

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2015
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/03/15 and 02/04/15</p> <p>Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</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>The main building is a three story, partially sprinklered building determined to be of Type I (332) construction with a basement. The Health and Rehabilitation building is a one story sprinklered</p>	K010000	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. With all of the supportive documentation submitted with our 2567, we respectfully request paper compliance. Thank you</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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K010011 SS=F	<p>building of Type I (332) construction. The main building has a fire alarm system with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The Health and Rehabilitation building has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detector in the resident rooms. The facility has a capacity of 213 and had a census of 114 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered with exception of the occupational therapy room. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/16/15.</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 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</p>			

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	<p>openings occur only in corridors and are protected by approved self-closing fire doors. 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 and Rehab Center's" fire barriers to nonconforming buildings was protected by a two hour fire rating. This deficient practice could affect all residents in the "Health and Rehab Center".</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 2/04/15 at 11:20 a.m., the firewall which separates the "Health and Rehab Center" from the first floor of the main building, a nonconforming building, had a set of 20 minute fire rated double doors that lacked latching hardware and failed to latch into the frame. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the doors were 20 minute fire rated and lacked hardware causing the door not to latch into the frame.</p> <p>3.1-19(b)</p>	K010011	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K011 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this deficient practice. Two 90 minute fire rated doors with the proper locking mechanisms were ordered on 2-19-2015, from CIH (Central Indiana Hardware, Fort Wayne, Indiana) with the sales order # 5087725. Approximate installation date is 3-16-2015 and will be conducted by CIH (see attached K011 – A). Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. Two 90 minute fire rated doors with the proper locking mechanisms were ordered on 2-19-2015, from CIH (Central Indiana Hardware, Fort</p>	04/15/2015	

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			Wayne, Indiana) with the sales order # 5087725. Approximate installation date is 3-16-2015 and will be conducted by CIH(see attached K011 – A). All other fire rated doors in the facility are up to code. No other doors were cited during survey. What Measures were put into place to ensure this does not happen again: No residents were directly affected by this deficient practice. Two 90 minute fire rated doors with the proper locking mechanisms were ordered on 2-19-2015, from CIH (Central Indiana Hardware, Fort Wayne, Indiana) with the sales order # 5087725. Approximate installation date is 3-16-2015 and will be conducted by CIH (see attached K011 – A). All other fire rated doors in the facility are up to code. No other doors were cited during survey. If additional doors need replaced, the replacement parts/process will be overseen by our Assistant Maintenance Director. How the corrective actions will be monitored: The Maintenance Director and/ or designee will monitor and oversee the installation and the correct working/functioning of these doors to ensure they close/latch correctly. The doors will be checked every 30 days (monthly) for 90 days to assure they are in good working order. The results from this monthly audit will be reviewed at our monthly QA meetings for compliance. Director of		

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K010025 SS=E	<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>1. Based on observation and interview, the facility failed to ensure penetrations caused by the passage of wire and/or conduit through 3 of 7 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</p>	K010025	<p>Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: K011 – A Sales Order for two fire rated doors.</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. K025 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this</p>	03/06/2015

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	<p>protected by an approved device designed for the specific purpose. This deficient practice could affect six of eight smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Assistant Director of Maintenance on 03/04/14 from 1:02 p.m. to 2:07 p.m., the following smoke barrier walls in the "Health and Rehab Center" had unsealed penetrations or penetrations sealed with an un-rated material:</p> <p>a) in the wall entering recreation, there is exposed fiberglass, an un-rated material, where the wall meets the roof decking. Also, there is a 4 inch by 2 inch hole around a conduit.</p> <p>b) in the wall entering C wing there is a gap at the top of the wall measuring 2 inches. Also there are seven penetrations in the wall around a metal beam and wires from one to five inches in size.</p> <p>c) in the wall entering the main dining room there is a three inch by five inch penetration around a support beam.</p> <p>Based on interview, measurements were provided by the Assistant Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p>deficient practice. 1a, the penetrations weresealed with the fire rated component (Boss Products – 813 Firestop) (see attached picture K025-A). For further reference, Boss Fire Products contain ASTM E814 1b, these penetrations weresealed with the fire rated component (Boss Products – 813 Firestop) (see attached 2 pictures K025 –B). 1c, this penetration entering the main dining room was sealed with the fire rated component (Boss Products –813 Firestop) (see attached picture K025 – C). 2a, these nine penetrationson the 2nd floor were all sealed with the fire rated component (Boos Products – 813 Firestop) (See attached 2 pictures K025 – 1A). These penetrations were allsealed on 2-3-2015. No other penetrations were found during the LSC inspectionas each fire wall was inspected. Other residents having thepotential to be affected and the corrective actions: No residents were directly affected by this deficient practice. 1a, the penetrations were sealed with the fire rated component (Boss Products – 813 Firestop) (see attached picture K025-A). For further reference - the Boss Products - 813 Firestop does contain ASTM E814 1b, these penetrations were sealed with the fire rated component (Boss Products – 813 Firestop) (see attached 2 pictures K025 –B).</p>				

