

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/07/2016
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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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K 0000  Bldg. 01	<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: 03/07/16</p> <p>Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200</p> <p>At this Life Safety Code survey, Indiana Veterans Home 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 facility located in three buildings identified as Mitchell Hall (3 story), Pyle Hall (3 story) and MacArthur Hall (4 story) was determined to be of Type 1 (443) construction and was fully sprinklered. The buildings were surveyed as one since they were all constructed prior to March 1, 2003. MacArthur and Pyle Halls have</p>	K 0000	<p>Preparation and/or execution of the Plan of Correction in general, or these corrective actions in particular, does not constitute an admission or agreement by this facility of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction and specific actions are prepared and/or executed in compliance of the Indiana State Department of Health Guidelines. This plan of correction is not meant to establish a standard of care, contract, obligation or position and the Indiana Veterans' Home reserves all possible contentions and defenses to the allegations and conclusions made by the inspection team.</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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K 0018 SS=E Bldg. 01	<p>basements. There is a partial basement under the mechanical room on Mitchell Hall. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 331 and had a census of 206 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services except for two detached generator buildings and maintenance shop which were not sprinklered.</p> <p>Quality Review completed on 03/16/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for</p>			

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	<p>keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 2 craft room doors, a pair of doors, were provided with positive latching hardware. This deficient practice could affect up to 10 residents in the craft room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Safety Director on 03/07/16 at 11:05 a.m., the set of craft room doors lacked a positive latching mechanism for one of the doors which manually latch into the frame. Based on interview at the time of observation, the Safety Director acknowledged the craft room door was not provided with positive latching hardware.</p> <p>3.1-19(b)</p>	K 0018	<p>K-18 Page 2 1. <b>What corrective actions(s) will be accomplished for those residents' found to have been affected by deficient practice?</b> The door coordinator for the Pyle Crafts and Hobbies Door, were inspected and Panic Hardware for positive latching was installed. 2. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> All other Panic Hardware on doors were tested ensuring all were operable. 3. <b>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b> Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and signed off by the Facility Operations Director or designee 4. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b> Modified door</p>	03/10/2016	

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</p> <p>(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</p> <p>(c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>Based on observation and interview, the</p>	K 0021	<p>inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and signed off by the Facility Operations Director or designee 5. <b>By what date the systemic changes will be completed?</b> Completed By; Panic Hardware installed by Dave Conwell 3/10/2016 A PM for Weekly Audits will be done for one month 3/21/2016 Monthly PM will be generated to inspect all doors Ongoing</p>	03/07/2016

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	<p>facility failed to ensure 1 of 26 sets of smoke barrier were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 30 residents in 2 of 27 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation during the tour with the Maintenance supervisor # 3 on 03/07/16 at 1:45 p.m., there was a cart of ceiling tiles in front of the smoke doors entering B wing on Mitchell second floor preventing the doors from closing. Based on interview at the time of observation, this was confirmed by the Maintenance Supervisor # 3 at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice?</b></p> <p>Door on Mitchell 3B was blocked by cart with ceiling tile, this cart was removed immediately.</p> <p><b>1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All doors will be inspected in all buildings to ensure no door is blocked.</p> <p><b>2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>An inservice was given to all Maintenance Personal on the safety of not blocking fire doors with objects. Inservices were</p>	

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			<p>completed on 3/21/2016.</p> <p>A PM will be generated to inspect all fire doors for items that may be blocking and with instructions to remove item immediately.</p> <p><b>3. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place.?</b></p> <p>Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and reported to QA by Facility Operations Director or designee</p> <p><b>4. By what date the systemic changes will be completed?</b> Completed by:  Cart moved immediately by Dave Conwell</p>	

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K 0022 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit from the second floor of Mitchell CD Lounge unit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect 35 residents on the second floor of the Mitchell Building.</p>	K 0022	<p>3/7/2016 A PM will be generated weekly X 1 Month</p> <p>3/28/2016 A PM will be generated bi-weekly X 1 Month</p> <p>4/28/2016 A PM will be generated monthly</p> <p>Ongoing</p>	03/18/2016			

