

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/31/2016
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/31/16</p> <p>Facility Number: 000224 Provider Number: 155331 AIM Number: 100267700</p> <p>At this Life Safety Code survey, Life Care Center of Valparaiso was found not in substantial 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 hardwired smoke detection in corridors, resident rooms and areas open to the corridor. The facility has the capacity for 110 and had a census of 100 at the time of this survey.</p>	K 0000	<p>I respectfully request consideration for paper compliance. I have forwarded a signed copy of the first sheet of the 2567 by fax today (4-15-16) to 1-317-233-7322. Please reference the attached 2567 as "Credible Allegation of Compliance" for our Life Safety Code survey conducted on 3-31-16. 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 conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you! Amber Janeczko, Executive Director</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0018 SS=D Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached mini barns and a garage located used for equipment storage.</p> <p>Quality Review completed on 04/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Beautician room corridor door closed and latched into the door frame. This deficient</p>	K 0018	K018 SS=D 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-6-16, the Maintenance Director installed a	04/06/2016

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	<p>practice could affect staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 03/31/16 at 12:13 p.m., the Maintenance Assistant #1 acknowledged the corridor door to the Beautician room had a Swiffer mop that prevented the corridor door from closing and latching into the door frame.</p> <p>3.1-19(b)</p>		<p>magnetic door holder to the back of the beauty shop room. When the fire alarm is activated, the beauty shop door closes automatically. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure there are no other doors being propped open. No further issues were identified. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will conduct weekly audits to ensure that all doors close and latch properly. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure compliance. 4. How corrective actions will be monitored to ensure the alleged deficient practice will nor recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an</p>	

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 46 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant #1 on 03/31/16 at 10:50 a.m., the fire doors near resident room 106 failed to latch when tested. Based on interview at the time of</p>	K 0044	<p>additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-6-16 THIS IS OUR CREDIBLE ALLEGATION</p> <p>K044 SS=E 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-4-16, the Maintenance Director adjusted the 100 fire barrier doors to ensure they both latch properly. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure that all fire doors latch properly. No further issues were identified. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will conduct weekly audits to ensure that all fire doors close and latch properly. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure compliance. 4. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Maintenance Supervisor</p>	04/04/2016

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K 0062 SS=C Bldg. 01	<p>observation, the Maintenance Assistant #1 acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause</p>	K 0062	<p>or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-4-16 THIS IS OUR CREDIBLE ALLEGATION</p> <p>K062 SS=C 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-5-16, Valley Fire Protection Systems conducted another 5 year internal pipe inspection. The facility did have a 5 year inspection completed on 4-29-14 by Valley Fire Protection System. The inspection tag was on the low point drain in the Maintenance office; however, it was not identified during the</p>	04/05/2016	

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	<p>obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of sprinkler system documentation with the Maintenance Assistant #1 on 03/31/16 at 9:27 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Maintenance Assistant #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>survey. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure all sprinkler inspection forms were in the fire inspection binder. No further issues were identified. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will conduct monthly audits to ensure the sprinkler inspection was conducted and all forms/tags are present. The Maintenance Supervisor will add to his monthly facility rounds checklist to ensure compliance. 4. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does</p>		

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K 0064 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10, 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 K type extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant #1 on 03/31/16 at 12:34 p.m., the gauge on the K type portable fire extinguisher in the Kitchen indicated the extinguisher was overcharged. Based on interview at the time of observation, the Maintenance</p>	K 0064	<p>not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-5-16 THIS IS OUR CREDIBLE ALLEGATION</p> <p>K064 SS=D 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-5-16, AAA Valley Fire replaced the gauge and recharged the K Guard fire extinguisher in the kitchen. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure all other fire extinguishers are properly charged. One fire extinguisher had a charge that was borderline and AAA Valley Fire recharged that extinguisher as well. No further issues were identified. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Departments was inserviced to inspect the gauge and to report any concerns to the Maintenance Supervisor or designee during the monthly inspections of the fire extinguishers. The Maintenance Supervisor will conduct monthly</p>	04/12/2016

