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	08/07/2023

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

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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: 08/07/23 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 Quality Review completed on 08/09/23 The facility has 164 certified beds. At the time of the survey, the census was 121.	E 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 9/1/23.**	
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: 08/07/23 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 9/1/23.**	

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 121 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 08/09/23			
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 the corridor doors to 1 of 1 laundry rooms which is a hazardous area containing fuel fired equipment and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/07/23 between 11:00 a.m. and 12:50 p.m., the laundry room, a hazardous storage room that was greater than 50 square feet, was equipped with self-closing device but did not latch into the frame	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Maintenance Director has adjusted auto closer on laundry room door to ensure the door fully closes and latches into door frame. **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:** Approximately 20 residents and staff are potentially affected by this alleged deficient practice. All	09/01/2023

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	when tested three times. Based on interview at the time of observation, the Maintenance Director agreed the room contained fuel fired equipment, was larger than 50 square feet, and acknowledged the door would not completely latch into the frame and the closer would need to be adjusted. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		auto closing doors have been inspected to ensure that the door fully closes and latches into door frame. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director has been educated to review functionality of all auto closing doors to ensure that they fully close and latch into door frame. Maintenance Director/designee will be responsible for checking all auto closing doors to ensure that the door fully closes and latches into door frame weekly for 4 weeks, monthly for 6 months and then quarterly for at least 2 quarters. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quarterly Assurance and Performance Improvement program. If 90% threshold is not met/maintained, then an action plan will be developed. Any findings will be submitted to QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** **9/1/23**	

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K 0353 SS=F 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 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states 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,	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility sprinkler system was last checked on 7/24/23. 5-year internal pipe inspection conducted by Integrated Electronics Inc. The water system supply source is a dedicated line from the city of Valparaiso water system. Purchase agreement through Integrated Electronics Inc. & Fire Protection was signed/approved 8/24/23 for full hydrostatic flush of sprinkler system. Full hydrostatic flush of facility sprinkler system is scheduled between 9/11/23 and	09/18/2023

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	the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 08/07/23 between 09:09 a.m. and 10:57 a.m. of the form documented "Form for inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems: Fifth Year" documentation dated 07/24/23 with the Maintenance Director, the Internal Pipe Inspection report stated, "system has build-up that requires a flush for a passing value." The deficiency was listed as non-critical and the system and that "all parts operate properly and are in good condition." Based on interview with Maintenance Director, he acknowledged that they were aware of the issue and are currently getting a quote from the sprinkler company to get the repairs fixed. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3-1.19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 water heater rooms. 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 approximately 4 staff and 15 residents that use the main dining area.		9/18/23 through Integrated Electronics Inc & Fire Protection. Missing ceiling tile in dietary water heater room has been replaced; 2-inch gap between ceiling pipe and suspended ceiling tile in dietary water heater room was filled with fire caulk. **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 are at risk of being affected by alleged deficient practice. All ceiling tiles have been visibly inspected to ensure there are no further missing tiles, gaps, or other penetrations. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director educated that sprinkler system flush must be completed no later than 5 years apart and that ceiling tiles cannot be missing or have any gaps/penetrations. The QAPI and PM calendar were updated for the Executive Director/Maintenance Director to review sprinkler system inspections quarterly. Maintenance director/designee will inspect facility ceiling tiles weekly for 4 weeks, monthly for 6 months, and then quarterly for at least 2 quarters. **How the corrective action(s)**	

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	Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/07/23 between 11:00 a.m. and 12:50 p.m., in the suspended ceiling the water heater room there was a ceiling tile missing and exposed the ceiling about one foot above the suspended ceiling. Furthermore, an approximately two-inch gap was noted in between the ceiling and a pipe going above the drop ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there was a missing ceiling tile and exposed the ceiling above the drop ceiling. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quarterly Assurance and Performance Improvement program. If 90% threshold is not met/maintained, then an action plan will be developed. Any findings will be submitted to QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** **9/18/23**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches			

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	for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Maintenance Director on 08/07/23 between 11:00 a.m. and 12:50 p.m., the set of smoke barrier doors by resident room 137 in the Cottage Wing would not fully close due to the coordinating device on the door frame not correctly working. When tested, the coordinating device would hold both doors open when the door without the astragal was shut first. This condition creates a two-inch gap between the doors when shut. Based on interview during the time of observations, the Maintenance Director and Administrator stated the coordinating device was not function properly and not allowing the doors to completely shut. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0374	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The coordinating device for smoke barrier doors by resident room 137 in the Cottage unit was replaced to ensure they are working properly to restrict movement of smoke for at least 20 minutes. **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:** Approximately 10 residents and staff are at risk of being affected by alleged deficient practice. All smoke barrier doors have been inspected to ensure proper functioning and that they fully close when released. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:** Maintenance Director was educated on ensuring smoke barrier doors are working properly. Maintenance director/designee will inspect all smoke barrier doors to ensure proper functioning weekly for 4 weeks, monthly for 6 months, and then quarterly for at least 2 quarters.	09/01/2023

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			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: Ongoing compliance with this corrective action will be monitored through the facility Quarterly Assurance and Performance Improvement program. If 90% threshold is not met/maintained, then an action plan will be developed. Any findings will be submitted to QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** **9/1/23**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Maintenance Director on 08/07/23 between 11:00 a.m. 12:50 p.m., in the East Wing nurses' station, a power strip used to power equipment, was not secured, and was dangling from the connected power cords. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference.	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** East wing nurses station power cord was replaced by another with a longer cord to ensure that it is secure and not dangling from connected cords. The extension cord and power strip were removed from room 150 and an additional outlet was installed. The power strip in MDS office was removed and microwave in MDS office plugged directly into wall outlet. **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:** Approximately 20 residents and staff are potentially affected by this alleged deficient practice. All residential and non-residential areas of facility inspected to ensure no extension cords are in use and that any movable PCREE are plugged into approved power strips. **What measures will be put into place or what systemic**	09/01/2023

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 2 residents in resident room 150. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/07/23 between 11:00 a.m. and 12:50 p.m., an extension cord was located in resident room 150 and was supplying power to a powerstrip that was used to power a television set. Based on interview at the time of observation, the Maintenance Director acknowledged an extension cord was in use and plugged into a power strip and stated it will be removed. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 5 staff and an unknown number of residents.		**changes will be made to ensure that the deficient practice does not reoccur:** Maintenance Director was educated regarding proper power strip usage and that no extension cords are allowed in facility. Maintenance director/designee will inspect all residential and non-residential areas of facility to ensure power strips are properly used and that no extension cords are in use weekly for 4 weeks, monthly for 6 months, and then quarterly for at least 2 quarters. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quarterly Assurance and Performance Improvement program. If 90% threshold is not met/maintained, then an action plan will be developed. Any findings will be submitted to QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** **9/1/23**	

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	Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/07/23 between 11:00 a.m. and 12:50 p.m., a microwave was plugged into and supplied power by a power strip in the MDS office. Based on interview at the time of observation, the Maintenance Director acknowledged power strip was supplying power to a high power draw equipment. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			