STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 10/29/2014
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	

(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
K010000	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: 10/29/14 Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670 Surveyor: Brett Overmyer, Life Safety Code Specialist At this Life Safety Code survey, Valparaiso Care and Rehabilitation 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after November 19, 2014.	

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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	155166		10/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

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	and battery operated smoke detectors in resident sleeping rooms. The facility has a capacity of 164 and had a census of 140 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two garages and one shed used for facility storage. Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010029 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 15 doors	K010029	**K 029 NFPA 101 LIFE SAFETY CODE STANDARD**	11/19/2014

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	serving hazardous areas, such as storage rooms greater than fifty square feet in size used to store combustible materials, were provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect at least 10residents, staff or visitor in the vicinity of the East Hall clean utility room. Findings include: Based on observation and interview on 10/29/14 between 10:30 a.m. and 12:15 p.m. with the facility maintenance director, on the east hall, the clean utility room door was provided with a self closing device and latching hardware but failed to lock into the frame. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		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 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The East Wing Clean Utility Room Door was repaired and now locks into the frame on 10/30/14. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All other doors were checked by the Maintenance Director to ensure proper latching occurs.	

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			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All hazardous areas will have automatic door closures and the doors will latch. Managers make daily rounds in the facility to monitor environmental safety issues. Areas found to need repair will be documented on a maintenance request form. Employees will be re-educated on the use of the maintenance request form for items needing repair by 11/20/104. An Environmental CQI tool will be utilized weekly x 4 and monthly thereafter ongoing to monitor compliance with door closures. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** An Environmental CQI tool will be utilized weekly x 4 and monthly thereafter ongoing, to monitor compliance with door closures. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	
K010046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and record review, the facility failed to ensure 1 of 1 emergency Cottage wing battery backup lights would provide lighting during periods of power outages to protect residents located in the Cottage wing. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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. This deficient practice could affect at least 10 residents as well as staff near the Cottage wing / East wing separation doors. Findings include: Based on observation on 10/29/14 between 10:30 a.m. and 12:15 p.m. with the maintenance director during the tour of the facility, the exit / battery operated	K010046	**K046 NFPA 101 Life Safety Code Standard** Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency light in the Cottage has been replaced. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All other exit battery emergency lights were check by the Maintenance Director and no other issues were noted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Managers make daily rounds in the facility to monitor environmental safety issues. Areas found to need	11/19/2014

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	emergency lighting located at the Cottage wing / East wing separation doors did not light when the test function button was pushed. Based on record review of the Preventive Maintenance Log with the maintenance director all battery powered emergency exit lighting were tested on 10/17/14 and passed. The records showed that an annual test had been conducted on 01/17/14 and all emergency lighting passed. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		repair will be documented on a maintenance request form. Employees will be re-educated on the use of the maintenance request form for items needing repair by 11/20/14 by the Maintenance Director/designee. Emergency lighting is physically checked monthly and documented on the Battery Operated Emergency Lights form in the Preventative Maintenance Manual by the Maintenance Supervisor/designee. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review. Actions plans are developed to improve performance, which may include re-education and/or disciplinary action	
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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	condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained below the level of the sprinkler deflector. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.1 says a continuous or non-continuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice affects staff and residents in and near the activity room storage closet and the staff in the kitchen area. Finding includes: Based on observations and interview on 10/29/14 between 10:30 a.m. and 12:15 p.m. with the maintenance supervisor, the minimum 18 inch clearance below the sprinkler head deflector was not provided in; 1) the activity room storage closet. The room contained shelving with boxes just below the sprinkler head that were within 18 inches of the sprinkler head deflector. 2) in the kitchen, 2 of 2 freezers contained shelving with cardboard boxes just below the sprinkler head that were	K010062	**K062 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. The Activity Room closet and Freezer items were immediately moved under the 18" line during the survey. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All sprinkler heads in storage areas were checked by the Maintenance Director to ensure that all had at least 18" clearance. **What measures will be put into place or what systemic changes**	11/19/2014