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling and floor smoke barriers was 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 was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation on 02/03/15 at 2:03 p.m. with the Director of Maintenance, there were nine unsealed penetrations in the linen storage room on the second floor in the main building ranging in size from one to eight inches around wires and cables. The wires and cables ran from the floor to the ceiling causing four penetrations in the floor and five penetrations in the ceiling. Based on interview, measurements were provided by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p>1c, this penetration entering the main dining room was sealed with the fire rated component (Boss Products –813 Firestop) (see attached picture K025 – C). 2a, these nine penetrations on the 2nd floor were all sealed with the fire rated component (Boos Products – 813 Firestop) (See attached 2 pictures K025 – 1A). These penetrations were all sealed on 2-3-2015. No other penetrations were found during the LSC inspection as each fire wall was inspected. What Measures were put into place to ensure this does not happen again: No residents were directly affected by this deficient practice. 1a, the penetrations were sealed with the fire rated component (Boss Products – 813 Firestop) (see attached picture K025-A). 1b, these penetrations were sealed with the fire rated component (Boss Products – 813 Firestop) (see attached 2 pictures K025 –B). 1c, this penetration entering the main dining room was sealed with the fire rated component (Boss Products –813 Firestop) (see attached picture K025 – C). 2a, these nine penetrations on the 2nd floor were all sealed with the fire rated component (Boos Products – 813 Firestop) (See attached 2 pictures K025 – 1A). These penetrations were all sealed on 2-3-2015. No other penetrations were found during the LSC inspection as each fire wall was inspected. Additionally,</p>				

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to maintain and secure the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4, 9.6 and 9.6.1.4, as well as, NFPA 72 - 1999 edition,</p>	K010052	<p>a policy /procedure was developed (see attached – K025 – D), where fire walls will be inspected on a semi-annual basis/ recorded. How the corrective actions will be monitored: These penetrations in the fire walls will be checked every 30 days (monthly) for 90 days to assure they are still secured/sealed with no gaps. The results from this monthly audit will be reviewed at our monthly QA meetings for compliance. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: Photo for 1a K025 – A Two photos for 1b K025 – B Photo for 1c K025– C Two photos for 2a K025 – 1A Policy/procedure K025 – D</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set</p>	03/06/2015	

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	<p>Sections 7-3.1, 7-3.2 and 7-5.2.2. This deficient practice could affect all 114 residents as well as an undetermined number of staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/04/14 at 11:45 p.m. with the Assistant Director of Maintenance, the electrical panel located in the hallway of D wing in the "Health and Rehab Center" contained the breaker for the Fire Alarm Control Panel. The door to the panel nor the breaker itself was locked. This condition could allow an untrained staff member, visitor, or resident access to the power of the Fire Alarm Control Panel. Based on Interview, the Assistant Maintenance Director confirmed that the panel contained the breaker to the Main Fire Alarm Panel and it was marked "FACP." The Assistant Maintenance Director tried to lock it but stated "I do not have a key to lock it."</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 2 manual fire alarm boxes in D wing of the "Health and Rehab Center" were mounted securely. NFPA 72, 1999 Edition of the National Fire Alarm Code at 2-8.1 states each</p>		<p>forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K052 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this deficient practice. 1a, the breaker box housing the fire alarm system breaker had a locking feature added, where as the breaker box is now locked and secured from any activity from untrained staff, residents or visitors. 2a, the fire alarm pull that was loose by room 411 on the D wing has been remounted and firmly secured back in place (see attached photo – K052 –2A) Facility has updated their policies /procedures to include a policy regarding checking this electrical panel (E-5) to assure it is locked at all times. (see attached policy – K052 –2. Additionally, the facility updated their policy regarding mounted firepulls (see attached – K052 – C). This also includes the audit form for QA. An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K052.</p> <p>Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. 1a, the</p>				