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with Maintenance Supervisor #3 on 03/07/16 at 1:52 p.m., in the Mitchell second floor CD lounge there was an exit sign above the double doors leading to the AB side. The double doors were closed and wired shut and the AB side was currently unoccupied. Based on an interview at the time of observation, Maintenance Supervisor confirmed the double doors leading to the AB side was not to be used as an exit</p> <p>3.1-19(b)</p>		<p><b>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All exits and doors were check to make sure all meet code requirements.</p> <p><b>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again?</b></p> <p>All Maintenance and Safety will be required to an in service about emergency exits and blocking doors. Inservice will be completed by 3/21/2016</p> <p>A monthly PM will be generated to check all doors for any violations and will be corrected.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice</b></p>	
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K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated		<p><b>will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>A monthly PM to check all doors for any violation by maintenance department. Audits will be conducted by Safety Director or designee every 6 month.</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p><b>Completed By:</b> Wire removed and door opened back to an exit by Dave Conwell 3/18/2016 A monthly PM will be generated to check all emergency exits ongoing A six month audit will be conducted by the Safety Director or designee ongoing</p>		

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	<p>glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 9 of 26 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 120 residents in 11 of 27 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Safety Director and Maintenance Supervisor #3 on 03/07/16 from 11:00 a.m. to 2:35 p.m., the following smoke barrier walls had unsealed penetrations: a) above the ceiling tiles of the smoke barrier wall by Admissions on MacArthur</p>	K 0025	<p>K-25 Page(s) 5/6/7</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b> All affected areas were sealed,</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> Inspect other areas with similar situations in all buildings. Inspect areas following all maintenance repairs or contract work and ensure free of penetrations.</p> <p><b>3. What measures will be put into place or what systemic changes will be make</b></p>	03/18/2016

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	<p>1st floor there was an unsealed one inch penetration around conduit.</p> <p>b) above the ceiling tiles of the smoke barrier wall by MacArthur Lounge on MacArthur 1st floor there was an unsealed one inch penetration around conduit.</p> <p>c) above the ceiling tiles of the smoke barrier wall by room 10 in the MacArthur basement there were two unsealed one inch penetration around conduits and wires.</p> <p>d) above the ceiling tiles of the smoke barrier wall by room 24 in the MacArthur basement there were unsealed two inch penetration around a pipe and a four by four inch hole.</p> <p>e) above the ceiling tiles of the smoke barrier wall by the west exit in the MacArthur basement there was an unsealed one inch penetration through a pipe sleeve containing wires.</p> <p>f) above the ceiling tiles of the smoke barrier wall by room 410 on MacArthur four there were four unsealed three inch penetration through a pipe sleeve containing wires.</p> <p>g) above the ceiling tiles of the smoke barrier wall by room 310 on MacArthur three there were four unsealed three inch penetration through a pipe sleeve containing wires, a two by two inch hole, and a half inch gap around an air duct.</p> <p>h) above the ceiling tiles of the smoke</p>		<p><b>to ensure that the deficient practice does not occur again?</b></p> <p>A PM will be generated to inspect all areas for compromise the 1 hour fire rating.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>Modified door inspections will be updated to our PM system and will be checked bi-weekly x one month, then monthly thereafter and reported to QA by Facility Operations Director or designee</p> <p><b>5. By what date the systemic changes will be completed?</b></p>		

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K 0027 SS=E Bldg. 01	<p>barrier wall by room 217 on MacArthur two there were four unsealed three inch penetration through a pipe sleeve containing wires.</p> <p>i) above the ceiling tiles of the smoke barrier wall by room 210 on MacArthur two there were four unsealed three inch penetration through a pipe sleeve containing wires and a half inch gap around an air duct.</p> <p>j) above the ceiling tiles of the smoke barrier wall by Admissions office of the MacArthur building, there was an one inch unsealed penetration around a conduct</p> <p>k) above the ceiling tiles of the smoke barrier wall near the MacArthur lounge, there was a one inch unsealed penetration around three orange wires</p> <p>Based on interview at the time of observation, the Safety Director and Maintenance Supervisor #3 acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors</p>		<p><b>Completed By:</b> All areas were sealed by Dick McClure, Chris Murphy and Larry King, all areas of sealing 3/18/2016 was verified by Dave Conwell  3/22/2016  A PM will be generated bi-weekly X 1 Month 3/22/2016 A PM will be generated monthly  ongoing</p>				

