

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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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: 03/10/14 and 03/11/14</p> <p>Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lutheran Life Villages 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>The main building is a three story, partially sprinklered building with all comprehensive care areas sprinklered determined to be of Type I (332) construction with a basement. The Health and Rehabilitation building is a one story sprinklered building of Type I</p>	K010000	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning / emailing attachments as supportive documentation. I spoke with Dennis Austil on Friday, March 28, 2014, @ 10:40am, asking for an extension to submit our LSC POC - which he granted through Monday, March 31, 2014.</p>	
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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>(332) construction. The main building has a fire alarm system with smoke detection in corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The Health and Rehabilitation building has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detector in the resident rooms. The facility has a capacity of 224 and had a census of 120 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the garage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 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.</p> <p>1. Based on observation and interview, the facility failed to ensure the door to 3 of 3 clean linen rooms and 1 of 1 Phrenic wing biohazard container storage rooms closed and latched into the door frame. This deficient practice affects 51 Health and Rehabilitation residents in A, B and C wings and residents in the activity room of Phrenic wing which is only used during special events.</p> <p>Findings includes:</p> <p>Based on observations with the Director of Maintenance and the Assistant Director of Maintenance on 03/11/14 during a tour of the Health and Rehabilitation building between 11:00 a.m. and 12:40 p.m., the clean linen</p>	K010018	<p>K 018</p> <p>Corrective action for residents affected:</p> <p>#1 No residents were directly affected by this deficient practice. One set of Ives FB 40 series fully automatic door hardware is being purchased for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing.</p>	04/10/2014

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	<p>rooms in the A, B and C wings and the storage room in the Phrenic wing where the empty plastic containers used for biohazardous waste are stored until needed, were designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was confirmed by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the doors protecting corridor openings in 1 of 1 Physical Therapy rooms was smoke resistive. This deficient practice could affect 4 or 5 residents in the Health and Rehabilitation building Physical Therapy room.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/11/14 at 10:55 a.m., there were four pencil size holes in each of the double corridor doors entering the Physical</p>				<p>#2 No residents were directly affected by this deficient practice. The four pencil size holes that were in the double corridor doors entering the Physical Therapy room from the nurses' station have been filled with fire rated wood putty.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>#1 One set of Ives FB 40 series fully automatic door hardware is being purchased for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing.</p> <p>#2 The four pencil size holes that were in the double corridor doors entering the Physical Therapy room from the nurses' station have been filled with fire rated wood</p>		

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	<p>Therapy room from the nurses' station. Based on an interview with the Director of Maintenance at the time of observation, it looked like someone changed out the door handles and forgot to plug the holes.</p> <p>3.1-19(b)</p>		<p>putty. Other doors were reviewed / looked at for similar issues, and none were found.</p> <p>Measures that will be put into place to ensure the practice does not recur:</p> <p>#1 One set of Ives FB 40 series fully automatic door hardware is being purchased for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing. The Director of Maintenance and/or designee will monitor all future installation of any new double doors; including the installation of properly latching hardware.</p> <p>#2 The four pencil size holes that were in the double corridor doors entering the Physical Therapy room from the nurses' station have been</p>	

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			<p>filled with fire rated wood putty. The Director of Maintenance and/or designee will monitor all future installation of any new double doors; including the installation of properly latching/locking hardware.</p> <p>The corrective action will be monitored by:</p> <p>#1 and #2</p> <p>The Director of Maintenance and/or designee will monitor the correct / working function of these doors to ensure the close/ latch and lock correctly, resisting the passage of smoke for @ least 20 minutes. The doors will be checked every 30 days (monthly) for 90 days to assure they are in good working order after installation. Results will be shared @ our quarterly QA meetings. The Director of Maintenance to monitor for compliance to tag K018.</p>		

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K010029 SS=E	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 kitchen double corridor door sets were self closing and would latch into the door frame. According to the Director of Maintenance, this deficient practice could affect 1 or 2 residents in the back hall near the kitchen of the main building.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/10/14 at 3:01 p.m., the crash bar of the corridor doors entering the main kitchen from the back hall were locked in the open position to prevent the doors from latching into the frame. Based on an interview with the Assistant Director of Maintenance at the time of observation, the kitchen staff move food carts through</p>	K010029	<p>K 029</p> <p>Corrective action for residents affected:</p> <p>#1 No residents were directly affected by this deficient practice. Facility procedures for unlocking doors on the morning shift by Security Personnel have been adapted to exclude the kitchen door that is currently being unlocked and left in a non-latching position.</p> <p>#2a No residents were directly affected by this deficient practice. One set of Ives FB 40 series fully automatic door hardware is being purchased</p>	04/10/2014			

