STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING -- B. WING	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR 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: 01/23/24 Facility Number: 000078 Provider Number: 155158 AIM Number: 100289310 At this Emergency Preparedness survey, Life Care Center of the Willows, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 53. Quality Review completed on 01/29/24	E 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tami Adams	Executive Director	02/09/2024

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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			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
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: 01/23/24 Facility Number: 000078 Provider Number: 155158 AIM Number: 100289310 At this Life Safety Code survey, Life Care Center of the Willows 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 verified to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and areas open to the corridors. Resident rooms are equipped with battery operated smoke detectors. The facility is fully protected by a 230 kW diesel-powered emergency generator. The facility has the capacity for 100 and had a census of 53 at the time of this survey.	K 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of	

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/29/24		Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet 1 of 1 service corridors clear width requirement exception per 19.2.3.4(1). LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect approximately 7 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 01/23/24 between 12:27 p.m. and 2:34 p.m., in the 8 foot service corridor contained numerous serving carts, food heater counters, and numerous other pieces of equipment that took	K 0232	**Plan of Correction K232** **1 What corrective action(s) will be accomplished for K232 to have been found deficient?** The facility failed to meet 1of 1 service corridors clear width requirement. Training was provided on 02/09/2024 to ensure that the hallway clearances is greater than 44 inches. Items were removed immediately from the hallway to create more space to ensure that the clearances will be adequate. **2 How will you identify K232 having the potential to be**	02/14/2024

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	over half the corridor width that left clear width of approximately 42 inches. Based on interview at the time of observation, the Maintenance Director acknowledged that the width was less than the required amount measured by the surveyor. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**affected by the same deficient practice and what corrective action will be taken?** The report was created for weekly monitoring and is submitted to the plan of correction. Staff was educated. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule will be revised to ensure that the deficiency does not recur. Training of staff has occurred on 02/09/2024 to ensure that the space requirements are correct. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program was put into place to ensure that documentation is done, and training provided to all staff. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **A Plan of Correction completion date has been**	

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			provided 02/14/2024	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 2 of 2 battery backup lights. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 01/23/24 between 08:46 a.m. and 12:22 p.m., the emergency light testing form titled "Emergency Lighting: Conduct a 30 second functional testing" indicated the battery operated lights were tested monthly but the form was not itemized to show that each emergency light in the facility was tested nor gave a result as to if the lights had passed or failed testing. Based on an interview at the time of record review, the Maintenance Director acknowledged the aforementioned issue and stated TELS is responsible for logging the results,	K 0291	**What corrective action(s) will be accomplished for K291 to have been found deficient?** The facility failed to maintain itemized records of the Inspections and tests for 2 of 2 battery backup lights. 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks Between tests, for not less than 30 seconds. **How will you identify K291 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The report was created and is submitted to the plan of correction. **What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule will be revised to ensure that the	02/14/2024

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	however was unsure why it did not grid out the results or list the places the lights are at. This finding was reviewed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		deficiency does not recur. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that documentation is done, and each light is itemized. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 52 of 52 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained	K 0300	**Plan of Correction K 300** **1 What corrective action(s) will be accomplished for K 300 to have been found deficient?** An itemized log for the battery operated smoke detectors was created to itemize each smoke detector to show that each were inspected instead of lumping them	02/14/2024

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	and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director and Administrator on 01/23/24 between 08:46 a.m. and 12:22 p.m., battery-smoke detector testing documentation titled "Detectors: Test all battery-operated smoke detectors in resident rooms" only had listed that 50 of 50 smoke detectors were tested monthly over the past 12 months. The list did not itemize each smoke detector tested. Furthermore, during a tour of the facility with the Maintenance Director between 12:27 p.m. and 2:34 p.m., one battery smoke detector was found in the kitchen and one detector was found in the therapy gym. Based on interview at the time of observation, the Maintenance Director stated that he was unaware that the battery smoke detectors were in the aforementioned locations and he had not been testing them on a monthly basis. He further agreed that the testing documentation did not itemize all the locations for each smoke detectors. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		together as the TELS task log did. **2 How will you identify K 300 having the potential to be affected by the same deficient practice and what corrective action will be taken?** All smoke detectors when tested will be documented individually on the newly created documentation form. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that testing is done weekly per manufacturer's instructions. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance.	

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			5 A Plan of Correction completion date has been provided. 02/14/2024	
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 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)			

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	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 hazardous rooms were 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 15 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/23/24 between 12:27 p.m. and 2:34 p.m., resident room 28 contained approximately 12 large cardboard boxes and miscellaneous boxes of PPE and other combustible material, larger than 50 square feet, but the door to the room was not self-closing. Based on interview at the time of observation, the Maintenance Director agreed that there was a large amount of combustible material and the door was not self-closing. Later during the exit conference, the Administrator stated that the boxes were recently moved in from a supply building outside due to weather. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	**Plan of Correction K 321** **1 What corrective action(s) will be accomplished for K321 to have been found deficient?** The facility failed to ensure the corridor doors to 1 of 1 hazardous rooms were provided with a Self-closing device which would cause the door to automatically close and latch into the door frame. The door latch was replaced and the door closer was adjusted to ensure proper closing and latching of the door. Resident room 28 was cleared of all materials and boxes and is now setup as a resident room **2 How will you identify K321 having the potential to be affected by the same deficient practice and what corrective action will be taken?** All areas of the building will be inspected weekly to ensure that door latches properly when closed. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice**	02/14/2024