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	within 18 inches of the sprinkler head deflector. The maintenance supervisor acknowledged the two aforementioned deficiencies. 3.1-19(b)		**you will make to ensure that the deficient practice does not recur?** All staff will be inserviced by the Maintenance Director/designee on the clearance requirements for sprinkler system operations by 10/20/14. An Environmental CQI tool will be utilized by the Maintenance Director/designee weekly x 4 and monthly thereafter ongoing, to monitor compliance. Maintenance Director will check storage areas to ensure that all sprinkler heads have at least an 18" clearance. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the Environmental CQI tool. Findings will be presented to the Safety Committee for review. Actions plans are developed to improve performance, which may include re-education and/or disciplinary action.	
K010064 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	K010064	**K064 NFPA 101 Life Safety Code**	11/19/2014

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	facility failed to ensure 1 of 28 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect any resident, staff and/or visitors in the area of the activity room. Findings include: Based on observation on 10/29/14 during the tour from 10:30 a.m. to 12:15 p.m. with the maintenance director, the annual maintenance tag attached to the portable ABC Class fire extinguisher located in the activity room indicated the last annual maintenance procedure for each extinguisher was performed in July 2013. Based on interview, the maintenance director acknowledged the annual maintenance was missed. 3.1-19(b)		**Standard** Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. The fire extinguisher was serviced prior to the survey but a new tag was not placed on the device. The provider was contacted and a new tag was provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. All fire extinguishers were checked by the Maintenance Director to ensure that all fire extinguishers have been checked annually. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Fire extinguishers will be serviced and will be replaced as needed by an	

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			outside contractor. Fire extinguishers are visually checked monthly by the Maintenance Director and documented in the Preventative Maintenance Manual. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Fire extinguishers are visually checked monthly by the Maintenance Director and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	
K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where			

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	smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect any residents and staff if they were utilizing the exit next to the outside generator during a fire emergency. Findings include: Based on observations on 10/29/14 between 10:30 a.m. and 12:15 p.m., the smoking area located along the outside wall next to the generator had 100 or more cigarette butts strewn about the area. Furthermore the approved long necked container for this area was located within thirty feet from where all the cigarette butts were found. Based on interview on 10/29/14 concurrent with the observations, the maintenance director acknowledged the facility's employees disposed of cigarette butts on the ground and around the approved container. 3.1-19(b)	K010066	**K066 NFPA 101 Life Safety Code Standard** Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in	11/19/2014

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			regard to this regulation. The grounds were immediately cleaned and all butts were removed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. The grounds were immediately cleaned and all butts were removed. Staff is to smoke in one designated area. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee will monitor/clean the facility grounds for cigarette butts daily. All staff will be educated on the proper disposal of cigarette butts by the Executive Director by 11/20/14. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director will visually check the grounds daily and	

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			documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review. Actions plans are developed to improve performance, which may include re-education and/or disciplinary action.	
K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview with the maintenance director, the facility failed to provide a properly constructed 1hr fire resistance rated enclosure designated for the transferring of liquid oxygen in accordance with LSC Section 19.3.2.4 and NFPA 99, 1999 edition. This deficient practice could affect 20 of the 140 residents, as well as an	K010143	**K143 NFPA 101 Life Safety Code Standard** Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has	11/19/2014

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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	

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	indeterminable number of staff and visitors, if oxygen contributed to the rapid spread of a fire. Findings include: Based on observations on 10/29/14 at approximately 11:30 a.m. revealed from the floor up a 4" x 24" hole in the wall for the west wing oxygen transferring room. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. The hole in the wall was repaired by the Maintenance Director. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. The wall was repaired on 10/30/14. The facility has one Oxygen Transferring Room. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The facility will provide a properly constructed 1 hour fire resistance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 10/29/2014
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			rated enclosure designated for the transferring of liquid oxygen. Department heads make daily rounds in the facility to monitor environmental safety issues. All staff will be re-educated on the use of the maintenance request for items needing repair by the Maintenance Director/designee by 11/20/14. An Environmental CQI tool will be utilized weekly x 4 and monthly thereafter ongoing, to monitor compliance. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the Environmental CQI tool. Findings will be presented to the Safety Committee for review. Actions plans are developed to improve performance, which may include re-education and/or disciplinary action.	