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 02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	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). Survey Date: 02/09/12 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 Surveyor: Phillip Komsiski, Life Safety Code Specialist 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. 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 in all resident sleeping rooms. The facility has a capacity of 104 and had a	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	census of 76 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/15/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure 1 of 7 doors leading to hazardous areas such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 18 residents on 200 north hall as well as visitors and staff. Findings include: Based on observation on 02/09/12 at 1:55 p.m. with the Maintenance Supervisor, the central supply room on 200 north hall had twenty five cardboard boxes, was greater than fifty square feet in size, and was without a self closing device on the corridor door. Based on interview on 02/09/12 at 1:58 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door leading into the central supply room was not equipped with a self closing device on	K0029	1. There were no residents affected by the alleged deficient practice. 2. Eighteen residents had the potential to be affected. See below for the corrective actions. 3. A self closing device has been installed on the central supply room door. The Maintenance Director has been re-educated on the life safety code and a preventative maintenance form has been initiated (See Attachment A). The Maintenance Director will check all doors that lead to hazardous areas one time weekly for one month then monthly thereafter for a minimum of six months to ensure to ensure self closing devices are present and working appropriately and the Preventative Maintenance form will be completed. 4. Results of these observations will be discussed during the facility'a quarterly QA meetings and the plan adjusted accordingly.	03/10/2012

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	the door. 3.1-19(b)			

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K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure 1 of 2 smoke detectors on 300 south hall was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 8 residents on 300 south hall as well as visitors and staff. Findings include: Based on observation on 02/09/12 at 1:20 p.m. with the Maintenance Supervisor, the smoke detector on 300 south hall just	K0051	1. No residents were affected by the deficient practice. 2. All residents residing on the 300 hall have the potential to be affected. See below for the corrective actions. 3. Elwood Fire Protection Service has been contracted to move the smoke detector located on the 300 hall just in front of room 309 to an appropriate distance away from the air diffuser. The Maintenance Director has been re-educated on the life safety code and a Preventative Maintenance form has been initiated (See Attachment A). The Maintenance Director will check smoke detectors one time weekly for one month then monthly thereafter for a minimum of six months to ensure they are the appropriate	03/10/2012

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	in front of room 309 was within three feet of an air diffuser. Based on interview on 02/09/12 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed within three feet of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability. 3.1-19(b)		distance away from the air diffusers and are in working order and the Preventative Maintenance form will be completed. 4. Results of these observations will discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.	

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K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (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. NFPA 99 4.3.1.1.2, 19.3.2.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect at least 14 residents, visitors and staff observed using the 300 hall exit. Findings include: Based on observation on 02/09/12 at 1:55 p.m. with the Maintenance Supervisor, two oxygen e-cylinders and six 180 liter liquid oxygen tanks were located in a chain link enclosure near the 300 hall	K0076	1. No residents were affected by the alleged deficient practice. 2. All residents residing on the 300 hall have the potential to be affected. See below for the corrective actions. 3. A protective cover will be constructed over the oxygen storage area located at the north end of 300 hall. The Maintenance Director has been re-educated on the life safety code and a Preventative Maintenance Form has been implemented (See Attachment A). The Maintenance Director will check the outside oxygen storage area one time weekly for one month, then monthly thereafter for a minium of six months to ensure the protective covering remains adequate to guard the tanks from weather extremes and complete the Preventative Maintenance form. 4. The results of these observations will be discussed during the facility'a quarterly QA and the plan adjusted accordingly. .	03/10/2012

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	north exit. The enclosure was not protected from sun, snow, or rain. Based on interview on 02/09/12 at 1:59 p.m. with the Maintenance Supervisor at the time of observation, it was agreed the equipment was exposed to all types of weather. 3.1-19(b)			