

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
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K010000	<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: 04/15/14</p> <p>Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400</p> <p>Surveyors: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Mishawaka 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke detectors are provided all resident sleeping rooms. The facility has a capacity of 87 and had a census of 61 at the time of the survey.</p> <p>All areas where the residents have</p>	K010000	Disclaimer StatementSubmission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law.* This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement.	

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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K010022 SS=E	<p>customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered garage and storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/21/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 11 paths in the exit means of egress to the public way were clearly identified. This deficient practice affects visitors, staff and 20 or more residents in the main dining room and Wing 2.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 04/15/14 at 2:05 p.m., a six foot chain link gated fence ran across the path of exit to the public way from the Wing 2 exit near room 216. The fence and gate were indistinguishable from one another from the exit discharge. The maintenance director acknowledged at the time of observation, the gate would be obvious if it were identified with an exit sign.</p> <p>b. Based on observation with the maintenance director on 04/15/14 at 2:50</p>	K010022	<p>1. Exit signs were placed on each fence/gate.2. Staff, visitors and 20 or more residents could be affected.3. Maihntenance Director will check for compliance during monthly fire drill and also when checking fire extinguishers.4. Non compliance will be reported to Executive Director or designee to share during monthly QAPI meeting.</p>	05/15/2014

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K010025 SS=E	<p>p.m., a six foot white vinyl gated fence ran across the path of exit to the public way from the main dining room. The fence and gate were indistinguishable from one another. The maintenance director acknowledged at the time of observation, the gate would be obvious if it were identified with an exit sign.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 3 of 6 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This</p>	K010025	<p>1. All areas were sealed with appropriate Fire/smoke prevention material.2. Staff, visitors and 20 or more residents could be affected.3. A preventative maintenance work order will be added to computer to have maintenance director to check that there are no holes on smoke barrier on a routine basis.4. Preventative maintenance work order inspections will be monitored by the ED for compliance. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>	05/15/2014

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K010029 SS=E	<p>deficient could affect visitors, staff and 20 or more residents on Wing 1, Wing 2 and in the physical therapy department.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 between 1:20 p.m. and 3:20 p.m.:</p> <p>a. Conduit and a two inch pipe were tied together and penetrated the kitchen ceiling. The penetration was unsealed leaving a one inch gap into the interstitial space above;</p> <p>b. Three conduit ceiling penetrations in the nourishment room near the Wing 1 nurses station were unsealed leaving 1/4 inch to 1/2 inch gaps;</p> <p>c. Drywall repairs to the entry foyer ceiling around two sprinkler heads leaving one and two inch gaps around the sprinkler piping;</p> <p>d. Four inch and six inch cut outs in the cement block wall of a storage room near room 217 were unsealed;</p> <p>e. Two, two inch holes were unsealed in the ceiling in the corridor between the physical therapy department and maintenance room. The maintenance director acknowledged at the time of the observations, the openings should have been sealed.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are</p>			

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K010046 SS=C	<p>self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide an automatic door closer on 1 of 8 doors providing access to hazardous areas such as a soiled lined and trash room. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents on Wing 2.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 at 2:15 p.m., a room near resident room 229 contained three full 30 to 50 gallon capacity barrels of soiled linen and trash. The access door had no means to self close. The maintenance director acknowledged at the time of observation, the door was not self closing.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p>	K010029	<p>1. A door closure was added to the door.2. Ten or more residents on wing 2 and staff and residents have the potential to be affective.3. A preventative maintenance work order will be added to computer to have maintenance director check all doors for proper operation of door closures.4. Preventative maintenance work order inspections will be monitored by the ED for compliance. Adverse results wil be shared during monthly QAPI meetings on a continual basis.</p>	05/15/2014			
	<p>1. Based on observation and interview, the facility failed to ensure 2 of 2 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient</p>	K010046	<p>1. Batteries were replaced in lights.2. Visitors, staff and residents who visit the generator room or Therapy Department could be affected.3. Documentation will be changed so visual inspections will be recorded for each fixture tested.4.</p>	05/15/2014			