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	<p>manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 31/2 ft (42 inches) and not more than 41/2 ft (54 inches) above floor level. This deficient practice could affect 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on record review on 02/03/15 at 2:45 p.m. with the Assistant Director of Maintenance, the "Inspection and Test Report" performed by Koorsen Fire and Security on 08/25/14 stated the pull station by room 411 in D wing needed to be remounted. During observation on 02/04/15 at 11:45 a.m. with the Assistant Director of Maintenance it was noted the pull station by room 411 in D wing was loose and was not securely mounted to the wall. Based on interview, the Assistant Director of Maintenance noted the the pull station was loose and not remounted to the wall.</p> <p>3.1-19(b)</p>		<p>breaker box housing the fire alarm system breaker had a locking feature added, whereas the breakerbox is now locked and secured from any activity from untrained staff, residents or visitors. 2a, the fire alarm pull thatwas loose by room 411 on the D wing has been remounted and firmly secured backin place (see attached photo – K052 –2A) Facility has updated theirpolicies /procedures to include a policy regarding checking this electrical panel (E-5) to assure it is locked at all times. (see attached policy – K052 –2. Additionally, the facility updated their policy regarding mounted firepulls (see attached – K052 – C). This also includes the audit form forQA. An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K052.</p> <p>What Measures were putinto place to ensure this does not happen again: No residents were directly affected by this deficient practice. 1a, the breaker box housing the fire alarm system breaker had a locking feature added, whereas the breakerbox is now locked and secured from any activity from untrained staff, residents or visitors. 2a, the fire alarm pull thatwas loose by room 411 on the D wing has been remounted and firmly secured backin place (see attached photo – K052 –2A) Facility has updated their policies /procedures to include a policy</p>				

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K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is		regarding checking this electrical panel (E-5) to assure it is locked at all times. (see attached policy – K052 –2. Additionally, the facility updated their policy regarding mounted firepulls (see attached – K052 – C). This also includes the audit form for QA. An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K052. How the corrective actions will be monitored: The proper mounting of the fire pull stations will be checked every 30 days (monthly) to assure they are still secured/tightly mounted to the wall. The breaker box housing the fire alarm system breaker will be checked weekly. The results from these audits will be reviewed at our monthly QA meetings for compliance. An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K052. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: Photo of the fire pull near room 411 K052 –2A Breaker box E-5 Policy K052 –2 Mounting of fire alarm pull station policy K052– C All staff in-service ZZ		

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	<p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler coverage was provided for 2 of 2 elevator equipment rooms to provide complete sprinkler coverage for all portions of the building. This deficient practice affects 1 of 2 basement smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 2/3/15 from 1:15 p.m. to 1:17 p.m., the following was noted:</p> <p>a. the service elevator equipment room in the basement lacked sprinkler coverage. The room was constructed of concrete and block with a non-rated steel door that lacked a self closing device.</p> <p>b. the passenger elevator equipment room in the game room lacked sprinkler coverage. The room was constructed of concrete and block with a non-rated steel</p>	K010056	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K056 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this deficient practice. 1a – b, the facility is currently installing new elevator systems, including the appropriate sprinkler coverage. The service elevator's date of completion is approximately 3-1-2015, with the state inspections following. Once the</p>	04/15/2015

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES				STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816			
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	<p>door that lacked a self closing device. Based on an interview at the time of observations, the Director of Maintenance was aware of this requirement, has gotten approval for the installation of the sprinkler heads, and is waiting for the construction to begin.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 Occupational Therapy (OT) closet and alcove in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect 1 of 2 smoke compartments on the second floor in the main building.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 02/02/15 at 2:47 p.m., the closet and the alcove in the (OT) room next to room 504 on the second floor in the main building lacked sprinkler coverage. Based on interview, the Director of Maintenance agreed the closet and the alcove is lacking sprinkler coverage.</p>		<p>service elevator passes its inspections, the passenger elevator will be renovated will a new elevator system, including the appropriate sprinkler coverage. A sprinkler has been installed in the new service elevator on 2-25-2015. We have provided this service report from Koorsens indicating the completion of the additional sprinkler head. (see attachment C). Approximate time of completion for the 2nd elevator (passenger) is two months from the completion of the service elevator. (see attached contract – K056 –A). 2, the facility has contacted an outside vendor to secure bids for the installation of the area in need of additional sprinklers on the 2nd floor. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate 3, the facility has contacted an outside vendor to secure bids for the installation of the area in need of additional sprinklers in the outside patio, located off of the main dining room in Health & Rehab Center. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate. Not other areas were cited during the LSC inspection and no other areas were found after a thorough inspection from the Assistant Director and Director of Maintenance. Other residents having the potential to be</p>				

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	<p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 patios in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect all residents using the patio in the "Health and Rehab Center."</p> <p>Findings include:</p> <p>Based on an observation with the Assistant Director of Maintenance on 02/03/15 at 12:50 p.m., the outside patio attached to the "Health and Rehab Center" had a noncombustible overhang covering the patio with combustible materials attached. On the outer side of the patio there was a wall consisting of wood (cedar) and screen mesh attached to the patio and the overhang. There was no sprinklers present for coverage of the patio. Based on interview, the Assistant Director of Maintenance noted the patio had one side constructed with wood and screen mesh, and there was no sprinkler coverage for the patio.</p> <p>3.1-19(b)</p>		<p>affected and the corrective actions: No residents were directly affected by this deficient practice. 1a – b, the facility is currently installing new elevator systems, including the appropriate sprinkler coverage. The service elevator's date of completion is approximately 3-1-2015, with the state inspections following. Once the service elevator passes its inspections, the passenger elevator will be renovated will a new elevator system, including the appropriate sprinkler coverage. A sprinkler has been installed in the new service elevator on 2-25-2015. We have provided this service report from Koorsens indicating the completion of the additional sprinkler head. (see attachment C). Approximate time of completion for the 2nd elevator (passenger) is two months from the completion of the service elevator. (see attached contract – K056 – A). 2, the facility has contacted an outside vendor to secure bids for the installation of the area in need of additional sprinklers on the 2nd floor. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate. (see attached K056 – B) 3, , the facility has contacted an outside vendor to secure bids for the installation of the area in need of additional sprinklers in the outside patio, located off of the main</p>				