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	<p>these doors during meal times.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 D wing soiled linen collection room's corridor doors and 1 of 1 A wing shower room corridor doors closed and latched into the door frame. This deficient practice affects 11 resident in the D wing and 17 residents in A wing in the Health and Rehabilitaiton building.</p> <p>Findings includes:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/11/14 between 10:50 a.m. and 11:50 a.m., the following was noted:</p> <p>a. the D wing soiled linen collection room was designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. The room had two large plastic containers, measuring 48 cubic feet, full of plastic bags of soiled linen. Additionally, the corridor doors were not equipped with</p>				<p>for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing.</p> <p>#2b No residents were directly affected by this deficient practice. Soiled linen and trash receptacles shall be located in a room that is protected / as a hazardous area when not attended with appropriately latching doors. In addition, soiled linen carts will not be stored in the shower room.</p> <p>#3 No residents were directly affected by this deficient practice. The Activity Staff have been in serviced regarding the appropriate location of the popcorn popper; to be used in authorized locations only and not in any corridor that is not separated by smoke resistive doors.</p>		

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	<p>self closing devices. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>b. there was a mobile soiled linen cart full of soiled linen stored in the A wing shower room. The corridor door to the shower room was equipped with a self closing device but lacked latching hardware. The Assistant Director of Maintenance stated the soiled linen cart should be stored in the soiled linen room.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors. This deficient practice could affect 1 of 11 smoke compartments in the Health and Rehabilitation building.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/11/14 at 12:55 p.m., popcorn was being popped in a mobile popcorn popper at the nurses' station. The popcorn popper required the use of hot oil in order to cook the popcorn. This was acknowledged by the Director of Maintenance at the time of</p>		<p>Other residents having the potential to be affected and corrective actions:</p> <p>#1 Facility procedures for unlocking doors on the morning shift by Security Personnel have been adapted to exclude the kitchen door that is currently being unlocked and left in a non-latching position.</p> <p>#2a One set of Ives FB 40 series fully automatic door hardware is being purchased for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing.</p> <p>#2b Soiled linen and trash receptacles shall be located in a room that is protected / as a hazardous area when not attended with appropriately</p>		

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	observation. 3.1-19(b)		<p>latching doors. In addition, soiled linen carts will not be stored in the shower room.</p> <p>#3 The Activity Staff have been in serviced regarding the appropriate location of the popcorn popper; to be used in authorized locations only and not in any corridor that is not separated by smoke resistive doors.</p> <p>Measures that will be put into place to ensure the practice does not recur:</p> <p>#1 Facility procedures for unlocking doors on the morning shift by Security Personnel have been adapted to exclude the kitchen door that is currently being unlocked and left in a non-latching position. Pertinent staff have been in serviced on the updated procedure change. The Director of Maintenance and/or designee will monitor</p>	

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			<p>that the kitchen doors are working appropriately.</p> <p>#2 One set of Ives FB 40 series fully automatic door hardware is being purchased for each of the four affected doors. Installation will occur by a third party vendor with our Director of Maintenance overseeing that the project meets the specific guidelines. This hardware will latch into the casing. The Director of Maintenance and/or designee will monitor all future installation of any new double doors; including the installation of properly latching hardware.</p> <p>#2b Soiled linen and trash receptacles shall be located in a room that is protected / as a hazardous area when not attended with appropriately latching doors. In addition, soiled linen carts will not be stored in the shower room. Pertinent staff have (nursing) been in serviced on the appropriate location of trash, soiled linen, etc. Shower</p>	

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			<p>rooms are not to be used as one of these areas. The Director of Maintenance and/or designee will monitor the appropriate use of said areas.</p> <p>#3 The Activity Staff have been in serviced regarding the appropriate location of the popcorn popper; to be used in authorized locations only and not in any corridor that is not separated by smoke resistive doors.</p> <p>The corrective action will be monitored by:</p> <p>#1, #2a, & #2b The Director of Maintenance and/or designee will monitor the correct / working function of these doors to ensure they are not left in a non-latching position; and to assure the updated procedures are being adhered to as well as proper storage areas are being utilized for waste or soiled linen. The doors, shower rooms and soiled linen rooms will be</p>	