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	<p>practice affects visitors and staff in the generator room and 10 or more residents in the Physical therapy department.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 between 1:30 p.m. and 2:00 p.m., the battery powered emergency lights failed to illuminate when tested twice in the emergency generator room and in the physical therapy room. The maintenance director acknowledged at the time of observations, the lights were not working.</p> <p>3.1-19 (b)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for testing 2 of 2 battery powered emergency lighting fixtures reflected monthly testing for 30 seconds each month and annually for 1 1/2 hours. LSC 7.9.3 requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours and a monthly test for 30 seconds. Written records of visual inspections and tests shall be kept. This deficient practice affects visitors and staff in the generator room and 10 or more residents in the Physical therapy department.</p> <p>Findings include:</p> <p>Based on review of facility Emergency Lighting, Battery Operated records for the inspection and testing of the generator room and physical therapy room battery powered emergency lighting with the maintenance director on 04/15/14 at 3:50 p.m., the was no record of an annual 1 1/2 hour test. Monthly tests for these battery powered emergency</p>		Preventative maintenance work order inspections will be monitored by the Executive Director for compliance. Adverse results will be shared during monthly QAPI meetings on a continual basis.	

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K010048 SS=F	<p>lighting fixture was limited to the comment, "functional test." There was nothing to identify which fixture was tested, the outcome of the test, length of time testing was conducted, the outcome of testing and what, if any maintenance was performed. The maintenance director said at the time of record review, the record provided was for all testing for both fixtures. He acknowledged the record did not provide details to confirm the testing and results for each fixture.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 61 of 61 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K010048	<p>1. Staff inserviced on location of battery operated smoke detectors, location and difference of room smoke detectors versus those that activate the fire alarm system.2. All residents, staff and visitors are equally affected.3. Smoke alarm drills will be completed quarterly. Information will be shared during new employee orientation.4. Results of drills will be reported to Executive Director to determine if further education is needed.</p>	05/15/2014	

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K010069 SS=E	<p>Based on review of the Fire Plan with the maintenance director on 04/15/14 at 4:10 p.m., the plan did not address the location of, and special response required for battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The maintenance director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He said no fire drill had been initiated by the activation of a battery powered resident room smoke detector to train and ensure staff were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation, record review and interview; the facility failed to ensure the complete range hood fire extinguishing system was UL 300 approved for 1 of 1 kitchen hood systems. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 7-2.2 requires automatic fire-extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. NFPA 96, 3.1 says listed grease filters, baffles or other approved grease removal devices shall be used. Mesh filters shall not be used. This deficient practice could affect kitchen staff, visitors and 10 or more</p>	K010069	<p>1. The mesh fillers were replaced with baffles.2. Kitchen staff, visitors and 10 or more residents could be affected.3. No further monitoring needed once system was replaced with baffles.4. This incident will be shared at QAPI meeting.</p>	05/15/2014

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K010074 SS=E	<p>residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation on 04/15/14 at 3:00 p.m. with the maintenance director, the commercial kitchen hood extinguishing system was labeled as an R102 wet chemical system and was equipped with mesh filters. The maintenance director said at the time of observation, he did not know if the system was UL 300 compliant. A review of the commercial hood extinguishing system test and inspection record dated 09/11/13 system was an Ansul R102 with mesh filters. A previous record of inspection and maintenance noted a 12 year hydrostatic test had been conducted in 2004. The maintenance director said at the time of record review, he did not know the system was required to be UL 300 compliant with baffled filters.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the</p>			

