

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155496	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/09/2015
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NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
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: 12/09/15</p> <p>Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930</p> <p>At this Life Safety Code survey, Kindred Nursing and Rehabilitation Valley View 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, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility has a</p>	K 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0025 SS=E Bldg. 01	<p>capacity of 126 and had a census of 82 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered.</p> <p>Quality Review completed 12/10/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 10 corridor walls and 1 of 1 ceiling barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed</p>	K 0025	<p>1. The following penetrations have been corrected: a) The gap in the corridor room door to room 102 b) The South Lounge exit ceiling penetration c) The 4 unsealed holes around the manual fire alarm box in the wall by resident room 201 d) The gap in corridor door to resident room 501 e) The 1 inch penetration by</p>	01/08/2016

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	<p>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 protected by an approved device designed for the specific purpose. This deficient practice could affect staff and at least 7 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Executive Director on 12/09/15 between 11:44 a.m. and 1:29 p.m., the following penetrations were discovered:</p> <p>a) the corridor room door to resident room 102 had a gap at the top of the door which measured 3/8 inches by 3/8 inches.</p> <p>b) the South Lounge exit had a ceiling penetration around sprinkler pipe which measured 5/8th inch.</p> <p>c) the corridor wall by resident room 201 had four unsealed holes around the manual fire alarm box which measured 3/8 inch.</p> <p>d) the corridor door to resident room 501 had a gap at the top of the door which measured 3/8th inches by 30 inches.</p> <p>e) the corridor wall by the South time</p>		<p>the South time clock 2. All doors and walls have been inspected for unsealed penetrations and corrected. 3. The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure there are no unsealed penetrations. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	

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K 0029 SS=E Bldg. 01	<p>clock had a one inch penetration Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned conditions and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Storage area greater than 50 sq ft, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff and up to 8 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Executive Director on 12/09/15 at 12:28 p.m.,</p>	K 0029	<p>1. The door to resident room 608 nowhas a self closer installed. The kitchen storage area door has been repaired and is now closing and latching properly. 2. All other hazardous area doors have been inspected for proper operation and closing of the door. 3. The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure that hazardous areas have self closers and are operating properly and closing and latching properly. These weekly audits are</p>	01/08/2016

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	<p>resident room 606 was converted into a storage room. Inside the room was four wooden drawers, four mattresses, one mattress in a cardboard box, and other miscellaneous storage. The resident room door did not have a self closer. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 kitchen storage room greater than 50 sq ft, a hazardous area, would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Executive Director on 12/09/15 at 1:25 p.m., the kitchen storage room door was tested and self closed, but failed to positively latch. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	

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K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 South Lounge Exit delayed egress locks was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual</p>	K 0038	<p>1. The South Unit Lounge exit door has been repaired and is now opening after 15 seconds of continuous pressure on the door as required. 2. All other exit doors have been inspected and are operating properly. 3. The Maintenance Director or designee will inspect all exit doors for proper operation weekly. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	01/08/2016

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K 0050 SS=C Bldg. 01	<p>means only. This deficient practice could affect staff, visitors, and up to 4 residents. Findings include: Based on observation with the Maintenance Director and Executive Director on 12/09/15 at 12:43 p.m., the south lounge exit door was equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force four separate times. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned condition. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure 19 of 24 fire</p>	K 0050	1. The Maintenance Director has been in-serviced on the need for fire drills to be held at unexpected	01/08/2016

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K 0056 SS=D Bldg. 01	<p>drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review of Fire/Disaster Drill Reports on 12/09/15 at 10:46 a.m. with the Maintenance Director and Executive Director, 19 of 24 fire drills conducted over the past four quarters were conducted after the 26th day of the month. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged fire drills have a pattern of being held toward the end of the month.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is 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</p>		<p>times under varying conditions. 2. A plan for future fire drills has been created to ensure drills are being done at unexpected times and under varying conditions. 3. The Executive Director will inspect fire drill reports on a monthly basis and make corrections as needed to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>				

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	<p>flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler in the soiled linen room near 701 was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Executive Director on 12/09/15 at 12:54 p.m., a sprinkler head in the soiled linen room near room 701 was located next to a ceiling box light. Measurements showed the sprinkler head was 4.75 inches away from the ceiling light and would obstruct the spray pattern of the sprinkler head. The ceiling light was measured to be vertically equal with the sprinkler head</p>	K 0056	<p>1. The sprinkler head in the soiled linen room near room 701 has been relocated as required to a position correct for unobstructed spray pattern. 2. All other sprinkler head placements have been inspected for potential spray pattern obstruction with none noted. 3. The Maintenance Director or designee will inspect sprinkler head placement on a monthly basis to ensure there are no spray pattern obstruction concerns. These monthly audits are to be reviewed by the Executive Director to ensure proper compliance.4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	01/08/2016

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K 0062 SS=E Bldg. 01	<p>deflector. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned condition and provided the measurements.</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 and interview, the facility failed to replace 1 of 1 corroded sprinkler head in the Alzheimer courtyard overhang. LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect up to 15 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Executive</p>	K 0062	<p>1. The sprinkler head in the Alzheimer's courtyard has been replaced as required. 2. All other sprinkler heads have been inspected for potential replacement needs with none noted. 3. The Maintenance Director or designee will inspect sprinkler heads on a monthly basis to ensure there are no concerns with corrosion and all are in reliable operating condition. These monthly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>	01/08/2016

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K 0066 SS=D Bldg. 01	<p>Director on 12/09/15 at 1:54 p.m., the only sprinkler head in the Alzheimer courtyard overhang was corroded. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to maintain 1 of 1 areas where smoking was permitted and 1 of 1 areas where smoking was not permitted</p>	K 0066	<p>1. The cigarette butts located in the Courtyard designated as a smoking area and in the "Service Entrance" exit have been cleaned up. 2. The remaining outdoor</p>	01/08/2016

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K 0147 SS=D Bldg. 01	<p>for staff and residents. This deficient practice could affect staff and the two residents allowed to smoke.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Executive Director on 12/09/15 at 12:31 p.m. then again at 1:13 p.m., there were at least 24 cigarette butts on the ground in the Courtyard which was the designated smoke area. Then again, the "Service Entrance" exit discharge which was not a designated smoking area had at least 30 cigarette butts on the ground. Based on interview at the time of observation, the Maintenance Director and Executive Director acknowledged each aforementioned condition and provided the estimated number of cigarette butts.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 8 of 8 flexible cords were not used as a substitute for</p>	K 0147	<p>areas of the facility have been inspected and any indications of smoking have been addressed as needed. The staff has been in-serviced on the facility smoking policy. Additional signage for non-smoking areas has been posted as needed. 3. The Maintenance Director or designee will inspect exterior areas on a weekly basis to ensure there are no concerns with smoking. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p> <p>1. The surge protectors and extension cords in both the Electrical Room #2 and Electrical Room #1 have been removed. 2.</p>	01/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/09/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING AND REHABILITATION VALLEY VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Executive Director on 12/09/15 at 12:02 p.m. then again at 1:41 p.m., a surge protector powering two separate surge protectors powering television equipment in Electrical room #2. Then again, a surge protector was powering two separate surge protectors and two extension cords were all powering phone/IT equipment in Electrical room #1. Based on interview at the time of each observation, the Maintenance Director and Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>The remaining Electrical Rooms of the facility have been inspected for the use of any surge protector or extension cords with none noted. 3. The Maintenance Director or designee will inspect Electrical Rooms on a weekly basis to ensure there are no surge protectors or extension cords in place. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4. The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained.</p>		