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			<p>checked every 30 days (monthly) for 90 days to monitor for compliance. Results will be shared @ our quarterly QA meetings. The Director of Maintenance to monitor for overall compliance to code K029.</p> <p>#3 The Neighborhood Coordinators & the Administrator will monitor the use the facility mobile popcorn popper. This will be reviewed every 30 days (monthly) for 90 days with the results reported in the quarterly QA.</p> <p>Due date: April 10, 2014</p>		

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review, and interview: the facility failed to ensure 2 of 2 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires Emergency Power Supply (EPS) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance and the Assistant</p>	K010046	<p>K 046 Corrective action for residents affected: No residents were directly affected by this deficient practice. There is a battery operated emergency task light at each emergency generator station. A written record has been established to record the monthly function test and the annual battery test for the operating emergency lighting @ each generator location. Other residents having the potential to be affected and corrective actions: There is a battery operated emergency task light at each emergency generator station. A written record has been established to record the monthly function test and the annual battery test for the operating emergency lighting @ each generator location. Measures that will be put into place to ensure the practice does not recur: There is a battery operated emergency task light at each emergency generator station. A written record has been established to record the monthly function test and the annual battery test for the operating emergency lighting @ each generator location. The corrective action will be monitored by: The Director of Maintenance and/or designee will</p>	04/10/2014			

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	<p>Director of Maintenance on 03/10/14 at 2:00 p.m. and 03/11/14 at 10:30 a.m., there was a battery operated emergency task light at each of the emergency generators. Based on an interview with the Assistant Director of Maintenance during the record review process on 03/10/14 at 1:20 p.m., there was no written record of a monthly function test or an annual test for the battery operated emergency task lights available for review.</p> <p>3.1-19(b)</p>		<p>monitor the recording / logging of the monthly function tests and the annual battery tests for compliance to tag K 046. This will be reviewed every 30 days (monthly) for 90 days with the results reported in the quarterly QA. The Director of Maintenance to monitor for overall compliance to tag K 046 Due date: April 10, 2014</p>		

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K010051 SS=D	<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>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen manual fire alarm boxes was readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director</p>	K010051	<p>K051</p> <p>Corrective action for residents affected:</p> <p>No residents were directly affected by this deficient practice. The boxes were removed immediately. The food carts were also removed.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>The boxes were removed immediately. The food carts were</p>	04/10/2014
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	<p>of Maintenance on 03/10/14 at 3:25 p.m., the manual fire alarm pull station located near the back corridor doors of the main kitchen was obstructed by food carts and cardboard boxes. This was acknowledged by the Director of Maintenance and the Assistant Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p>also removed.</p> <p>Measure that will be put into place to ensure the practice does not recur:</p> <p>The storage area for these boxes, food carts, etc. has been re-located. Dietary were in-serviced on 3-21-2014 regarding the importance of not obstructing any manual fire alarm pull box area. It is important that these areas are readily accessible and leading to a safe, exit passageway.</p> <p>The corrective action will be monitored by:</p> <p>The Director of Maintenance and/or designee will monitor the corridors for obstructions to fire pull boxes on a daily basis for compliance, sharing the results @ QA every 30 days (monthly) for 90 days. The Director of Maintenance to monitor for overall compliance to tag K 051.</p> <p>Due date: April 10, 2014</p>		

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K010052 SS=F	<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 record review and interview, the facility failed to ensure 377 of 377 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p>	K010052	<p>K 052</p> <p>Corrective action for residents affected:</p> <p>No residents were directly affected by this deficient practice. The vendor, Koorsens, was contacted to set up an immediate visit to facility to test all 377 smoke detectors sensitivity to comply with code K 052. Koorsens was scheduled and completed the 377 sensitivity tests by 3-18-2014, all within acceptable limits.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>The vendor, Koorsens, was contacted to set up an immediate visit to facility to test all 377 smoke detectors sensitivity to comply with code K 052. Koorsens was scheduled and came to facility to complete the 377 sensitivity tests. This was accomplished by</p>	04/10/2014			