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			dining room in Health & Rehab Center. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate. (see attached K056 – B) Not other areas were cited during the LSC inspection and no other areas were found after a thorough inspection from the Assistant Director and Director of Maintenance. What Measures were put into place to ensure this does not happen again: No residents were directly affected by this deficient practice. 1a – b, the facility is currently installing new elevator systems, including the appropriate sprinkler coverage. The service elevator's date of completion is approximately 3-1-2015, with the state inspections following. Once the service elevator passes its inspections, the passenger elevator will be renovated with a new elevator system, including the appropriate sprinkler coverage. A sprinkler has been installed in the new service elevator on 2-25-2015. We have provided this service report from Koorsens indicating the completion of the additional sprinkler head. (see attachment C). Approximate time of completion for the 2nd elevator (passenger) is two months from the completion of the service elevator. (see attached contract – K056 – A). 2, the facility has contacted an outside vendor to secure bids for the installation of		

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			<p>the area in need of additional sprinklers on the 2nd floor. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate. 3, , the facility has contacted an outside vendor to secure bids for the installation of the area in need of additional sprinklers in the outside patio, located off of the main dining room in Health & Rehab Center. Vendor was at the building on 2-24-2015 to inspect the area and start to work on an estimate Not other areas were cited during the LSC inspection and no other areas were found after a thorough inspection from the Assistant Director and Director of Maintenance. How the corrective actions will be monitored: The elevators will be checked every week for the first month and then every 30 days (monthly) for the next 90 days (after passing the state inspection) to assure they are working correctly/functioning correctly. The results from these audits will be reviewed at our monthly QA meetings for compliance. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance.</p> <p>Please find the following attachments: Elevator contract K045 – A Added sprinkler head confirmation report for the service elevator K056 - C</p>		

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K010062 SS=C	<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 record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on record review of the sprinkler system with the Assistant Director of Maintenance on 02/04/15 at 11:15 a.m., there was no third quarter of 2014 sprinkler system inspection report</p>	K010062	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K062 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this deficient practice. The vendor, Koorsen, was contacted on 2-10-2015 to complete the inspection tests. The inspections were completed on 2-13-2015 for all sprinklers, all within acceptable limits. (see the several attached documents K062 – A, K062- B, K062 – C, K062 – D, K062– E, K062 – F, K062 – G, K062 – H, K062 – I). Other residents having the potential to be affected and the corrective actions: No residents were</p>	03/06/2015	

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	<p>available. Based on interview during record review, the Assistant Director of Maintenance indicated there was no written documentation or other evidence the sprinkler system had been inspected during the third quarter of 2014.</p> <p>3.1-19(b)</p>		<p>directly affected by this deficient practice. The vendor, Koorsen, was contacted on 2-10-2015 to complete the inspection tests. The inspections were completed on 2-13-2015 for all sprinklers, all within acceptable limits. (see the several attached documents K062 – A, K062- B, K062 – C, K062 – D, K062 – E, K062 – F, K062 – G, K062 – H, K062 – I).</p> <p>What Measures were put into place to ensure this does not happen again: No residents were directly affected by this deficient practice. The vendor, Koorsen, was contacted on 2-10-2015 to complete the inspection tests. The inspections were completed on 2-13-2015 for all sprinklers, all within acceptable limits. (see the several attached documents K062 – A, K062- B, K062 – C, K062 – D, K062 – E, K062 – F, K062 – G, K062 – H, K062 – I). How the corrective actions will be monitored: The Director of Maintenance and/or designee will monitor for compliance & be responsible for the scheduling of such tests with our vendor annually. The results from our sprinkler inspections will be reviewed at our monthly QA meeting for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: Several sprinkler inspection reports (9 total) K062 – A, K062- B, K062 – C, K062 – D, K062 – E, K062 – F, K062 – G, K062 – H,</p>		