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			will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible? QA program will be put into place to ensure that testing is done. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be			

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	enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:27 p.m. and 2:34 p.m. on 01/23/24, two separate hood exhaust systems were noted. One system did have a grease trap installed with a metal container. The second, which was over the griddle and partially over the range top, did not have a grease drip system nor an approved enclosed metal container. Based on interview at the time of observation, the Maintenance Director confirmed that the second filter system did not have a grease drip system and was unsure why only one had it. This finding was reviewed with the Administrator and Maintenance director at the exit conference. 3.1-19(b)	K 0324	**Plan of Correction K 324** **1 What corrective action(s) will be accomplished for K 324 to have been found deficient?** A kitchen hood grease trap pan was ordered and has been installed. **2 How will you identify K 324 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The kitchen will be inspected weekly and to ensure that grease trap pans are not missing. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule will was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspection is done	02/14/2024

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			weekly. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 01/23/24 between 08:46 a.m. and 12:22 p.m., the fire watch plan titled	K 0346	**Plan of Correction K 346** **1 What corrective action(s) will be accomplished for K 346 to have been found deficient?** The fire watch plan will be changed to reflect the IDOH gateway https://gateway.isdh.in.gov and the secondary method. **2 How will you identify K 346 having the potential to be affected by the same deficient practice and what corrective**	02/14/2024

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(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
	"Fire Watch Policy" did address contacting the designated state agency, however it failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director and Administrator acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**action will be taken?** The fire watch plan will be inspected yearly to ensure that gateway address and secondary method are not missing. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The yearly review schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that testing is done yearly. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0351 SS=E	NFPA 101 Sprinkler System - Installation			

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	155158	A. BUILDING 01 B. WING	01/23/2024

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LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

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Bldg. 01	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage rooms in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect approximately 15 residents and staff. Findings include:	K 0351	**Plan of Correction K 351** **1 What corrective action(s) will be accomplished for K 351 to have been found deficient?** The boxes in the closet were moved to allow for 18 inches of clearance for the sprinkler heads. **2 How will you identify K 351 having the potential to be affected by the same deficient practice and what corrective action will be taken?** All areas of the building will be inspected weekly to ensure that sprinkler heads are not obstructed and have 18 inches of clearance.	02/14/2024

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	Based on observation with the Maintenance Director on 01/23/24 from 12:27 p.m. to 2:34 p.m., the nursing storage closet near the admissions office had cardboard boxes within approximately 6 inches of the sprinkler head. Based on interview at the time of record review, the Maintenance Director confirmed that the boxes were less than 18 inches from the sprinkler head and would have to move storage around. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspections are done. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
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,			

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	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 ensure 2 of 10 sprinkler heads in the Main hall and 2 of 6 sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 20 residents and staff in two smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/23/24 between 12:27 p.m. and 2:34 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) Two sprinkler heads located next to air vents near the main lobby were covered with dirt and	K 0353	**Plan of Correction K353** **1 What corrective action(s) will be accomplished for K353 to have been found deficient?** The 2 sprinkler heads in the main hallway were cleaned of foreign material. . **2 How will you identify K353 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The sprinkler heads will be monitored to ensure that the sprinkler heads are free of debris. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective**	02/14/2024

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	liny that left the fuse barely visible. b) Two sprinkler heads located in the kitchen adjacent to the food storage area were covered in a black oily substance noticible on the sprinkler head. Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned conditions for the sprinkler heads. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspection is done. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility	K 0354	**Plan of Correction K 354**	02/14/2024

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	failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 01/23/24 between 08:46 a.m. and 12:22 p.m., the fire watch plan titled "Fire Watch Policy" did address contacting the designated state agency, however it failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director and Administrator acknowledged the fire watch documentation provided stated to contact the		**1 What corrective action(s) will be accomplished for K 354 to have been found deficient?** A sprinkler policy has been created to address when the sprinkler system is out of service for more than 10 hours. **2 How will you identify K 354 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The fire policy will be inspected yearly to ensure that the fire policy is updated to notify the IDOH gateway when fire watch is instituted due to a sprinkler outage of 10 or more. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspection is done yearly. The Director of Maintenance will submit audits	

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	IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or			

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	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 2 of 2 linen closet corridor doors on the East and West Hall and 1 of 7 service corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 406. Findings include: Based on observation with the Maintenance Director and Administrator on 01/23/24 between 12:27 p.m. and 2:34 p.m., the corridor door for the linen closet near resident room 38 did not latch when tested three timmes. The inactive door had self-latching hardware, but did not self-latch when testing the door. Furthermore, the linen closet across from resident room 13 did not latch as well. The inactive door did not self-latch. Based on interview at the time of observation, the Maintenance Director agreed that the door would not self-latch and would have to be adjusted. Including the aforementioned doors above, the corridor door separating the main dining room and the service hall contained latching hardware, but did not latch into the frame when tested three	K 0363	**Plan of Correction K 363** **1 What corrective action(s) will be accomplished for K 363 to have been found deficient?** The East and west linen closet door latches have been repaired. **2 How will you identify K 363 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The east and west will be inspected weekly to ensure that the door latches function properly. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule was revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to**	02/14/2024

