

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/20/15</p> <p>Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150</p> <p>At this Life Safety Code survey, Glen Oaks Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The healthcare portion of the facility has a capacity of 68 and had a census of 55 at the time of this</p>	K 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Life Safety Code survey July 20, 2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K 0027 SS=E Bldg. 01	<p>visit.</p> <p>All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 18.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 11 residents who reside on the 300 Hall.</p>	K 0027	<p>K027</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 300 Hall Set of smoke barrier doors leading to the Service Hall were adjusted. The doors come together in a closed position leaving only the minimum clearance necessary for proper operation.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	07/20/2015

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K 0067 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 07/20/15 at 12:10 p.m. with the director of plant operations, the 300 Hall set of smoke barrier doors leading to the Service Hall had a one inch gap along the center where the doors came together in the closed position. This was verified by the director of plant operations at the time of observation and acknowledged at the exit conference on 07/20/15 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview, the facility failed to ensure 56 of 56 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A.</p>	K 0067	<p>action(s) will be taken? All residents have the potential to be affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Executive Director will review the Life Safety Code, Section 8.3.4 with the Director of Plant Operations.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Plant Operations will tour and audit smoke barriers 5 times weekly for 2 weeks; monthly thereafter for 6 months. Audit results will be presented to the campus Quality Assessment and Assurance Committee for review and recommendation.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by</p>	08/19/2015

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	<p>LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 07/20/15 at 10:40 a.m. with the director of plant operations, the most recent record provided for the maintenance of fifty six health care fire/smoke dampers was the Fire/Smoke Damper Maintenance Record dated 05/19/11, which was a period exceeding four years. Based on an interview with the director of plant operations on 07/20/15 at 10:45 a.m., there were no other records available for review to indicate a current four year maintenance had been performed on the fifty six fire/smoke dampers located in the health care portion of the facility. This was verified by the director of plant</p>		<p>the deficient practice? Fire dampers will be inspected and provide necessary maintenance.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Executive Director will review the Life Safety Code, Section 8.2.1 and NFPA 90A, 1999 Edition, Section 3.4.7 with the Director of Plant Operations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Plant Operations will schedule fire damper inspection and necessary maintenance to be completed at least every 4 years. A confirmation of the next scheduled inspection will be reviewed quarterly in the campus Quality Assessment and Assurance Committee for review and recommendation.</p>	

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	operations at the time of interview and acknowledged at the exit conference on 07/20/15 at 1:45 p.m. 3.1-19(b)				