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K010064 SS=B	<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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in rehabilitation room was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect up to 10 residents in the "Health and Rehab Center's" rehabilitation room</p> <p>Findings include:</p> <p>Based on an observation with the Assistant Director of Maintenance on 02/04/15 at 11:55 a.m., access to the "Health and Rehab Center" rehabilitation room's fire extinguisher located in a cabinet by the rehabilitation work center was obstructed by computer screen, not allowing the door to the cabinet to be full opened. Also, paper was taped to the cabinet obstructing the visibility of the fire extinguisher. Based on interview, the Assistant Director of</p>	K010064	<p>K062 – I).</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K064 Corrective Actions to be accomplished for those residents affected: No resident were directly affected by this deficient practice. 1, the fire extinguisher in the therapy gym has been unobstructed. The computer blocking the opening of the recessed cabinet it resides in has been moved and the notes covering the recessed cabinet housing this fire extinguisher have also been removed – 2-4-2015. (see attached – K064 – A) 2, the fire extinguisher that was found on the floor has been remounted & secured appropriately. (see attached – K064 – B). The facility has</p>	03/06/2015			

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	<p>Maintenance acknowledged the blocked extinguisher at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers was mounted so the bottom of the extinguisher was no less than four inches above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor and no less than 4 inches from the floor. This deficient practice could affect 1 of 8 smoke compartments in the "Health and Rehab Center."</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance on 02/04/15 at 12:09 p.m., a fire extinguisher was sitting on the floor unsecured in the Balcony Equipment Room. Based on Interview, the Assistant Director of Maintenance acknowledged that the fire extinguisher was sitting on the floor and not secured.</p> <p>3.1-19(b)</p>		<p>updated its policy and procedure on fire extinguishers. (see attached –K064 – C). An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K064.</p> <p>Other residents having the potential to be affected and the corrective actions: No resident were directly affected by this deficient practice. 1, the fire extinguisher in the therapy gym has been unobstructed. The computer blocking the opening of the recessed cabinet it resides in has been moved and the notes covering the recessed cabinet housing this fire extinguisher have also been removed –2-4-2015. (see attached – K064 – A) 2, the fire extinguisher that was found on the floor has been remounted & secured appropriately. (see attached – K064 – B). The facility has updated its policy and procedure on fire extinguishers. (see attached –K064 – C). An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K064.</p> <p>What Measures were put into place to ensure this does not happen again: No resident were directly affected by this deficient practice. 1, the fire extinguisher in the therapy gym has been unobstructed. The computer blocking the opening of the recessed cabinet it resides in has been moved and the notes covering the recessed cabinet</p>		

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			<p>housing this fire extinguisher have also been removed -2-4-2015. (see attached – K064 – A) 2, the fire extinguisher that was found on the floor has been remounted & secured appropriately. (see attached – K064 – B). The facility has updated its policy and procedure on fire extinguishers. (see attached –K064 – C). An all staff in-service (ZZ) was presented on 2-25-2015 to educate staff on the corrective actions for K064.</p> <p>How the corrective actions will be monitored: The Maintenance Director and/ or designee will monitor compliance of attached policy for the placement /un-obstruction of all fire extinguishers. The fire extinguishers will be checked every 30 days (monthly) for 90 days to assure that facility is in compliance. The results from this monthly audit will be reviewed at our monthly QA meetings for compliance. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance.</p> <p>Please find the following attachments: Photo of un-obstructed fire extinguishers in therapy gym K064 –A Photo of fire extinguisher in loft no longer on the floor K064 – B Policy/procedure for fire extinguishers K064 - C All staff in-service on 2-25-2015 ZZ</p>		

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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure all fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 02/03/15 at 3:20 p.m. with the Assistant Director of Maintenance; there were no inspection records available for review for any of the facility's fire dampers. During</p>	K010067	<p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K067 Corrective Actions to be accomplished for those residents affected: No residents were directly affected by this deficient practice. The facility has contacted several vendors for quotes & has selected a vendor - the inspections were started on 3-10-2015 Other residents having the potential to be affected and the corrective actions: No residents were directly affected by this deficient practice. The facility has contacted several vendors for quotes. What Measures were put into place to ensure this does not happen again: No residents were directly affected by</p>	04/15/2015			

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K010074 SS=B	<p>interview on 02/04/15 at 2:30 p.m. the Assistant Director of Maintenance stated there were not any records available to show completed maintenance on the facility's fire dampers.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 1 of 1 resident rooms were flame</p>	K010074	<p>this deficient practice. The facility has added this every 4-year into their TELS (preventative maintenance program). How the corrective actions will be monitored: The Director of Maintenance and/or designee will monitor for compliance & be responsible for the scheduling of such tests with our vendor every 4 years per code The results from these inspections will be reviewed at our monthly QA meeting for compliance. Administrator will monitor for ongoing compliance.</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of</p>	04/15/2015

