

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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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: 11/04/15</p> <p>Facility Number: 000078 Provider Number: 155158 AIM Number: 100289310</p> <p>At this Life Safety Code survey, Life Care Center of the Willows 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and areas open to the corridors. Resident rooms are equipped with battery operated smoke. The facility has the capacity for 100 and had a census of 59 at the time of this</p>	K 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission bythe facility. This facility respectfully requests	

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 0025 SS=D Bldg. 01	<p>survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 11/12/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator</p>	K 0025	<p>consideration of paper compliance for the cited deficiencies</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/09/2015 Maintenance Director replaced missing ceiling tile in media room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit was conducted on 11/09/2015 to ensure all ceiling tiles smoke barriers/ceiling tiles were in place. No further issues</p>	12/04/2015

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K 0029 SS=E Bldg. 01	<p>on 11/04/15 at 11:30 a.m., one of fourteen ceiling tiles were missing in the Media Room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 East Shower room used as Soiled Linen storage, a hazardous area, would positively latch into the frame.</p>	K 0029	<p>were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/09/2015 Maintenance Director replaced the shower room door latch. Latch now catches into</p>	12/04/2015	

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K 0064 SS=D Bldg. 01	<p>This deficient practice could affect up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 11/04/15 at 12:11 p.m., the East Shower room contained two separate thirty two gallons of soiled linen and trash. The corridor door self closed but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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 facility failed to ensure 1 of 1 resident smoking area portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable</p>	K 0064	<p>door frame. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit was conducted on 11/09/2015 to ensure all that all shower room latch assemblies are functioning correctly. No further issues were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/06/2015, the Maintenance Director replaced the fire extinguisher in the designated</p>	12/04/2015	

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K 0066 SS=D Bldg. 01	<p>maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect the one resident who is allowed to smoke in the area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 11/04/15 at 10:57 a.m., the maintenance tag on the fire extinguisher in the resident smoking area indicated the last six year test was completed 2005. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids,</p>				<p>resident smoking area outside with a fire extinguisher that meets the NFPA 10 standard. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit was conducted on 11/06/2015 of all fire extinguishers to ensure that all fire extinguishers meet the NFPA 10 standard. No further issues where identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. Also SafeCare will continue to monitor fire extinguishers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p>		

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	<p>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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 area where smoking was permitted for staff was maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations and interview on 11/04/15 at 10:52 a.m., the Maintenance Director and Administrator acknowledged there were at least 50 cigarette butts on the ground in the designated staff smoke area.</p> <p>3.1-19(b)</p>	K 0066	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 11/04/2015 Maintenance Director cleaned and swept cigarette butts up in employee designated smoking area.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</p> <p>The Maintenance Director/designee will continue to monitor the designated smoking area for cigarette butts on ground daily. Any further issues will be addressed daily.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur :</p>	12/04/2015

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K 0070 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Administrator on 11/04/15 at 10:51 a.m., the space heater policy states the facility does not allow space heaters. Based on</p>	K 0070	<p>A daily audit was created and it will be documented in the daily preventative maintenance log to ensure compliance. Staff reeducated of proper disposal of cigarette butts 11/18/2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/04/2015 Maintenance Director disposed of portable space heater that was located in facility maintenance shed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit was conducted on 11/05/2015 to ensure there were no other portable space heaters on the property. No other issues</p>	12/04/2015

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K 0076 SS=D Bldg. 01	<p>observation, a space heater was found in the Maintenance Shed. Based on interview at the time of observation, the Maintenance Director acknowledged the space heater was a violation of the facility's policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder</p>	K 0076	<p>were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A Monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/04/2015 Maintenance Director placed the oxygen cylinder in approved rack in the west oxygen room. How other residents</p>	12/04/2015

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K 0130 SS=E Bldg. 01	<p>or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 11/04/15 at 11:42 a.m., one of two oxygen cylinders was unsupported in the West Oxygen Transfer room. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire</p>	K 0130	<p>having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: An audit was conducted on 11/05/2015 by Administrator of east and west oxygen rooms to ensure oxygen cylinders were stored correctly. No further issues were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A weekly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/04/2015, the Maintenance Director sealed penetration measuring ½ inch around a bundle of data cables above the</p>	12/04/2015			

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	<p>emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and at least 25 residents.</p> <p>Findings include:</p> <p>Based on an observation with the</p>		<p>ceiling tiles in fire barrier wall near room 7 proper fire rated caulk. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: An audit was conducted on 11/04/2015 of areas above ceiling tiles at fire barrier walls for unsealed penetrations. No further issues were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p>				

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K 0147 SS=D Bldg. 01	<p>Maintenance Director and Administrator on 11/04/15 at 12:42 p.m., the fire barrier wall near resident room 7 had an unsealed penetration measuring one half inch around a bundle of data cables above the ceiling tile. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director and Administrator on 11/04/15 between 11:10 a.m. and 11:34 a.m. the</p>	K 0147	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 11/04/2015, the Maintenance Director removed a multiple plug extension cord and relocated a refrigerator to enable it to be plugged directly into the wall and removed a cell phone charger in the central supply room. On 11/20/2015 a 4 way receptacle was installed in the business office and refrigerator was plugged directly into the wall. On 11/17/2015 the surge protector was removed from the media room and the layout reworked to plug in each power strip to the wall. On 11/06/2015 a box was installed over the wandergard</p>	12/04/2015

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	<p>following was discovered:</p> <p>a) a multiplug extension cord was powering a refrigerator and a cell phone charger in Central Supply.</p> <p>b) a surge protector was powering a refrigerator in the Business Office.</p> <p>c) a surge protector was powering another surge protector powering computer equipment in the Media Room</p> <p>Based on interview at the time of each observation, the Maintenance Director and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical device in 1 of 1 sprinkler riser room. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 11/04/15 at 11:21 a.m. the WonderGuard electrical board was screwed on the wall, with the power wires exposed. Based on interview at the time of observation, the Maintenance</p>		<p>electrical box in main dining room sprinkler control room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: An audit was conducted on 11/06/15 of all wandergard boxes was completed to ensure all wandergard electrical boards were covered with proper boxes. No further issues were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : A monthly audit was created and it will be documented in the preventative maintenance log to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383		
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	Director and Administrator acknowledged the aforementioned condition. 3.1-19(b)				