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K010143 SS=E	<p>criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 6 smoke compartments were rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 10 or more residents in the west and east smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 between 1:20 p.m. and 4:00 p.m., flame resistance labeling was not found on the full length sheer curtain covering the glass fire exit door near room 216 and the lace curtains in the employee break room. The maintenance director said at the time of observations, he had no evidence the materials were treated to make them flame resistant.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of</p>	K010074	<p>1. Appropriate treated curtains replaced those covering the glass fire door and in employee breakroom. 2. All residents, staff and visitors have the potential to be appected.3. Maintenance staff has been educated regarding ensuring flame retardant certification is on file for all newly introduced window coverings.4. Complaiance will be monitored by ED, DNS and Maintenance Director. Each will keep copies of flame retardant certifications on file so certifications will be accessible dring survey. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>	05/15/2014

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	<p>1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen transfer sites was provided with continuous mechanical ventilation to the outside and separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 20 or more residents on Wing 1.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 at 2:00 p.m., four liquid oxygen supply containers, four oxygen e-cylinders and a portable oxygen tank were stored in a room identified by oxygen signs on the door frame on Wing 1. The maintenance director confirmed at the time of observation, the room was used for the transfilling of portable oxygen tanks. There was no fire rating on the door. When asked at the time of observation, the maintenance director said the mechanical ventilation provided exhausted to the facility ductwork.</p> <p>3.1-19(b)</p>	K010143	<p>1. Installed exhaust fan to the outside in the oxygen closet to meet the continuous mechanical ventilation regulation. All electrical fixtures under the 5 foot standard were removed. A new door was installed which meets the fire rating standard. 2. Staff, visitors and 20 or more residents could be affected.3. A Preventative Maintenance work order will be added to computer to check operation of fan on a weekly basis.4. Compliance of preventative maintenance work order inspections will be monitored by the Executive Director. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>	05/15/2014			

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K010147 SS=E	<p>2. Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 2 sprinklered oxygen storage/transfer locations was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires that storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice affects visitors, staff and 20 or more residents on Wing 1.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 at 2:00 p.m., the Wing 1 oxygen storage and transfer room had four 181 liter capacity liquid oxygen storage tanks, four e-cylinders, and a portable oxygen tank stored in the room with one electrical wall outlet located 48 inches above the floor. The maintenance director acknowledged at the time of observation, the outlet was lower than the minimum five feet allowed.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical wiring and equipment in 1 of 6 smoke compartments was in compliance with NFPA 70, National Electrical Code. NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable</p>	K010147	<p>1. The illuminated exit light above the smoke barrier was securely attached. All extension cords, power strips and nonfused multiplug adapters were removed.2. Staff, visitors and 20 or more residents had the potential to be affected.3. A</p>	05/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/15/2014	
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	<p>assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect staff, visitors and 20 or more residents in the Wing 2 smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/15/14 at 1:55 p.m., an illuminated exit light above the smoke barrier near room 211 hung below the lay in ceiling tile. When the ceiling tile was removed to examine the area above the lay in ceiling, the light fixture dangled from the conduit attached to a junction box. The maintenance director acknowledged at the time of observation, the installation was not fastened in place.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension cords including power strips and nonfused multiplug adapters were not used as a substitute for fixed wiring in 3 of 6 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff, visitors, and 20 or more residents in the 100 Wing, 200 Wing and the therapy smoke compartments.</p> <p>Findings include:</p>		<p>preventative maintenance work order will be added to computer for maintenance director to monitor weekly for improper use of extension cords and power strips.4. Compliance of preventative maintenance work order inspections will be monitored by the Executive Director. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>				

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	<p>Based on observation with the maintenance director on 04/15/14 between 1:15 p.m. and 3:00 p.m., the following was noted:</p> <ul style="list-style-type: none"> a. A power strip was piggybacked to an extension cord to power equipment in the physical therapy department; b. A multitap adapter was screwed into a wall receptacle to provide extra plugs for equipment in room 213; c. A multitap adapter used on an upholstered chair in room 116; <p>The maintenance director acknowledge the aforementioned conditions at the time of observations.</p> <p>3.1-19(b)</p>			