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816		
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	<p>retardant. This deficient practice could 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations and interview with the Assistant Director of Maintenance on 02/04/15 at 1:22 p.m., the window coverings in resident room 327 in the "Health and Rehab Center" was brought in and hung by family lacked attached documentation confirming they were inherently flame retardant. Based on interview at the time of observation, the Assistant Director of Maintenance indicated there was no documentation regarding flame retardancy for the window coverings available for review.</p> <p>3.1-19(b)</p>		<p>Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K074 Corrective Actions to be accomplished for those residents affected: No residents were negatively affected by this deficient practice. The draperies in question from room 327 were removed on 2-4-2015. The facility has ordered new fire retardant vertical blinds/window treatments on 2-23-2015, with approximate ship date of March 19, 2015. The facility personnel to install the new fire retardant window coverings within 7 days of receiving the supplies. The facility has ordered these through HP products with the order #SO2390628 (see attached K074 – A). Staff were presented with an in-service (see attached ZZ) on 2-25-2015 regarding the corrective actions of K074. The Director of Environmental Services will oversee the installation of the project and will monitor for compliance. Other residents having the potential to be affected and the corrective actions: No residents were negatively affected by this</p>		

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			<p>deficient practice. The facility will also be replacing all of the draperies on this unit, (Tulip Lane), a total of 32 resident rooms as these draperies were lacking in the appropriate fire rated documentation as well. The facility has ordered 33 new sets of fire retardant vertical blinds/window treatments on 2-23-2015, from HP products with the order #SO2390628 (K074 – A); approximate ship date of March 19, 2015. The facility personnel to install the new fire retardant window coverings within 7 days of receiving the supplies. Staff were presented with an in-service (see attached ZZ) on 2-25-2015 regarding the corrective actions of K074. The Director of Environmental Services will oversee the installation of the project and will monitor for compliance. What Measures were put into place to ensure this does not happen again: No residents were negatively affected by this deficient practice. The facility will also be replacing all of the draperies on this unit, (Tulip Lane), a total of 32 resident rooms as these draperies were lacking in the appropriate documentation as well. The facility has ordered 33 new sets of fire retardant vertical blinds/window treatments on 2-23-2015, from HP products with the order#SO2390628 (K074 – A); approximate ship date of</p>	

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K010130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview;	K010130	<p>March 19, 2015. The facility personnel to install the new fire retardant window coverings within 5 days of receiving the supplies. Staff were presented with an in-service(see attached ZZ) on 2-25-2015 regarding the corrective actions of K074. The Director of Environmental Services will oversee the installation of the project and will monitor for compliance. How the corrective actions will be monitored: The Environmental Services Director and / or designee will monitor compliance of attached policy for Window Treatments (see attached K074 – B). All resident rooms will be checked every 30 days (monthly) to assure that facility is in compliance with window treatment policy. The results from this monthly audit will be reviewed at our monthly QA meetings for compliance. Director of Environmental Services will monitor for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: Confirmation order for new blinds K074-A Window Treatment Policy/Procedure K074 – B Staff in-service 2-25-2015 ZZ</p> <p>Please accept this as our credible</p>	03/06/2015	

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	<p>the facility failed to implement and maintain a battery replacement program for battery operated smoke alarms installed in 101 of 101 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the "Health and Rehab Center."</p> <p>Findings include:</p> <p>Based on an interview and record review on 02/03/15 at 3:58 p.m. with the Assistant Director of Maintenance, the facility has 101 resident rooms with battery operated smoke Alarms located in each of the resident rooms in the "Health and Rehab Center." Furthermore, there was no battery replacement program to ensure annual battery replacement for each battery operated smoke alarm. Based on interview, the Assistant Director of Maintenance verified the lack of an annual battery replacement program for the 101 resident room battery operated smoke alarms.</p> <p>3.1-19(b)</p>		<p>allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K130 Corrective Actions to be accomplished for those residents affected: No residents were negatively affected by this deficient practice. All batteries in all smoke detectors for all 101 resident rooms were changed on 2-6-2015, and documented in our records per our updated policy. (see attached policy K130 – A). The facility updated their policy and procedure to reflect these changes for our battery replacement program. The resident rooms are the only locations that have battery operated smoke detectors. The building corridors and common areas have smoke detectors that are hard wired into our fire alarm systems. Other residents having the potential to be affected and the corrective actions: No residents were negatively affected by this deficient practice. All batteries in all smoke detectors for all 101</p>				

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			<p>resident rooms were changed on 2-6-2015, and documented in our records per our updated policy. (see attached policy K130 – A). The facility updated their policy and procedure to reflect these changes for our battery replacement program. The resident rooms are the only location that have battery operated smoke detectors. The building corridors and common areas have smoke detectors that are hard wired into our fire alarm systems. What Measures were put into place to ensure this does not happen again: No residents were negatively affected by this deficient practice. All batteries in all smoke detectors for all 101 resident rooms were changed on 2-6-2015, and documented in our records per our updated policy. (see attached policy K130 – A). The facility updated their policy and procedure to reflect these changes for our battery replacement program. The resident rooms are the only location that have battery operated smoke detectors. The building corridors and common areas have smoke detectors that are hard wired into our fire alarm systems. How the corrective actions will be monitored: The Assistant Director of Maintenance and/or their designee are responsible for checking the function of the smoke detectors each month and</p>		

