

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155744	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2016
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 351 N ALLEN CHAPEL RD KENDALLVILLE, IN 46755
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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: 04/11/16</p> <p>Facility Number: 000570 Provider Number: 155744 AIM Number: 100275010</p> <p>At this Life Safety Code survey, Lutheran Life Villages was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement 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, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 127 and had a census of 75 at the time of this survey.</p>	K 0000	<p>This plan of correction is being submitted as our allegation of compliance Please consider this Plan of Correction for "paper 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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K 0011 SS=E Bldg. 01	<p>All areas where the residents have customary access are sprinklered. The facility does have a garage providing facility services that was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 "Health Care/ Day Care" fire barriers to a nonconforming occupancy was protected by a two hour fire rating. LSC 19.1.2.1 states sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions:</p> <ol style="list-style-type: none"> 1. They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. 2. They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours. 	K 0011	<ol style="list-style-type: none"> 1. Construction firm, Hagerman Construction, evaluated common barrier wall between Health Care/Day Care on 4/18/16 and 4/19/16 in reference to building materials for the common barrier wall and the lower level ceiling/first level floor. It was confirmed the barrier wall is constructed with 7 5/8" x 16" concrete blocks and the ceiling for this lower level/first level floor is constructed with steel and concrete. 2. Architect firm, MKM, evaluated common barrier wall between Health Care/Day Care on 4/19/16 to determine if the common barrier wall prior code rating of "1 Hour FR Separation" met the current code rating of "2 Hour FR Separation" Life Safety Code Standard. 3. On 4/20/16, MKM 	05/10/2016

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K 0025 SS=D Bldg. 01	<p>This deficient practice could affect all staff, visitors, and at least 10 residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance and Maintenance Technician #1 on 04/11/16 between 9:36 a.m. and 11:10 a.m., the site plans indicated the floor which separates the Lutheran Life Villages Health Care Occupancy on the main level and the "Early Adventures Child Care" on the lower level, a nonconforming occupancy, was not available for review. The site plans did indicate the lower level barrier wall was only constructed to 1 hour separation. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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</p>		utilized <u>NCMA TEK</u> , TEK 7 – 1A, Fire Resistance(2003), Fire Resistance Rating of Concrete Masonry Assemblies guide todetermine the common barrier wall did meet the "2 Hour FR Separation" standard. 4 On 4/21/16, LLV obtained letter from MKM statingthe common barrier wall between Health Care/Day Care assembly meets the "2 HourFR Separation" requirement.5 MKM will update the facility Life Safety SitePlan by 5/10/16 to reflect the "2 Hour FR Separation" for the common barrierwall between Health Care/Day Care.		

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	<p>accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 ceiling smoke barriers were maintained to provide a one half 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 Director of Maintenance and Maintenance Technician #1 on 04/11/16 at 11:43 a.m. then again at 1:36 p.m., there was a half inch unsealed ceiling gap around the sprinkler pipe in the North Clean Utility Room. Then again, there was a two inch unsealed ceiling penetrations in the Basement Dietary Storage room. Based on interview at the time of each observation, the Director of Maintenance and Maintenance Technician #1 acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>	K 0025	<p>1.The half inch unsealed ceiling gap around the sprinkler pipe in the North Clean UtilityRoom was filled in with a Firestop Pillow, Cat. No. SSB14, on 4/11/16.</p> <p>2.The two inch unsealed ceiling penetration in the Basement Dietary Storage Room was fixed by replacing the ceiling tile on 4/11/16.</p> <p>3.A facility environmental tour was completed on4/12/16 reviewing ceiling tiles, searching for additional ceiling penetration issues; no other ceiling penetrations identified.</p> <p>4.Maintenance Director reviewed the NFPA 101 Life Safety Code Standard regarding ceiling penetrations on 4/11/16.</p> <p>5.Maintenance Director (designee) will audit ceiling and ceiling tile for penetrations during monthly environmental rounds - see Ceiling Penetrations Audit Form</p> <p>6.Audit findings will be reported during the monthly QAA Committee Meeting.</p>	04/12/2016

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K 0027 SS=D Bldg. 01	<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 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, the facility failed to ensure 1 of 1 Basement Storage Room, 1 of 2 Laundry, and 1 of 1 Boiler Room sets of corridor 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 & Medicaid Services (CMS) requires sets of smoke barrier 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 could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and Maintenance Technician #1 on 04/11/16 between 1:04 p.m. and 1:14 p.m., the following sets of corridor doors, which swung in the same</p>	K 0027	<p>1.Maintenance Director ordered three coordinateddoor closures on 4/11/16; so, the doors would align when closing to ensure atight latch.</p> <p>2.The coordinated door closures were installed on4/19/16.</p> <p>3.The Maintenance Director reviewed the NFPA 101Life Safety Code Standard regarding door openings in smoke barriers on 4/11/16.</p> <p>4.The Maintenance Director completed a facilitydoor audit regarding closures on 4/11/16; no other doors were identified inneed of a coordinated door closure.</p> <p>5.The Maintenance Director (designee) will audit door closures during monthly fire drills - see Fire Drill Form.</p> <p>6.Audit findings will be reported during themonthly QAA Committee Meeting.</p>	04/19/2016			