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K 0066 SS=D Bldg. 01	<p>Assistant #1 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</p>		<p>audits to ensure that all fire extinguishers remain in an acceptable range. The Maintenance Supervisor will add to his monthly facility rounds checklist to ensure compliance.</p> <p>4. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-12-16 THIS IS OUR CREDIBLE ALLEGATION</p>	

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff only was maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant #1 on 03/31/16 at 11:55 a.m., there were at least 55 cigarette butts on the ground in the designated smoke area. There were at least 100 cigarette butts in the staff smoking area's trash can containing trash and other combustible materials. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition.</p>	K 0066	<p>K066 SS=D 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-5-16, the Maintenance Director removed the trash can by the smoking area and picked up the cigarette butts on the ground. The Maintenance Supervisor ordered a new ash tray and a fire rated self closing metal trash can to empty the ash tray into before disarding.</p> <p>2. How the facility will identify other residents potentially affected by the same alleged deficient practice: This deficient practice only affects staff as the facility is a non-smoking facility for residents. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: We did have 2 self containing ash trays present for staff to extinguish their cigarettes into. Once they were filled, Maintenance would take the</p>	04/27/2016

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	3.1-19(b)		containers out of the ash trays and hose them down and then dispose of them in the trash. We now have a bigger self containing ash tray and a separate red fire rated self closing trash can, which is designated for cigarette butts only. When the ash trays are ready to be emptied, Maintenance will empty them into the red can to make sure they are fully extinguished until they are disposed of properly. The Maintenance Supervisor or designee will conduct weekly audits to ensure that all cigarettes are disposed of properly. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure compliance. 4. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit	

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K 0143 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure electrical fixtures in 1 of 1 300 Hall sprinklered oxygen storage/transfer locations was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could</p>	K 0143	<p>schedules. DATE CERTAIN: 4-27-16 THIS IS OUR CREDIBLE ALLEGATION</p> <p>K143 SS=D 1. Corrective action accomplished for resident affected by the alleged deficient practice: On 4-4-16, the Maintenance Director removed both electrical outlets located in the 300 hall oxygen room. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure both oxygen rooms are in compliance. No further issues were identified. 3. What measures were put into place or</p>	04/04/2016
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K 0147 SS=D Bldg. 01	<p>affect staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Assistant #1 on 03/31/16 at 11:30 a.m., the 300 Hall oxygen transferring room with at least 5 large liquid oxygen cylinders had two electrical outlets on the wall two and a half feet above the floor. The oxygen transfill room had a self-closure which latched into the door frame. Based on an interview at the time of observation, Maintenance Assistant #1 acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the</p>	K 0147	<p>systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will conduct weekly audits to ensure that all outlets in facility are installed per code. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure compliance.</p> <p>4. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-4-16 THIS IS OUR CREDIBLE ALLEGATION</p>	04/04/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/31/2016
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	<p>facility failed to ensure 3 of 3 flexible cords were used in accordance to manufacturer's recommendation. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant #1 on 03/31/16 at 11:45 a.m., there was a surge protector powering two separate surge protectors powering phone equipment in the Phone Room. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>accomplished for resident affected by the alleged deficient practice: On 4-4-16, the Maintenance Director removed the surge protector that was "piggy-backed" in the main electrical room that houses the telephone room. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: A full facility audit was completed on 4-4-16 to ensure all surge protectors are being used per code. No further issues were identified. 3. What measures were put into place or systematic changes made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or designee will conduct weekly audits to ensure that surge protectors are used per Life Safety guidelines. The Maintenance Supervisor will add to his weekly facility rounds checklist to ensure compliance. 4. How corrective actions will be monitored to ensure the alleged deficient practice will nor recur: The Maintenance Supervisor or designee will follow the above audits for 6 months and provide the Executive Director with the results of those audits. The Executive Director will present a report of the findings at the monthly QA/QI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100%</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2016
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			accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 4-4-16 THIS IS OUR CREDIBLE ALLEGATION	