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K010147 SS=B	<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>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as a power strip were not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 of 8 smoke compartments in the "Health and Rehab Center".</p> <p>Findings include:</p> <p>Based on observation with the Assistant</p>	K010147	<p>changing of the batteries annually, both issues per policy. The results from this monthly audit and the requirement for the annual changing of the smoke detector batteries will bereviewed at our monthly QA meetings for timely compliance. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance.</p> <p>Please find the following attachments: Policy and audit sheet/documentation K130 – A</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>K147 Corrective Actions to be accomplished for those residents affected: No residents were negatively affected by this deficient practice. Resident room</p>	03/06/2015	

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	<p>Director of Maintenance on 02/04/15 at 11:17 a.m., an oxygen concentrator was supplied with electricity by extension cord power strip in resident room 409 on D wing. Based on Interview, this was acknowledged by the Assistant Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>		<p># 409 on D wing hasbeen corrected as that oxygen concentrator is now connected into a wall outlet, and not the extension power cord strip. An in-service (ZZ) regarding thisissue & the expectations was presented to all staff on 2-25-2015. The facility updated the policy on uses of extension power cord strips to clarifyits uses; where as no medical devices can be plugged into the extension powercord strips. (see attached policy K147 – A). The facility has also reviewed all resident rooms that utilize medical devices. Other residents having thepotential to be affected and the corrective actions: No residents were negatively affected by this deficient practice. Resident room # 409 on D wing has been corrected as that oxygen concentrator is now connected into a wall outlet, and not the extension power cord strip. An in-service (ZZ) regarding thisissue & the expectations was presented to all staff on 2-25-2015. The facility updated the policy on uses of extension power cord strips to clarifyits uses; where as no medical devices can be plugged into the extension powercord strips. (see attached policy K147 – A). The facility has also reviewed all resident rooms that utilize medical devices utilizing the updated policy. What Measures</p>		

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			<p>were put into place to ensure this does not happen again: No residents were negatively affected by this deficient practice. Resident room # 409 on D wing has been corrected as that oxygen concentrator is now connected into a wall outlet, and not the extension power cord strip. An in-service (ZZ) regarding this issue & the expectations was presented to all staff on 2-25-2015. The facility updated the policy on uses of extension power cord strips to clarify its uses; whereas no medical devices can be plugged into the extension power cord strips. (see attached policy K147 – A). The facility has also reviewed all resident rooms that utilize medical devices. The facility will utilize its updated policy to assure no medical devices are plugged into extension power cord strips.</p> <p>How the corrective actions will be monitored: The facility will monitor the compliance to our updated policy – where no medical devices can be plugged into an extension power strip cord; on a weekly basis for the first 30 days, and then monthly thereafter to assure facility is in compliance with proper usage of extension power cord. The results from the initial weekly audits (see attached K147 – B) will be reviewed @ our monthly QA meeting. The monthly audits will be reviewed there after, at our monthly QA meetings</p>		

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K010160 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation, record review, and interview; the facility failed to ensure 2 of 2 elevators was provided with annual inspection. NFPA 101, 9.4.6 states elevators shall be subject to routine and periodic inspection and tests as specified in ASME/ANSI A17.1. This deficient practice could affect any residents, as well as visitors and staff in the elevator.</p> <p>Findings include:</p> <p>Based on record review with the Assistant Maintenance Director on 02/03/15 at 2:50 p.m., there was no</p>	K010160	<p>for compliance as well. Director of Nursing is responsible for monitoring nursing compliance with the Director of Maintenance monitoring for overall compliance. Please find the following attachments: All staff in-service on 2-25-2015 ZZ Policy for use of power cords K147 - A Audit form K147 - B</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. K160 Corrective Actions to be accomplished for those residents affected: The facility vendor (ThyssenKrupp) has been</p>	04/15/2015