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	times. The Maintenance Director confirmed upon observation that the door did not latch and would have to be fixed to make it work like it is installed to do so. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 46 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 4 residents. Findings include: Based on observation with the Maintenance Director on 01/23/24 from 12:27 p.m. to 2:34 p.m., the corridor doors to resident rooms 40 and 23 had trash cans in front of the door to prop them open impeding the door to close in an emergency. Based on interview at the time of observation, the Maintenance Director agreed that the trash cans were in front of the door. Findings were discussed wtih the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspection is done weekly. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date has been provided.** **02/14/2024**	
K 0521 SS=C Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in			

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	accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire damper systems in the facility were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect approximately all residents and staff. Findings include: Based on records review with the Maintenance Director on 01/23/24 between 08:46 a.m. and 12:22 p.m., when asked, the Maintenance Director	K 0521	**Plan of Correction K 521** **1 What corrective action(s) will be accomplished for K 521 to have been found deficient?** The fire damper inspection was performed on 2/19/2020. A copy of the inspection report is provided. The fire/smoke damper did indicate the last inspection was 02/19/20. **2 How will you identify K 521 having the potential to be affected by the same deficient practice and what corrective action will be taken?** The next inspection of the fire dampers is scheduled for the 1st quarter of 2024. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The inspection schedule will be revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?**	02/14/2024

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	indicated to the surveyor that no fire and or smoke dampers were installed in the facility and had no documentation of any inspections. Based on observation during a tour of the facility between 12:27 p.m. and 2:34 p.m., above the drop ceiling at the smoke barrier near the East hall nurse's station had a combination fire/smoke damper installed. Based on interview at the time of observation, the Maintenance Director agreed that there was a fire/smoke damper within the smoke barrier and was unaware he had any in the building. When asked, he did not know how many were located within the building and had no inspection paperwork at the time of discovery. The fire/smoke damper did indicate the last inspection was 02/20/20. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		QA program will be put into place to ensure that testing is done every 4 years as stated in K521. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date.** **02/14/2024**	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility	K 0711	**Plan of Correction K 711**	02/14/2024

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	failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on records review with the Maintenance Director and the Administrator on 01/23/24 between 08:46 a.m. and 12:22 p.m., the provide facility's fire safety plan did not completely address response to alarms. The facility did address how to respond if the fire alarm system was activated but did not include the response if an individual battery smoke alarm that is not connected to the fire alarm system is activated. Based on interview at the time of record review, the Administrator acknowledged the lack of information on the fire plan and stated the only policy on fire response was provided at the time of the survey. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**1 What corrective action(s) will be accomplished for K 711 to have been found deficient?** A fire plan for responding to battery operated smoke alarms has been created to train staff on proper response. **2 How will you identify K 711 having the potential to be affected by the same deficient practice and what corrective action will be taken?** Staff were trained on the policy and procedure of responding to a battery operated smoke detector located in a resident room on 02/09/2024 **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The staff will be trained at orientation upon hiring and yearly. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that training is done upon hire and yearly. The trainer will submit audits monthly to the Executive Director to be reviewed	

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	155158	A. BUILDING 01 B. WING	01/23/2024

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			at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date 02/14/2024**	
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 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 not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7	K 0920	**Plan of Correction K920** **1 What corrective action(s) will be accomplished for K20 to have been found deficient?**	02/14/2024

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	155158	A. BUILDING 01 B. WING	01/23/2024

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	flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/23/24 between 12:27 p.m. and 2:34 p.m., a microwave located in the business office, near the main entrance, was plugged into an extension cord that was laying on the ground ready to use. When interviewing the staff member at the desk area, she had confirmed the extension cord was used for the microwave and would plug it into a power strip when used. The Maintenance Director then acknowledged the aforementioned issue with the extension cord at the time of observation. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b) 2. 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 2 staff an an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator		The facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. The power strip found in the office has been removed and the power cords redistributed to power outlets in the wall. The mini fridge in the admissions office was removed from the power strip and plugged into the wall receptacle. **2 How will you identify K920 having the potential to be affected by the same deficient practice and what corrective action will be taken?** All areas of the building will be inspected weekly to eliminate the use of power strips. Staff educated on 02/09/2024. **3 What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur?** The weekly inspection schedule will be revised to ensure that the deficiency does not recur. **4 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person(s) responsible?** QA program will be put into place to ensure that inspection is done	

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	on 01/23/24 between 12:27 p.m. and 2:34 p.m., the business/admissions office contained a minifridge that was plugged into and supplied power by a power strip. Based on interview at the time of observation, the Maintenance Director confirmed that the fridge was plugged into the power strip and was able to unplug it at the time of observation. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		weekly. The Director of Maintenance will submit audits monthly to the Executive Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. **5 A Plan of Correction completion date 02/14/2024**	