STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155331	A. BUILDING -- B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/09/24 Facility Number: 000224 Provider Number: 155331 AIM Number: 100267700 At this Emergency Preparedness survey, Life Care Center of Valparaiso was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 110 and had a census of 86 at the time of this survey. Quality Review completed on 12/12/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/09/24 Facility Number: 000224 Provider Number: 155331 AIM Number: 100267700 At this Life Safety Code survey, Life Care Center Valparaiso was found not in compliance with Requirements for Participation in	K 0000	I respectfully request consideration for paper compliance. I have forwarded the signed 2567 via fax today (12-20-24) to 1-317-233-7322. I will also forward all supportive documents as well to the number listed above. Please reference the attached 2567 as "Credible Allegation of Compliance" for our Life Safe Code survey conducted on 12-9-24. Preparation and/or execution of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Janeczko	Executive Director	12/23/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 II (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with hard-wired smoke detection in the corridors, areas open to the corridors and hardwired smoke detectors in the resident rooms. The facility has a capacity of 110 and had a census of 86 at the time of this survey. Quality Review completed on 12/12/24		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	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states that a readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include:	K 0324	K 324 1. Corrective action accomplished for residents affected by the alleged deficient practice: On 12-11-24, AAA Valley Fire lowered the kitchen hood manual activation pull station to the regulatory height. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: All facility residents had the potential to be affected. 3. What measures were put into place or systematic changes were made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor or	12/20/2024

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	Based on observation and interview with the Maintenance Director from 11:15 a.m. to 12:20 p.m. on 12/09/24, the ANSUL "Remote Pull Station" was mounted 56 1/2 inches above the floor next to the door leading out of the kitchen. Based on interview at time of observation, when asked if he agreed the measurement was 56 ½ inches above the floor as measured with a tape measure, the Maintenance Director acknowledged the measurement and stated: "Yah, Yah, Yah." This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		designee will monitor monthly to ensure the kitchen hood manual activation pull station is located between 42 inches and 48 inches. The Maintenance Supervisor will add to his weekly facility checklist to monitor the height of the kitchen hood manual pull station is within the proper height requirements. 4. How corrective actions will be monitored to ensure the alleged deficient practices to ensure it will not recur: The Maintenance Supervisor or designee will complete monthly audits for 6 months and provide the Executive Director with the results of these 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 12-20-24 THIS IS OUR CREDIBLE ALLEGATION	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:47 a.m. to 11:10 a.m. on 12/09/24, no documentation of a semi-annual fire alarm system inspection was provided. Based on interview at the time of record review, the Maintenance Director stated he did not agree that a semi-annual visual inspection of the fire alarm system was required and stated a semi-annual visual inspection was not completed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.	K 0345	K 345 1. Corrective action accomplished for residents affected by the alleged deficient practice: On 12-18-24, the Maintenance Director contacted Allegiant Fire Protection to conduct a semi-annual visual of our Fire Alarm system. Allegiant Fire Protection will be out on 12-20-24 to conduct the semi-annual visual inspection. 2. How the facility will identify other residents potentially affected by the same alleged deficient practice: All facility residents. Staff, and family members had the potential to be affected. 3. What measures were put into place or systematic changes were made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor had Allegiant Fire Protection update the annual service agreement to include conducting the semi-annual fire alarm inspection. The Maintenance Supervisor will add to his internal facility spreadsheet to ensure that the required inspections are conducted. 4. How corrective actions will be monitored to ensure the alleged deficient practices will not recur: The Maintenance Supervisor or designee will complete monthly	12/20/2024

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	3.1-19(b)		audits for 6 months and provide the Executive Director with the results of these 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 12-20-24 THIS IS OUR CREDIBLE ALLEGATION	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure a power strip in 2 of 59 resident rooms met UL rating of 1363A or 60601-1. NFPA 99, Section 3.3.139 states that the patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects at least 2 residents, staff and visitors.	K 0920	K 920 1. Corrective action accomplished for residents affected by the alleged deficient practice: On 12-17-24, the Maintenance Director conducted a facility audit and removed all non-medical grade surge protectors in the patient rooms. On 12-9-24, the Maintenance Director also ordered 40 medical grade UL 1363A surge protectors. 2. How the facility will identify other residents potentially affected	12/20/2024

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	Findings include: Based on observation and interview with the Maintenance Director from 11:15 a.m. to 12:20 p.m. on 12/09/24, 1) In resident room 205 a power strip that did not have a label indicating it meets the UL rating of 1363A or 60601-1 was supplying power to an electronic picture frame that was located less than four feet from the foot end of the bed. 2) In resident room 212 a power strip that did not have a label indicating it meets the UL rating of 1363A or 60601-1 was supplying power to 2 phone chargers and a microwave oven that was located less than four feet from the foot end of the bed. Based on interview at the time of observation, the Maintenance Director acknowledged the use of the power strips, but stated they were not next to the bed and did not agree they were not in compliance. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		by the same alleged deficient practice: All facility residents had the potential to be affected. 3. What measures were put into place or systematic changes were made to ensure that the alleged deficient practice does not recur: The Maintenance Supervisor ordered 40 medical grade surge protectors. The Maintenance Supervisor will add to his weekly facility checklist to monitor the proper use of surge protectors. 4. How corrective actions will be monitored to ensure the alleged deficient practices will not recur: The Maintenance Supervisor or designee will complete weekly audits for 6 months and provide the Executive Director with the results of these 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 12-20-24 THIS IS OUR CREDIBLE	

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