

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155685	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/09/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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K 000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/10//2015 and 02/11/2015 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/09/2015</p> <p>Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130</p> <p>At this PSR survey, Golden Living Center - Elkhart 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 V (111) construction and was fully sprinklered. The original facility (North, East, South Units) were constructed in 1968 with an addition (Primrose and Southwest Units) built in</p>	K 000	Please accept this response of the facility's Plan of Correction for the Life Safety Revisit completed on 4-2-15. I have included several documents to confirm that this citation has been corrected for your review. If possible, I would like to request consideration of a desk review for paper 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 029 SS=E Bldg. 01	<p>1975. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all the resident rooms. The facility has a capacity of 175 and had a census of 175 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>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 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>1. Based on observation and interview, the facility failed to ensure 1 of 1 rolling fire doors at the opening between the kitchen and the main dining room, a hazardous area, would self close upon activation of the fire alarm system. This</p>	K 029	<p><b>K-0029</b></p> <p><b>It is the practice of this facility to maintain compliance with this life</b></p>	04/13/2015

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	<p>deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/09/2015 at 12:30 p.m., there was a rolling fire door in the corridor wall protecting the opening from the kitchen to the main dining room. During a fire alarm trip test the rolling fire door failed to close. Based on interview with the Maintenance Director at the time of observation, he agreed the fire door should have released and closed after the activation of the fire alarm.</p> <p>This deficiency was cited on 02/11/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview the facility failed to ensure the corridor doors to 1 of 1 Kitchens and 1 of 1 Laundry rooms, both hazardous areas, were provided with self closer's and would latch into the frame. This deficient practice was not in a resident care area but could affect staff in the service corridor.</p>				<p><b>safety standard.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p>1) 4T Door Systems provided maintenance to the rolling door on 3-5-15 after the initial citation. At that time the door released and closed properly. It was tested several times after that by our fire monitoring system and the Maintenance Director (3-12 and 4-2) and it worked properly. Unfortunately during the revisit survey on 4-2, the rolling door malfunctioned during the fire testing. Per our POC, facility contacted Safe Care for scheduled maintenance and the system was repaired on 4-9-15. The alarm system has been tested several times since repair and continues to release and close upon activation of the fire alarm system.</p> <p>Attachments:</p> <p>Service Call Logs</p> <p>QA Monitor log</p>		

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director on 04/09/2015 at 12:15 p.m., the two doors entering the laundry room and one door entering the kitchen were large metal sliding doors. Based on interview with the Maintenance Director at the time of observation, the self closing features were no longer functional and none of the doors would self close and latch into the door frame. The Maintenance Director stated the new doors with self closing and latching features were scheduled for installation.</p> <p>This deficiency was cited on 02/11/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		<p>2) The corridor doors at the kitchen and Laundry entrance have been replaced with 4 new 48" fire doors with electronic closures connected to the alarm system. and which latch into the frames. Completion of this project was 4-13-15.</p> <p>Attachments:</p> <p>Pictures</p> <p>Certificate for payment from contractor.</p> <p>-</p> <p><b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p>A facility fire drill was conducted with staff assigned to different areas throughout building to monitor closure of the doors. All areas functioned properly at this time.</p> <p><b><u>Measures put into place to ensure alleged deficient practice does not recur:</u></b></p> <p>The facility system was updated whereas staff are assigned areas</p>	

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			<p>throughout the building during routine fire drills to monitor the closure of the doors properly and to report malfunctions for immediate response. A QA tool was developed for identification of areas that require further action to be communicated to management.</p> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not</u></b></p> <p><b><u>RECUR:</u></b></p> <p>-</p> <p><b>It is the practice of this facility to maintain compliance with this life safety standard,.</b></p> <p><b><u>Corrective Action taken for residents found to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p>1)Facility had originally repaired the rolling window on 3/6/15 after malfunction during our life safety survey. It was tested several times after that, most recently on 3/12 by our alarm monitoring company and was noted to release and close properly when system was activated. Unfortunately on day of revisit the system mis-functioned.</p>		

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			<p>Per our original POC, maintenance repairs were made on 4-2-15 by Safe Care. System has been tested several times since by maintenance department and found to release and close properly when system is activated.</p> <p>Attachments:</p> <p>Service Call Reports</p> <p>QA monitoring Form</p> <p>-</p> <p>-</p> <p><b><u>Identification of other residents with potential to be affected by alleged deficient practice:</u></b></p> <p>-</p> <p>Monthly fire drill completed with staff monitoring at fire doors throughout building. Results find no other affected areas at this time.</p> <p><b><u>Measures put into place to ensure alleged deficient practice does not recur:</u></b></p>	

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			<p>-</p> <p>Staff members are being assigned to monitor the service corridor area and dining room area each month during the fire drills to ensure that areas are functioning properly when the system is activated.</p> <p>Any negative findings will be corrected immediately.</p> <p><b><u>How corrective action will be monitored to ensure alleged deficient practice does not recur:</u></b></p> <p>-</p> <p>ED/Designee will maintain a monitoring log that will be utilized to record all monitoring completed during the fire drills. The log will be reviewed monthly in QAPI</p> <p>-</p> <p>-</p> <p>-</p>	

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			-  -  -  -  <u>Corrective Date:</u>  -	