

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2015
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NAME OF PROVIDER OR SUPPLIER  LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
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K 000  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: 03/12/15</p> <p>Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Liberty Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident sleeping rooms. The</p>	K 000	<p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=E Bldg. 01	<p>facility has 52 resident rooms in which 13 resident rooms on Rosewood have hard wired smoke detectors and 39 resident rooms have battery powered smoke detection. The facility has a capacity of 104 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered except for the one detached garage for facility storage and was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/17/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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,</p>			

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	<p>19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 smoke barrier walls was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire 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 36 residents on 200 hall as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observation on 03/12/15 at 2:50 p.m. with the Maintenance Supervisor, the 200 hall center smoke barrier wall had a one inch diameter opening around twelve low voltage wires which penetrated the smoke barrier wall and was not sealed with a fire rated material. Based on interview on 03/12/15 at 2:59 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier wall had an unprotected opening which was not sealed with a fire</p>	K 025	<p>1 No residents were affected by this alleged deficient practice. The 7 smoke walls have been inspected and updated with material capable of maintaining the smoke resistance of the smoke barrier. 2. No residents were affected by this alleged deficient practice with all residents having the potential to be affected. The 7 smoke walls have been inspected and updated with material capable of maintaining the smoke resistance of the smoke barrier. 3. In an effort to identify any other issues with the smoke barriers an observation by the Administrator and Maintenance Director of all barriers has been completed with no additional findings. To ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for smoke barriers. 4. As a means of Quality Assurance, the Maintenance Director or designee will do a monthly walk-through of the entire building checking the smoke barriers and will document findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of monitoring will be reviewed in quarterly QA meetings for continued compliance, monitoring will be ongoing.</p>	03/20/2015	

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K 062 SS=C Bldg. 01	<p>rated material.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 4 pressure gauges for the sprinkler system in the Riser room were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents in the facility as well as staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 03/12/15 at 1:38 p.m. with the Maintenance Supervisor, one sprinkler pressure gauges located in the sprinkler riser room on 200 hall north hall had a sprinkler vendor replacement date of 2008. Based on Sprinkler</p>	K 062	<p>1. No residents were affected by this alleged deficient practice. The pressure gauge has been replaced, tested and inspected by Elwood Fire. 2. No residents were affected with all residents having potential to be affected by this alleged deficient practice. The pressure gauge has been replaced, tested and inspected by Elwood Fire. 3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for pressure gauges in regards to replacing gauges every 5 years and testing 4. As a means of Quality Assurance the Administrator will review all reports from Elwood Fire to ensure all recommendations of service are scheduled and completed. Any recommended service will be reviewed in the facility's quarterly QA meeting for continued compliance, monitoring will be ongoing.</p>	03/20/2015			

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	<p>Inspection Records review on 03/12/15 at 3:15 p.m. with the Maintenance Supervisor, documentation did not reveal the sprinkler system gauge had been calibrated or replaced since the date listed on the pressure gauge. Based on interview on concurrent with the observation it was acknowledged by the Maintenance Supervisor the pressure gauge had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p>				