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	<p>comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 26 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 30 residents in 2 of 27 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation during the tour with the Maintenance supervisor # 3 on 03/07/16 at 12:00 p.m., the smoke barrier doors entering the first floor of MacArthur did not completely close due to air pressure leaving a seven inch gap. Based on interview at the time of observation, this was confirmed by the Maintenance Supervisor # 3 at the time of observation.</p> <p>3.1-19(b)</p>	K 0027	<p>K-27 Page 7/8</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice?.</b></p> <p>The door closure has been adjusted so it closes properly</p> <p><b>2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All other door closures were tested and adjusted if needed.</p> <p><b>3. What measures will be put into place</b></p>	03/11/2016			

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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906		
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			<p><b>or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and reported to QA by Facility Operations Director or designee</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b></p> <p>Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and reported to QA by Facility</p>		

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K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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		Operations Director or designee  <b>5. By what date the systemic changes will be completed?</b>  Completed By: Doors adjusted to close properly by Dick McClure 3/11/2016 Verified by Dave Conwell  3/21/2016 A PM will be generated weekly X 1 Month  3/28/2016 A PM will be generated bi-weekly X 1 Month 4/28/2016 A PM will be generated monthly  ongoing		

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	<p>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 the corridor door to 1 of 1 Records Offices and 1 of 1 Craft Rooms used to store combustibles and measuring over 50 square feet in size was provided with a self-closing device. This deficient practice could affect up to 20 resident in the Pyle basement and craft room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Safety Director on 03/07/16 at 11:00 a.m., the corridor door to the Records Offices in the Pyle basement which contained 300 cardboard boxes of resident records and other documentation, measuring over 50 square feet in size, lacked a self-closing device. Also, the corridor double doors to the Craft room in the Pyle basement which contained large amount of combustible craft supplies and a usable kiln, measuring over 50 square feet in size, lacked a self-closing device. Based on interview at the time of observation, this was acknowledged by the Safety</p>	K 0029	<p>K-29 Page 9</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p> <p>Door in Pyle Basement Medical Records and Crafts and Hobbies, holding combustibles, will have door closures installed.</p> <p><b>2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>A door closures of all rooms larger than 50 square feet will be done</p>	03/18/2016
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	<p>Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 2 sets of corridor doors to a room used to store combustibles and measuring over 50 square were equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare &amp; Medicaid Services (CMS) requires sets of double doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door that must close first always closes first. This deficient practice affects up to 10 residents in the Macarthur Library.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor #3 on 03/07/16 at 12:30 p.m., the library double doors on Macarthur first floor near the resident media room, which swung in the same direction and were equipped with an astragal, lacked a coordinator to allow the non astragal side of the door to close first. The library measured over 50 square feet in size and contained over 15 shelves</p>				<p>and repaired/replaced as needed. All rooms of 50 square feet or more will be installed with a door closure.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>A PM will be generated to inspect all rooms for door closure weekly for 1 month, then monthly thereafter.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b></p> <p>Audits will be done weekly for 1 month and then monthly thereafter</p>		

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K 0034 SS=E Bldg. 01	<p>of books. Based on interview at the time of observation, the Maintenance Supervisor #3 acknowledged the double doors lacked a coordinator.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 soiled utility rooms on Mitchell second floor, a hazardous area, was smoke resistive. This deficient practice could affect up to 30 residents on Mitchell second floor</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor #3 on 03/07/16 at 11:45 a.m., the door to the soiled utility room on Mitchell second floor had an unsealed half inch hole below the door knob. Based on interview at the time of observation, the Maintenance Supervisor #3 acknowledged and provided the measurements of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 12</p>	K 0034	<p><b>5. By what date the systemic changes will be completed?</b></p> <p>Completed By: Repairs were completed by Dick McClure and  David Conwell</p> <p>3/18/2016 A PM will be generated weekly X 1 Month 3/21/2016 A PM will be generated monthly  ongoing</p>	03/17/2016			
			K-34 Page 10/11/12 1. <b>What corrective</b>				

