

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  03/17/2014
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NAME OF PROVIDER OR SUPPLIER  LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
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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: 03/17/14</p> <p>Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and in all resident sleeping</p>	K010000	<p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</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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K010046 SS=F	<p>rooms. The facility has 52 resident rooms in which 13 resident rooms on Rosewood have hard wired smoke detectors and 39 resident rooms have battery powered smoke detection. The facility has a capacity of 104 and had a census of 74 at the time of this survey.</p> <p>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 was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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. Based on interview and observation, the facility failed to provide exterior</p>	K010046	1 No residents were affected by this alleged deficient practice The	04/03/2014

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	<p>emergency lighting for 10 of 10 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all residents as well as staff and visitors if the occupants in the facility were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observation on 3/17/14 at 12:59 p.m. with the Maintenance Supervisor and Administrator, outside lighting was available at all the exits and exit discharges, but they were not on battery or generator backup. Based on interview on 3/17/14 at 1:00 p.m. with the Maintenance Supervisor and Administrator, it was acknowledged the exterior emergency lights outside the exits and exit discharges were not equipped with batteries or on generator backup which would provide illumination during a power outage.</p> <p>3.1-19(b)</p>		<p>outdoor lighting for all 10 exits and exit discharges was placed on the generator backup by the corporate electrician. 2. In an effort to identify any other issues with the exit lighting, an observation by the Administrator and Maintenance Director of all exits has been completed with no additional findings. 3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the LifeSafety Code Standard for emergency exits. 4. As a means of QualityAssurance, the Maintenance Director or designee will do a monthly walk-through of the entire building checking emergency exit lighting and will document findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of monitoring will be reviewed in quarterly QA meeting for continued compliance, monitoring will be ongoing.</p>				

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K010062 SS=F	<p>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</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 03/17/14 at 3:09 p.m. with the Maintenance Supervisor, there was one fire hydrant located at the northwest part of the facility. Based on review of Fire Systems report on 03/17/14 at 3:21 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual</p>	K010062	<p>1. No residents were affected by this alleged deficient practice. The private fire hydrant located on the northwest side of the facility has been inspected and tested by Elwood Fire. 2. All residents have the potential to be affected by this alleged negative practice. The private fire hydrant located on the northwest side of the facility has been inspected and tested by Elwood Fire. 3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for private fire hydrants in regards to annual inspection and testing 4. As a means of Quality Assurance the Administrator will review all reports from Elwood Fire to ensure all recommendations of service are scheduled and completed. Any recommended service will be reviewed in the facility's quarterly QA meeting for continued compliance, monitoring will be ongoing.</p>	04/03/2014			

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	<p>inspections for the private fire hydrant. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant inspection was not available for review and the facility was unaware the fire hydrant needed to be inspected annually.</p> <p>3.1-19(b)</p>			