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	<p>record available to show a annual inspection was performed on the elevators. Based on observation with the Assistant Maintenance Director on 02/04/15 at 2:45 p.m., the elevators did not have the annual inspection form inside of the elevators. Based on interview, the Assistant Maintenance Director stated that there was no record for review and the facility does not keep the forms in the elevators due to them being damaged or stolen.</p> <p>3.1-19(b)</p>		<p>contacted for a copy of two elevator inspections that they conduct on an annual basis. The elevators were inspected on 1-9-2014 and the facility now has the copies of those certificates, but has provided supportive documentation that the tests for each elevator was completed – see attached K160 S and K160P. Assistant Director of Maintenance contacted this vendor on 2-13-2015 asking for the elevator certificates. Please note, for the two elevators in question, the service elevator has been completely replaced, with state approval on 3-4-2015 after its inspection - see attached. The passenger elevator replacement has been started. LLV will have 2 new elevators in operation, thus having two new, different certificates. Other residents having the potential to be affected and the corrective actions: 1a – b, the facility is currently installing two new elevator systems, including the appropriate sprinkler coverage. The service elevator's date of completion is approximately 3-1-2015, with the state inspections following (scheduled for 3-4-2015). The service elevator passed it's State inspections, and received its certificate. The passenger elevator is undergoing renovation now with a new elevator system, including the appropriate sprinkler coverage. A sprinkler has been</p>		

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			<p>installed with the new service elevator on 2-25-2015. We have provided this service report from Koorsens indicating the completion of the additional sprinkler head. (see attachment C). Approximate time of completion for the 2nd elevator (passenger) is two months from the completion of the service elevator. (see attached contract – K056 – A). What Measures were put into place to ensure this does not happen again: No residents were directly affected by this deficient practice. 1a – b, the facility is currently installing two new elevator systems, including the appropriate sprinkler coverage. The service elevator's date of completion is approximately 3-1-2015, with the state inspections following. The service elevator passed its inspections from the State receiving approvals/certificates for operation. The passenger elevator is currently undergoing renovations with a new elevator system, including the appropriate sprinkler coverage. A sprinkler has been installed in the new service elevator on 2-25-2015. We have provided this service report from Koorsens indicating the completion of the additional sprinkler head. (see attachment C). Approximate time of completion for the 2nd elevator (passenger) is two months from the completion of the service</p>		

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K019999	<p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(a) A health facility licensed under 16-28 and this rule states the facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure the electrical</p>	K019999	<p>elevator. (see attachedcontract – K056 – A). How the corrective actions will be monitored: Director of Maintenanceand/or designee will monitor for compliance & be responsible for thescheduling of such tests with our vendor annually. The certificates from these annual inspections will be kept on file @ the facility; also reviewed at our monthly QA meeting for compliance as appropriate given its an annual inspection. Administrator will monitor for ongoing compliance.</p> <p>Please find the following attachments: Two elevator certificates K160S and K160P See attached new certificate for approval on 3-4-15</p> <p>Please accept this as our credible allegation of compliance to our recent LSC annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. F9999 Corrective Actions to be accomplished for those</p>	03/06/2015	

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816		
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	<p>equipment in 1 of 2 elevator equipment rooms was properly maintained to protect personnel. This deficient practice was not in a resident care area but could affect maintenance staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Assistant Director of Maintenance on 02/03/15 at 2:50 p.m., the electrical elevator equipment in the main building lacked an enclosure and/or safety guards. Based on an interview with the Director of Maintenance at the time of observation, he was aware of this requirement and the facility will be removing of the old equipment and the installing new equipment.</p> <p>3.1-19(a)</p>		<p>residents affected: The equipment in this room as mentioned on the 2567, no longer exists as it has been completely removed, as of 2-10-2015. The facility was in the process of removing one elevator system and completely replacing it with a new elevator system. (see attached contract – K 056 – A). This project of the service elevator has an approximate completion date of 3-4-2015. This equipment room now has all new elevator equipment, electronic devices, etc. to operate our new elevator system. (see attached photo – F9999 – A).</p> <p>Other residents having the potential to be affected and the corrective actions: The equipment in this room as mentioned on the 2567, no longer exists as it has been completely removed, as of 2-10-2015. The facility was in the process of removing one elevator system and completely replacing it with a new elevator system. (see attached contract – K 056 – A). This project of the service elevator has an approximate completion date of 3-1-2015. This equipment room now has all new elevator equipment, electronic devices, etc. to operate our new elevator system. (see attached photo – F9999 – A).</p> <p>What Measures were put into place to ensure this does not happen again: The equipment in this room as mentioned on the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2015
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			2567, no longer exists as it has been completely removed, as of 2-10-2015. The facility was in the process of removing one elevator system and completely replacing it with a new elevator system. (see attached contract – K 056 – A). This project of the service elevator has an approximate completion date of 3-1-2015. This equipment room now has all new elevator equipment, electronic devices, etc. to operate our new elevator system. (see attached photo – F9999 – A). How the corrective actions will be monitored: The Maintenance Director and/ or designee will monitor and oversee the installation and the correct working/functioning of the elevator systems / equipment rooms to ensure they are safe. The ongoing progress on the removal/installation of our elevator systems will be reviewed at our monthly QA meetings for compliance. Director of Maintenance will monitor for compliance. Administrator will monitor for ongoing compliance. Please find the following attachments: Elevator contract K056 – A Photo of new equipment room F9999		