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	<p>stairway enclosure doors in the Mac building were in accordance with 7.2. LSC Section 7.2.1.5.4 requires a latch or other fastening device to be provided. This deficient practice affects up to 20 residents in the MacArthur Basement.</p> <p>Findings include:</p> <p>Based on observations during the tour with the Safety Director on 03/07/16 at 12:30 p.m., one of the west side stairwell double doors in MacArthur Basement did not latch into the frame. Based on interview at the time of observation, the Safety Director acknowledged one of the double stairwell doors would not latch.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 1 sets of stair doors were equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare &amp; Medicaid Services (CMS) requires sets of double doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door that must close first always closes first. This deficient practice affects up to 20 residents in the MacArthur Basement.</p>		<p><b>action(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p> <p>The door coordinators were inspected in MacArthur Basement was found to not have door coordinators on double doors with astragal.</p> <p><b>2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All other door coordinators were tested and adjusted if needed.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the</b></p>				

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	<p>Findings include:</p> <p>Based on observation during the tour with the Safety Director on 03/07/16 at 12:30 p.m., the west side stairwell double doors in MacArthur Basement , which swung in the same direction and were equipped with an astragal, lacked a coordinator to allow the non astragal side of the door to close first. Based on interview at the time of observation, the Safety Director acknowledged the double stairwell doors lacked a coordinator.</p> <p>3.1-19(b)</p>		<p><b>deficient practice does not occur again?</b></p> <p>A PM will be generated monthly to inspect all doors for door coordinators with astragals</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b></p> <p>Preventive Maintenance Work Orders to be completed monthly for proper functions.</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p>Completed By: Repairs was completed by Dick McCLure</p>		

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K 0044 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 sets fire doors were equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare &amp; Medicaid Services (CMS) requires sets of double doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door that must close first always closes first. This deficient practice affects up to 50 residents in the Mitchell Dining room.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor # 3 on 03/07/16 at 1:20 p.m., the fire doors to the Mitchell dining room, which swung</p>	K 0044	<p>3/17/2016 Verified by Dave Conwell</p> <p>3/21/2016 Monthly PM will be generated to inspect all doors ongoing</p> <p>K-44 Page 12/13 1. <b>What corrective actions(s) will be accomplished for those residents' found to have been affected by deficient practice?</b></p> <p>The door coordinators were inspected the Mitchell Dining Room Fire Doors has no coordinator and Mitchell 3AB Door not automatically latching.</p> <p>2. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will</b></p>	03/10/2016

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	<p>in the same direction and were equipped with an astragal, lacked a coordinator to allow the non astragal side of the door to close first. Based on interview at the time of observation, the Maintenance Supervisor # 3 acknowledged the double doors lacked a coordinator and confirmed they were fire doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets on Mitchell third floor was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 30 residents on the third floor of Mitchell.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor # 3 on 03/07/16 at 11:11 a.m., the fire door set</p>		<p><b>be taken?</b></p> <p>All other coordinators and automatic latching on doors was tested ensuring all were operable.</p> <p><b>3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and reported to QA by Facility Operations Director or designee</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>Modified door inspections will be updated to our PM</p>	

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K 0051 SS=D	<p>on the AB side of the third floor of Mitchell failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed these were fire doors by the Maintenance Supervisor # 3.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>system and will be checked weekly for one month, then bi-weekly x one month, then monthly thereafter and signed off by the Facility Operations Director or designee</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p>Completed By; Repair were completed by Dan Schmitz 3/10/2016 Verified by Dave Conwell 3/11/2016 A PM for Weekly Audits will be done for one month 3/24/2016 A PM will be generated bi-weekly X 1 Month 4/24/2016 Monthly PM will be generated to inspect all doors Ongoing</p>		

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Bldg. 01	<p>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 smoke detectors in the Mac PT office, church room and the Gene Wilson history room were installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 3 residents.</p>	K 0051	<p>K 051-Page 10/15</p> <p><b>1. What corrective actions(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p> <p>Ceiling Smoke Detectors are located 12 to 24 inches from an air supply or return in many locations, these must be three feet from air supply. Smoke Detectors were removed from affected areas.</p>	03/08/2016			

