant. 2.16 other residents could be affected by this practice. 3.Additional flame retardant privacy curtains have been ordered to replace any additional privacy curtains which lack flame retardant documentation, and will be placed into use as soon as they arrive at the facility. 4.The Environmental Services Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure all the privacy curtains in use meet proper flame retardant	10/18/2012

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	needed to prevent obstruction of the sprinkler heads. These privacy curtains lacked attached documentation confirming they were inherently flame retardant. Based on interview with the Maintenance Director at the time of observation, he could not provide documentation regarding flame retardancy for the privacy curtains in resident room 108. 3.1-19(b)		requirements. The results of these audits will be forwarded to the monthly facility Performance Improvement Committee for follow up as needed. The PI committee will review for 6 months. The PI committee will review for 6 months.	