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K 0076 SS=D Bldg. 01	<p>direction and were equipped with an astragal, lacked a coordinator to allow the astragal side of the door to close first:</p> <p>a) Basement Storage Room b) Laundry c) Boiler Room</p> <p>Based on interview at the time of each observation, the Director of Maintenance and Maintenance Technician #1 acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 50 cylinders in the Oxygen Room of nonflammable gases such as oxygen 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 or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires</p>	K 0076	<p>1.The two oxygen tanks that were found on the floor on 4/11/16, inside the Oxygen Storage Room, were placed in an oxygen tank cylinder secured bin for empty cylinders.</p> <p>2.Maintenance Director did not find any other unsecured oxygen tanks during environmental rounds on 4/11/16.</p> <p>3.The DON reviewed oxygen</p>	04/20/2016

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K 0144 SS=F Bldg. 01	<p>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 Director of Maintenance and Maintenance Technician #1 on 04/11/16 at 12:29 p.m., the oxygen room had two oxygen cylinders that was freestanding on the floor. Based on interview at the time of observation, the Director of Maintenance and Maintenance Technician #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator</p>	K 0144	<p>tank placement in the Oxygen Storage Room with nursing staff on 4/12/16.</p> <p>4.The QAA Coordinator posted reminder signs for staff on the Oxygen Room Door and inside the Oxygen Storage Room on 4/19/16.</p> <p>5.The Administrator emailed "all staff" regarding oxygen tank placement within the Oxygen Storage Room on 4/20/16.</p> <p>6.The DON (designee) will audit the Oxygen Storage Room for oxygen tank placement to ensure the tanks are secured appropriately weekly for four weeks starting the week of 4/11/16 and then transition the audit to monthly, if compliance is at 100% starting the week of 5/9/16 – see Oxygen Room Audit Form.</p> <p>7.Audit findings will be reported during the monthly QAA Committee Meeting.</p> <p>A. Annunciator Panel Visual & Audible Alarm 1.Please note the generator annunciator panel is located in the Maintenance Office and the SW Nurse's Station; the CMS-2567 lists the Maintenance Office</p>	04/29/2016			

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	<p>to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 04/11/16 at 12:43 p.m., the generator annunciator panel goes to the maintenance office then to the North Nurse's Station. When the generator toggle switch was switched to the manual position the generator annunciator panel at the nurse's station failed to provide an audio or visual alarm. Based on an interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and confirmed the maintenance office is not constantly attended.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test.</p>		<p>and the "North" Nurse's Station.</p> <p>2. The visual alarm was tested on 4/11/16 and it did visually alarm at both the Maintenance Office and the SW Nurse's Station.</p> <p>3. The audible alarm was tested on 4/11/16 and it did alarm in the Maintenance Office. An audible alarm is not connected at the SW Nurse's Station; so, there was no audible alarm in this area.</p> <p>4. The Maintenance Director reviewed NFPA 101 LifeSafety Code Standard regarding the generator annunciator panel for visual and audible alarms on 4/11/16.</p> <p>5. The Maintenance Director reviewed the need for an audible alarm installation with Two Brothers, Generator, on 4/12/16. The installation of the audible alarm is scheduled to occur the week of 4/25/16.</p> <p>6. The Generator Test Log Form was revised on 4/19/16 to include documentation to record the visual and audible alarm for the annunciator panel located at the SW Nurse's Station - see revised Generator Test Log Form</p> <p>7. The Maintenance Director (designee) will complete a visual and audible alarm audit monthly during the generator load test.</p> <p>8. Audit findings will be reported during the monthly QAA Committee Meeting.</p> <p>B. Generator 5 Minute Cool Down Period</p> <p>1. The Maintenance Director</p>				

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	<p>LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Director of Maintenance and Maintenance Technician #1 on 04/11/16 at 10:16 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Director of Maintenance and Maintenance Technician #1 confirmed</p>		<p>reviewed NFPA 101 LifeSafety Code Standard on 4/11/16.</p> <p>2.The Generator Test Log Form was revised on 4/19/16 to include documentation to record the 5 Minute Cool Down period – see revised Generator Test Log Form.</p> <p>3.The Maintenance Director (designee) will complete the 5 Minute Cool Down period start and stop time on a monthly basis during the generator load test.</p> <p>4.The Generator Test Log form will be reviewed during the monthly QAA Committee Meeting.</p>				

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K 0147 SS=E Bldg. 01	<p>the generator runs a cool down period but is unable to provide documentation to confirm.</p> <p>3.1-19(b)</p> <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 and interview, the facility failed to ensure 2 of 2 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 and up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and Maintenance Technician #1 on 04/11/16 at 11:49 a.m. then again at 1:26 p.m., a surge protector was powering a coffee pot in the North Nurse's station. Then again, a surge protector was powering a microwave and a refrigerator in the MDS office. Based on interview at the time of each</p>	K 0147	<p>1.The items identified with a high current draw were removed from the surge protector and plugged directly into a wall outlet on 4/11/16.</p> <p>2.All office and nursing station areas were audited on 4/11/16 for surge protector usage for high current draw items; no other items were identified.</p> <p>3.Maintenance Director reviewed the NFPA 101 Life Safety Standard.</p> <p>4.Administrator reviewed surge protector usage with key staff members during the morning huddle on 4/12/16.</p> <p>5.Administrator revised the Fire Plan Policy (Page3) to include information regarding surge protector utilization – see revised Fire Plan Policy.</p> <p>6.Maintenance Director (designee) will audit office areas and nursing stations for surge protector usage during monthly environment rounds – see Surge Protector Audit Form</p> <p>7.Audit findings will be reported during the monthly QAA</p>	04/11/2016			

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	observation, the Director of Maintenance and Maintenance Technician #1 acknowledged each aforementioned condition. 3.1-19(b)		Committee Meeting.		