STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING -- B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/22 Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670 At this Emergency Preparedness survey, Valparaiso Care & Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 164 certified beds. At the time of the survey, the census was 116. Quality Review completed on 08/31/22	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: 08/30/22 Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670 At this Life Safety Code survey, Valparaiso Care	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests a desk review for compliance on or after 9/14/22.	

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 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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	& Rehabilitation was found not in compliance with Requirements for Participation in 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 fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery-operated smoke detectors in resident sleeping rooms. The facility maintains a ventilator unit, and the building is fully protected by a 400-kW diesel-powered generator. The facility has a capacity of 164 and had a census of 116 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached garages and one shed that is being used for facility storage. Quality Review completed on 08/31/22			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or			

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the Laundry room in the Main hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:20 p.m. to 2:45 p.m. on 08/30/22, the corridor door to the clean side of the Laundry room in the Main Hall which contained fuel-fired dryers was equipped with a self-closing device but the door failed to fully close and latch into the door frame when	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Director of Maintenance adjusted the laundry room door closure on 9/7/22. It now latches properly.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents, visitors and staff in vicinity of laundry room in main hallway of facility have the	09/14/2022

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	tested three separate times. When swinging to close, air coming in from the corridor prevented the door from positively latching into the frame. Based on interview at the time of observation, the Maintenance Director agreed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		potential to be affected by alleged deficient practice. All self-closing and automatic-closing doors will be checked to ensure proper latching. Doors will be fixed as necessary. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Environmental team will be in-serviced by Executive Director (ED)/Designee to notify Director of Maintenance if door is not working properly. Director of Maintenance will do random observational checks of door for proper functioning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** **To ensure ongoing compliance with this corrective action, Director of Maintenance/Designee will complete Fire-Smoke Door Inspections audit tool x8 weeks, then monthly x6 months. If 100% compliance is not achieved, an action plan will be developed. Findings will be submitted to the QAPI**	

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			Committee for review and follow up.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction of the facility. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect up to 15 residents and staff in the vicinity of the West Whirlpool Room. Findings include: Based on observation with the with the	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Ceiling tile in West Whirlpool Room was replaced on 9/7/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents and staff in the vicinity of the West Whirlpool	09/14/2022

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	Maintenance Director on 08/30/22 during a tour of the facility from 1:20 p.m. to 2:45 p.m., in the west Whirlpool room, a two inch by one inch hole was cut out of a lay in ceiling tile, exposing the area above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observation, the Maintenance Director agreed there was a hole in the ceiling tile and would make sure it is fixed. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		Room have the potential to be affected by alleged deficient practice. Director of Maintenance/Designee will audit all ceiling tiles in facility. Ceiling tiles will be replaced as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director will in-service Director of Maintenance on sprinkler system pertaining to ceiling construction. Director of Maintenance will conduct random observational rounds of ceiling tiles.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** To ensure ongoing compliance with this corrective action the Director of Maintenance/Designee will be responsible for completing the Sprinkler audit tool weekly x 8 weeks then monthly x6 months. If 100% compliance is not achieved, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6			
	Based on observation and interview, the facility failed to ensure 1 of 9 smoke compartments was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to	K 0753	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Door of Room 240 has had decorations removed on 9/7/22 and now has less than 30% of area covered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents and staff in the vicinity of West South smoke compartment have the potential to be affected by alleged deficient practice. Director of Maintenance	09/14/2022

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	the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect 17 residents, staff and visitors in the vicinity of resident sleeping Room 240 in the West South smoke compartment. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:20 p.m. to 2:45 p.m. on 08/30/22; multiple photographs, wooden signs, and decorations were affixed to the face of the corridor door to resident sleeping Room 240 and covered more than 90% of the door.		or Designee will check all doors to ensure they are in compliance with combustible decorations regulation. Any doors not in compliance will be corrected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Executive Director (ED) will in-service Director of Maintenance on Combustible Decorations. Director of Maintenance will do random observational rounds to ensure all doors are in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** **To ensure ongoing compliance with this corrective action, Director of Maintenance/Designee will complete Doors, Locks, Gates & Alarms audit tool x8 weeks, then monthly x6 months. If 100% compliance is not achieved, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.**	

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	Based on interview at the time of the observation, the Maintenance Director stated the items affixed to the door were not treated with fire retardant material and agreed that more than 90% of the door surface was covered. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(a)			