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	<p>(1) Calibrated test method</p> <p>(2) Manufacturer ' s calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Assistant Director of Maintenance of Koorsen Fire and Safety smoke detector record titled "Detector Sensitivity Test Report" on 03/11/14 at 10:10 a.m., the last smoke detector sensitivity test occurred on 02/16/12. This was acknowledged by the Assistant Director of Maintenance at the time of record review.</p> <p>3.1-19(b)</p>		<p>3-18-2014, all tests within acceptable limits.</p> <p>Measure that will be put into place to ensure the practice does not recur:</p> <p>This function of tag K 052 has been entered in facility TELS system (ongoing preventative maintenance program); to be conducted on an annual basis in accordance with the requirements and will be reviewed during quarterly QA as appropriate in the first quarter.</p> <p>The corrective action will be monitored by:</p> <p>The Director of Maintenance and/or designee will monitor for compliance & be responsible for scheduling such testing with Koorsens annually; sharing the results @ QA in the first quarter. The Director of Maintenance to monitor for overall compliance to tag K 052.</p> <p>Due date: April 10, 2014</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler coverage was provided for 2 of 2 elevator equipment rooms to provide complete sprinkler coverage for all portions of the building. This deficient practice affects 1 of 2 basement smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/10/14 from 2:28 p.m. to 3:00 p.m., the following was noted:</p> <p>a. the service elevator equipment room in the basement lacked sprinkler coverage. The room was constructed of concrete and block with a nonrated steel door that lacked a self closing device.</p>	K010056	<p>K 056 Corrective action for residents affected: No residents were directly affected by this deficient practice. Facility will purchase and have door closers installed in both the service elevator and passenger elevator by professional vendor. Additionally, facility scheduled vendor (Koorsens) to come in and remove all obsolete, redundant fire suppression sprinkler heads in the noted areas on this 2567 LSC report (activity office, B wing storage rooms, soiled linen rooms), this was completed by 3-28-20-14. The facility has contracted vendor (Koorsens) to install sprinkler heads in both service and passenger elevators in conjunction with the elevator modernization plan outlined in the plan of correction at K_9999. This will not be</p>	04/10/2014	

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	<p>b. the passenger elevator equipment room in the game room lacked sprinkler coverage. The room was constructed of concrete and block with a nonrated steel door that lacked a self closing device. Based on an interview with the Director of Maintenance at the time of observations, he was aware of this requirement, has gotten quotes for the installation of a sprinkler head and is awaiting approval to begin the construction.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 1 activity room offices, 1 of 1 B wing storage rooms and 1 of 5 soiled linen rooms. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in compartmented space shall be changed. This deficient practice could affect 17 residents on C wing and staff in the B wing supply room and Activity office in the Health and Rehabilitation building.</p> <p>Findings include:</p>		<p>completed by April 10, 2014. We respectfully request a temporary wavier be granted. The anticipated completion date for the elevator upgrade installation project is October 1, 2014.</p> <p>Other residents having the potential to be affected and corrective actions: Facility will purchase and have door closers installed in both the service elevator and passenger elevator by professional vendor. The Director of Maintenance and/or designee will monitor the installation of the door closers and any other additional maintenance work on either elevator. Additionally, facility scheduled vendor (Koorsens) to come in and remove all obsolete, redundant fire suppression sprinkler heads in the noted areas on this 2567 LSC report (activity office, B wing storage rooms, soiled linen rooms) as well as survey the rest of the building for other, obsolete, redundant fire suppression sprinkler heads (and remove additional findings), which was completed by 3-28-2014. The facility has contracted vendor (Koorsens) to install sprinkler heads in both service and passenger elevators in conjunction with the elevator modernization plan outlined in the plan of correction at K_9999. This will not be completed by April 10, 2014. We respectfully request a temporary wavier be granted. The anticipated completion date for</p>				

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	<p>Based on observations with the Director of Maintenance and the Assistant Director of Maintenance 03/11/14 between 11:45 a.m. and 12:30 p.m., the B wing supply room, the Activity room and the C wing soiled linen room each had quick response red liquid glass rod sprinkler heads and standard response metal sprinkler heads. Based on an interview with the Director of Maintenance and the Assistant Director of Maintenance at the time of observations, this portion of Health and Rehabilitation was recently sprinklered and they believe the old sprinkler system with the standard response metal sprinkler heads was disconnected but were unable to confirm at this time. Additionally, the new system sprinkler heads were all mounted within two feet of the existing metal sprinkler heads.</p> <p>3.1-19(b)</p>		<p>the elevator upgrade installation project is October 1, 2014. Measures that will be put into place to ensure the practice does not recur: The Director of Maintenance and/or designee will monitor the installation of the door closers and any other additional maintenance work on either elevator as well as the proper removal of the obsolete, redundant fire suppression sprinkler heads. This will be reviewed on an annual basis when our preferred vendor (Koorsens) completes the sensitivity testing in the first quarter of each calendar year for all smoke detectors. The Director of Maintenance and/or designee will monitor the elevator and sprinkler head installation progress to ensure the goal completion date of October 1, 2014 is achieved. The corrective action will be monitored by: The Director of Maintenance and/or designee will monitor any renovations of future areas to ensure the proper upgrades are appropriate and within code; sharing the results/reports @ the quarterly facility QA. The Director of Maintenance to monitor for overall compliance to tag K056. Due date: April 10, 2014</p>		