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	<p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Supervisor #3 on 03/07/16 from 2:15 p.m. to 2:40 p.m., the smoke detectors in the MacArthur PT office, the library church room and the library Gene Wilson history room were installed within three feet of an air supply duct. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor #3.</p> <p>3.1-19(b)</p>		<p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All Smoke Detectors in all buildings will be inspected for the same problems and moved/or add a diffuser.</p> <p><b>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again?</b></p> <p>All smoke detectors will be reviewed and put in proper location</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality</b></p>	
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K 0069 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on observation and interview, the facility failed to ensure 1 of 2 manual hood fire extinguishing activation devices in the Pyle building was accessible. Section 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 0069	<b>assurance program will be put into place?</b> All smoke detectors will be inspected monthly <b>5. By what date the systemic changes will be completed?</b>  <b>Completed by:</b> Smoke detectors were moved by Dave Conwell 3/8/2016 Move smoke detectors to required dimensions. 3/8/2016 A PM will be generated to check monthly Ongoing  K-69 Page 16/17 1. <b>What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice?</b>	03/18/2016	

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NAME OF PROVIDER OR SUPPLIER  INDIANA VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906			
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	<p>Operations. NFPA 96 at Section 7-5.1 states a readily accessible means for manual activation shall be located between 42 inches and 60 inches above the floor, located in a path of exit or egress, and clearly identify the hazard protected. This deficient practice could affect up to 50 residents in the snack bar and kitchen staff.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Safety Director on 03/07/15 at 11:35 a.m., the activation device for the snack bar kitchen hood fire protection system was mounted on the wall next to the door of the snack bar kitchen. When the door to the snack bar was door is open, the door covers the activation device making the device inaccessible. Based on interview at the time of observation, this was acknowledged by the Safety Director.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure fire suppression system nozzles for 1 of 1 kitchens in the Mitchell building were correctly positioned in relation to moveable cooking equipment. LSC 9.2.3 requires commercial cooking equipment</p>				<p>1. Pyle Snack Bar Kitchen Fire Hood Suppression System; door covers the activation device make the device inaccessible. Ace Fire Protection Company to move, scheduled on 3/25/2016, the Hood Suppression System device to other side of door to make is accessible.</p> <p>2. Mitchell Kitchen; a kitchen range Hood Fire Suppression System not placed above the griddle/two stove burner. The Griddle/Two Stove Burner was removed.</p> <p><b>2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Pyle Kitchen inspected and found to be in compliance with regulations.</p>		

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	<p>to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> <li>a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems</li> <li>b. NFPA 13, Standard for the Installation of Sprinkler Systems</li> <li>c. NFPA 17, Standard for Dry Chemical Extinguishing Systems</li> <li>d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems</li> </ul> <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 3-6.3 states moveable cooking equipment shall be provided with a means to ensure that it is correctly positioned in relation to the appliance discharge nozzle during cooking operations. This deficient practice could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor #3 on 03/07/16 at 1:15 p.m., a kitchen range hood fire suppression system nozzle was not placed above the</p>		<p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p> <p>Facility Operations Director and Safety Director will meet before any modifications in either kitchen.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b></p> <p>A monthly PM will be generated to ensure compliance with regulations.</p> <p><b>5. By what date the systemic changes will</b></p>	

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K 0070 SS=B Bldg. 01	griddle/two burner stove unit in the Mitchell kitchen. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor #3.  3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 Based on observation and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient	K 0070	<b>be completed?</b>  Completed By: Griddle/Burner was removed by Dave Parrish 3/18/2016 Verified by Dave Conwell  3/21/2016 Pyle Suppression Devices to be moved by Ace Fire 3/25/2016 Monthly PM will be generated  ongoing	03/07/2016	
			K 70-Page 18 <b>1. What corrective actions(s) will be accomplished for</b>		

