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	12/17/2024

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: 12/17/24 Facility Number: 000078 Provider Number: 155158 AIM Number: 100289310 At this Emergency Preparedness survey, Life Care Center of the Willows, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 92 certified beds. At the time of the survey, the census was 64. Quality Review completed on 12/20/24	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	01/02/2025

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.

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	12/17/2024

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
			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop	E 0039	**E039 EP testing requirements** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice **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:** The facility will Participate in a full-scale exercise that is community-based every year or when a community-based exercise is not accessible, conduct a facility-based functional exercise. A mock disaster drill; or A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Table top discussion will be completed for 05/09/2024 disaster	01/12/2025

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	12/17/2024

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
	exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director at 3:10 p.m. on 12/17/24, the facility was able to provide documentation of a facility based exercise dated 05/09/24, however, there was not an after action report available that analyed the response to the exercise. Additionally, the facility was unable to provide documentation of a second exercise of choice that was designed to challenge the emergency plan during the past 12 month period. At time of record review the Maintenance Director stated no other exercises were available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		plan. Maintenance supervisor and assistant will be educated on proper mock disaster drill and group discussion. Also, proper completion of paperwork after all drills. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 2 Drills will be scheduled each year to ensure compliance. One in spring and one in fall. Beginning 2025. Table top discussion will be completed for 05/09/2024 disaster plan. Maintenance supervisor and assistant will be educated on proper mock disaster drill and group discussion. Also, proper completion of paperwork after all drills. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit Drills to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements	E 0041	**E041 Emergency Power** **What corrective action(s) will be accomplished for those**	01/12/2025