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K010144 SS=F	<p>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. Based on record review and interview, the facility failed to ensure 2 of 2 emergency generators were exercised a minimum of 30 minutes under load at least monthly. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the untitled generator log from the TELS program with the Director of Maintenance and the Assistant Director of Maintenance on 03/10/14 at 1:22 p.m., the documentation indicated both emergency generators were exercised under load for 15 minutes and then both generators had a 15 minute</p>	K010144	<p>K 144</p> <p>Corrective action for residents affected:</p> <p>No residents were directly affected by this deficient practice. Facility records indicate that all required generator testing was completed per regulation; the facility had utilized an incorrect form that did not indicate the true parameters at which the tests were conducted. The protocol and related documentation & records for testing the generators were updated to include the following steps. The generator will perform and run on load for the main building generator for 30 minutes and on cool down for an additional 15 minutes, with this information documented accordingly in facility records.</p> <p>Other residents having the potential to be affected and corrective actions:</p> <p>Facility records indicate that all</p>	04/10/2014			

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	cool down time. Based on an interview with the Assistant Director of Maintenance at the time of record review, he was not aware the generators were required to exercise under load to 30 minutes monthly. 3.1-19(b)		required generator testing was completed per regulation; the facility had utilized an incorrect form that did not indicate the true parameters at which the tests were conducted. The protocol and related documentation & records for testing the generators were updated to include the following steps. The generator will perform and run on load for the main building generator for 30 minutes and on cool down for an additional 15 minutes, with this information documented accordingly in facility records. Measure that will be put into place to ensure the practice does not recur: Facility records indicate that all required generator testing was completed per regulation; the facility had utilized an incorrect form that did not indicate the true parameters at which the tests were conducted. The protocol and related documentation & records for testing the generators were updated to include the following steps. The generator will perform and run on load for the main building generator for 30 minutes and on cool down for an additional 15 minutes, with this information documented accordingly in facility records. Facility contracted with a generator vendor who adjusted the time		

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			<p>frames on the generator to now meet code appropriately. The Director of Maintenance and/or designee will monitor the installation of the door closers and any other additional maintenance work on either elevator as well as the proper removal of the obsolete, redundant fire suppression sprinkler heads. This will be reviewed on an annual basis when our preferred vendor (Koorsens) completes the sensitivity testing in the first quarter of each calendar year for all smoke detectors.</p> <p>The corrective action will be monitored by:</p> <p>The Director of Maintenance and/or designee will monitor testing and appropriate documentation of the generators; sharing the results/reports @ the quarterly facility QA. The Director of Maintenance to monitor for overall compliance to tag K144 .</p>		

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			Due date: April 10, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES				STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816			
(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
K019999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) A health facility licensed under 16-28 and this rule states the facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure the electrical equipment in 2 of 2 elevator equipment rooms was properly maintained to protect personnel. This deficient practice was not in a resident care area but could affect maintenance staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 03/10/14 at 2:28 p.m., the electrical elevator equipment in the main building lacked an enclosure and/or safety guards. Based on an interview with the Director of Maintenance at the time of observation, he was aware of this</p>			K019999	<p>Facility is in the process of obtaining bids / quotes for two completely new elevator systems; one for the service elevator & the other for the passenger elevator. This includes: all operational equipment, new cars, proper professional installation of each elevator system, proper connection to electrical and fire suppression systems, etc. These new elevators will not be installed by April 10, 2014; however, we are developing a plan to change out one elevator system @ a time (so we always have one functioning) this summer / fall of 2014. When this project is complete, each elevator will be equipped to protect the health & safety of the residents, personnel and public.</p>		04/10/2014

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	<p>requirement, has gotten quotes to replace the old equipment and is awaiting approval to begin the removal of the old equipment and the installation of the new equipment.</p> <p>3.1-19(a)</p>			
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