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	<p>practice is not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Safety Director on 03/07/16 at 12:51 p.m., an unplugged space heater was located in the MacArthur Basement Business Office. Based on record review with the Safety Director on 03/07/16 at 10:20 a.m., the facility does not allow space heaters. Based on interview at the time of observation, the Safety Director acknowledge and removed the space heater.</p> <p>3.1-19(b)</p>		<p><b>those residents found to have been affected by deficient practice?</b></p> <p>Remove all space heaters from all offices/rooms in all buildings</p> <p><b>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Inspect all building/rooms for a similar situation and removed from building if found.</p> <p><b>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not occur again?</b></p> <p>This deficiency will be added to an existing Maintenance PM for all buildings for monthly inspections</p> <p><b>4. How the corrective</b></p>		

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K 0103 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 Based on observation and interview, the facility failed to ensure interior walls in 1 of 4 second floor corridors of the Mitchell building were comprised of	K 0103	<p><b>action(s) will be monitored to ensure the deficient practice will not occur, i.e, what quality assurance program will be put into place?</b></p> <p>This Maintenance PM generates monthly</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p><b>Completed By:</b> Completion of removal of all space heaters by Jeff LaCosse 3/7/2016 A PM will be generated monthly Ongoing</p> <p>K-103 Page 18/19 1. <b>What corrective action(s) will be accomplished for</b></p>	03/18/2016
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	<p>noncombustible or limited combustible materials. LSC 19.1.6.3 states all interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited combustible materials.</p> <p>Exception: Listed, fire retardant treated wood studs shall be permitted within non-load bearing 1-hour fire rated partitions. This deficient practice could affect 35 residents on the second floor of the Mitchell building.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor #3 on 03/07/16 at 2:27 p.m., a wall in the center corridor on the second floor of the Mitchell building was constructed of plywood with two by fours wood studs. Based on an interview with Maintenance Supervisor #3 at the time of observation, the wall was constructed by facility staff to prevent residents from entering the AB side which was currently unoccupied.</p> <p>3.1-19(b)</p>		<p><b>those residents found to have been affected by deficient practice?</b></p> <p>Mitchell 2 Construction Wall had been placed; this wall was built out of plywood and did not meet code requirements. The wall was removed on 3/18/2016</p> <p><b>2. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>All buildings were inspected and no plywood walls were found.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b></p>		

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			<p>Facility Operations Director and Safety Director will meet prior to any wall construction to ensure compliance.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b></p> <p>A PM will be generated to ensure all is in compliance</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p>Completed By: Wall was removed by Dick McClure</p> <p>3/18/2016 Verified by Dave Conwell</p>	

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K 0147 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation, the facility failed to ensure 1 of 1 electrical junction observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice was in an area closed to residents but could affect staff in the area.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor #3 on 03/07/16 at 11:10 a.m., there was exposed wires from a removed wall clock hanging out of a wall in the nurse's station on the third floor of Mitchell.</p>	K 0147	<p>3/18/2016 A PM will generatored quarterly  Ongoing</p> <p>K-147 Page 19/20 1. <b>What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice?</b></p> <p>Mitchell 3 Nurse Station there were wires exposed where an electric clock had been hanging. The area was covered with fire proof required drywall, the wires are not exposed.</p> <p>2. <b>How other resident having the potential to be affected by the same deficient practice will be</b></p>	03/08/2016
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	Based on an interview during observation, the Maintenance Supervisor #3 acknowledged the electrical wires hanging from the wall.  3.1-19(b)		<b>identified and what corrective action(s) will be taken?</b>  All units and buildings will be checked to ensure no wires are exposed, and if found they will be covered.  <b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur again?</b>  A quarterly PM will be generated to ensure compliance  <b>4. How the corrective action(s) will be monitored to ensure the deficient will not occur, i.e. what quality assurance program will be put into place?</b>		

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			<p>A quarterly PM will be generated to ensure compliance</p> <p><b>5. By what date the systemic changes will be completed?</b></p> <p>Completed By:</p> <p>Hole in wall was covered by Dave Conwell 3/8/2016</p> <p>Any deficiencies will be corrected 4/28/2016</p> <p>A quarterly PM will be generated</p> <p>Ongoing</p>	