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	12/17/2024

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
	found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of 'Execcise Generator Under Load' documentation with the Maintenance Director on 12/17/24 at 12:48 p.m., documentation of a load test for November 2024 was not available for review. Based on interview at the time of record review, the Maintenance Director confirmed monthly load testing for November 2024 was not conducted. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		**residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice **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:** Education was provided to the maintenance director on policy and procedure on proper timeliness of generator load test **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** A monthly audit will be created and it will be documented in the preventative maintenance log (TELS). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit Generator load testing monthly to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000	The facility requests that this plan of correction be considered its	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/17/24 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 92 and had a census of 64 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/20/24		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 the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous area doors, such as oxygen storage/transfilling rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 15 residents, staff and visitors in one smoke compartment. Findings include: Based on observation and interview with the Maintenance Director and Maintenance Assistant on 12/17/24 during a tour of the facility at 3:57 p.m., the corridor door to the oxygen storage room across the corridor from the west nurse station did not self-close and latch into the door frame when tested three times. The oxygen corridor door contained liquid oxygen containers and E Type cylinders. Based on interview at the time of observation, the Maintenance Director confirmed that the oxygen room's self closing corridor door did not latch into the frame when tested. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0321	**K321 Hazardous areas** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice . Door to oxygen room was repaired (door Closer adjusted) on 12/18/2024 all other doors were audited and repaired if non-compliant on 12/18/2024. **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:** Audit will be completed on all self-closing doors to ensure compliance. Maintenance assistant will be educated in proper functioning and testing door latching also documentation. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** The weekly inspection schedule will be revised to ensure that the deficiency does not recur in the TEL's preventative maintenance program **How the corrective action(s) will be monitored to ensure the deficient practice will not**	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
			recur: QAPI program will be put into place to ensure that testing 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.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design	K 0324	**K324 Cooking Facilities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice **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:** Safe care will be called to assist in setting up a functional method that would ensure that the appliances were returned to an approved design location after being moved for maintenance and cleaning. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** A weekly audit was created and it	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	location. This deficient practice could affect kitchen staff only. The findings include: Based on observation and interview with the Maintenance Director at 4:30 p.m. on 12/17/24 during a tour of the facility; cooking appliances including a six burner range, grill, oven and steamer located under the hood in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after being moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		will be documented in the TELS preventative maintenance log to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit Audits to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to provide complete fire drill documentation for 3 of 12 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 12/17/24 at 12:04 p.m. with the Maintenance Director present, the following fire drills reports	K 0712	**K712 Fire Drills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice. The paper work for the fire drills dated 03/14/24, 02/26/24 and 01/11/24 that were missing have been	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	did not include a sign in sheet of the participating staff: a) 03/14/24 at 11:00 a.m. (first shift of the first quarter) b) 02/26/24 at 10:00 p.m. (second shift of the first quarter) c) 01/11/24 at 6:00 a.m. (third shift of the first quarter) Based on interview at the time of record review, the Maintenance Director stated he had been on the job for about six months and confirmed the lack of staff sign in sheets for the previously mentioned fire drill reports at the time of the survey. 2. Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of "Fire Drills" with the Maintenance Director on 12/17/24 at 12:10 p.m., the 11/27/24 fire drill at 9:00 p.m. did not include transmission of signal to the monitoring station. Based on interview at the time of record review, the Maintenance Director confirmed that the 11/27/24 fire drill did not include documented transmission of fire alarm signal to the monitoring station. These findings were reviewed with the Executive		located and will be part of our plan of correction sent in by 01/12/2025. **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:** Education was provided to the maintenance director on the policy and procedure of verification of transmission of the fire alarm signal to the monitoring station. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Fire drills with verification of transmission will be submitted to the monthly safety committee meeting and QAPI to ensure compliance and the deficient practice does not reoccur. TELS pm logs will monitor transmission. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit monthly to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	Director and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review of 'Exercise Generator Under Load' documentation with the Maintenance Director on 12/17/24 at 12:48 p.m., documentation of a load test for November 2024 was not available for review. Based on interview at the time of record review, the Maintenance Director confirmed that monthly load testing for November 2024 was not conducted.	K 0918	**K918 Electrical Systems** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice **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:** Life safety surveyor educated Maintenance director maintenance assistant and executive director on this requirement to ensure we had the knowledge and proper tools to move forward to ensure this does not reoccur. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance director/ designee will maintain a complete written record of monthly generator load testing and electrolyte specific gravity. Battery conductance testing in TELS and through	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	2. Based on records review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator. NFPA 101, 9.1.3.1 states Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 8.3.7.1 states Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. Findings include: Based on records review with the Maintenance Director on 12/17/24 at 12:44 p.m., the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Based on interview at the time of record review, the Maintenance Director stated that battery conductance testing on the diesel generator is not completed monthly. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		vendor (safe care) this will be monitored monthly at the safety committee and at Monthly QAPI to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit Generator load testing and battery conductance testing monthly to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility	K 0920	**K920 Electrical Equipment**	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	failed to ensure 1 of 1 flexible cords 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 2 residents and staff in resident room 22. Findings include: Based on observations with the Maintenance Director and Maintenance Assistant on 12/17/24 at 3:42 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by an extension cord in resident room 22. Based on an interview at the time of observation, the Maintenance Director confirmed an extension cord was supplying power to high power draw equipment. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice. Cord removed at time of survey and refrigerator moved to other side of room and plugged into the wall. **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:** The Maintenance Director or designee will conduct a facility audit to ensure compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** A facility audit was completed with no further issues found. A weekly inspection schedule will be revised to ensure that the deficiency does not recur. This will be monitored in the TEL's preventative Maintenance program. Staff re-educated to not using power stripes in the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Director of Maintenance or designee will submit monthly to the Executive Director to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
			reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include:	K 0921	**K921 testing and maintenance electrical equipment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents have been affected by the deficient practice **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:** An audit will be conducted by 01/12/2025 by Maintenance Director or designee of all Willows current fixed and portable patient-care related electrical equipment of the physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** The monthly inspection of Fixed and portable patient-care related	01/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 01 B. WING	12/17/2024

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
	Based on records review and interview with the Maintenance Director on 12/17/24 at 3:10 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for residents. The Maintenance Director stated that PCREE such as air mattresses, oxygen concentrators and other electrical medical equipment either owned or leased was present and in use at the facility. The Maintenance Director stated he was not aware of the testing requirement of PCREE, and no inspection documentation was available at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		equipment will be put into our preventative maintenance to ensure no items are missed when the equipment is being put into service or after any repairs to ensure that the deficiency does not recur. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** QAPI program will be put into place to ensure that inspection is done. The Director of Maintenance or designee will submit monthly to the Executive Director to be reviewed at safety committee and QAPI for a period of 6 months to ensure 100% compliance.	