

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 07/20/2012
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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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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/20/12</p> <p>Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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)</p>	K0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of 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 Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Life Safety Survey on July 20, 2012. 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.</p>	

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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	<p>construction and fully sprinklered.</p> <p>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.</p> <p>The healthcare portion of the facility has a capacity of 67 and had a census of 52 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/30/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 78 healthcare room corridor doors would resist the passage of smoke. This deficient practice could affect any residents near the center nurses' station area.</p> <p>Findings include:</p> <p>Based on observation on 07/20/12 during a tour of the healthcare nurses' station area with the director of plant operations from 10:45 a.m. to 12:45 p.m., the corridor door to the nurses' station nourishment pantry and nurses' station janitor closet room each had a one inch gap from the door latch to the top of the latching sides of each door in the closed position. Furthermore, the nourishment pantry door and the janitor closet door each lacked a latching strike plate for the door to latch into closed. This was verified by the director of plant operations at the time of observations and at the exit conference on 07/20/12 at 1:30 p.m.</p> <p>3.1-19(b)</p>	K0018	<p>K 018 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the Nourishment pantry door and the janitor closet door in the nurse's station area to ensure the corridor doors would resist the passage of smoke: 1. Adjustments were made to each door to correct the one inch gap from the door latch to the top of the latching sides of each door in the closed position. 2. A latching strike plate was installed to each door for the door to latch into closed. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This alleged deficient practice could affect any residents near the center nurses' station area. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Director of Plan Operations or designee 1 times per week times</p>	08/19/2012	

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			4 weeks, then monthly times 5 months to ensure compliance: The Nourishment pantry door and the janitor closet door will be observed to ensure the doors remain adjusted and latching striking plate remains in place to ensure the prevention of passage of smoke. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee 1 times per week times 4 weeks, then monthly times 5 months to ensure compliance: The Nourishment pantry door and the janitor closet door will be observed to ensure the doors remain adjusted and latching striking plate remains in place to ensure the prevention of passage of smoke. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		

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K0021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 7 of 7 sets of smoke barrier doors would remain automatically closed while the fire alarm system was activated and silenced. This deficient practice could affect all residents, staff and visitors in the healthcare portion of the facility.</p> <p>Findings include:</p> <p>Based on observations with the director of plant operations on 07/20/12 during two separate tests of the fire alarm system at 12:10 p.m. and 12:30 p.m., the healthcare nurses' station pull station box was active on both tests, and within ten seconds the fire alarm system main panel, located across from the healthcare nurses' station, was placed in a silence mode. Both tests</p>	K0021	<p>K 021 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the 7 sets of smoke barrier doors to ensure they would remain automatically closed while the fire alarm system was activated and silenced: The campus vendor Simplex was called and an appointment was scheduled for Thursday 8/16/2012 to have the fire panel reprogrammed.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This alleged deficient practice could affect all residents, staff and visitors in the healthcare portion of the facility. Measures put in place and systemic changes</p>	08/19/2012

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	revealed all seven sets of smoke barrier doors in the healthcare portion of the facility remagnetized when the fire alarm system was still in an alarm mode with the main fire alarm panel silenced. This was verified by the director of plant operations at the time of fire alarm system testing, a tour of the smoke barrier doors during two tests of the fire alarm system, and at the exit conference on 07/20/12 at 1:30 p.m. 3.1-19(b)		made to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee at least monthly times 6 months to ensure compliance: During all scheduled and unscheduled tests of the fire alarm system, the 7 sets of smoke barrier doors in the healthcare portion of the facility will be checked to ensure they do not remagnetize when the fire alarm system is still in alarm mode with the main fire alarm panel silenced. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee at least monthly times 6 months to ensure compliance: During all scheduled and unscheduled tests of the fire alarm system, the 7 sets of smoke barrier doors in the healthcare portion of the facility will be checked to ensure they do not remagnetize when the fire alarm system is still in alarm mode with the main fire alarm panel silenced. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observations and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers in 2 of 78 healthcare rooms were constructed to provide at least a one hour fire resistance rating. This deficient practice affects any residents in the facility near the Service Hall maintenance office and the healthcare nurses' station area.</p> <p>Findings include:</p> <p>Based on observations with the director of plant operations on 07/20/12 during a tour of the facility from 10:00 a.m. to 1:20 p.m., the Service Hall maintenance office and the healthcare nurses' station supply storage room each had a three inch circular metal</p>	K0025	<p>K 025 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the 1 of 1 ceiling smoke barrier in the 2 health center rooms located in the Service Hall maintenance office and the health center nurses' station supply storage room to ensure the construction will provide at least a one hour fire resistance rating: the ceiling smoke barrier in these areas will be re-caulked with fire caulking.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This alleged deficient practice could affects any residents in the facility near the Service Hall maintenance office and the healthcare nurses' station area.</p> <p>Measures put in place and systemic changes made to</p>	08/19/2012

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	<p>conduit with cable television and computer cables penetrating through to the attic with both circular conduits open between each room and the attic space above with no fire stopping material used to seal each penetration. This was verified by the director of plant operations at the time of observations and confirmed at the exit conference on 07/20/12 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee one time per week times 4 weeks, then monthly times 5 months to ensure compliance: Audit the fire caulking that was installed to ensure it remains intact. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee one time per week times 4 weeks, then monthly times 5 months to ensure compliance: Audit the fire caulking that was installed to ensure it remains intact. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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K0027 SS=E	<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 7 sets of smoke barrier doors in the healthcare portion of the facility would restrict the movement of smoke for at least 20 minutes. LSC, Section 18.3.7.6 requires 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 any residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the director of plant operations on 07/20/12 at 11:20 a.m., the main dining room smoke barrier doors were closed on three separate</p>	K0027	<p>K 027</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the 1 set of smoke barrier doors in the healthcare portion of the facility to ensure it will restrict the movement of smoke for at least 20 minutes: adjustment made to the door to comply with the requirement that requires doors in smoke barriers to close the opening only leaving only a minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and</p>	08/19/2012			

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	attempts and left a two inch gap in the closed position. This was verified by the director of plant operations at the time of observation and confirmed at the exit conference on 07/20/12 at 1:30 p.m. 3.1-19(b)		<p>corrective actions taken: This alleged deficient practice could affect any residents who use the main dining room.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: the set of barrier doors located in the healthcare portion of the facility will be observed to ensure to close the opening only leaving only a minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: the set of barrier doors located in the healthcare portion of the facility will be observed to ensure to close the opening only leaving only a minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke.</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of 9 hazardous areas such as a kitchen and soiled linen room, were provided with smoke tight doors. This deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen, and any residents near the healthcare nurses' station.</p> <p>Findings include:</p> <p>Based on observations on 07/20/12 during a tour of the facility with the director of plant operations from 10:00 a.m. to 1:20 p.m., the kitchen door to the Service Hall had a one half inch circular hole in the door near the latching hardware. Based on an interview with the director of plant operations on 07/20/12 at 11:55 a.m., the door had new latching hardware installed and a hole was left in the door. Furthermore, based on observation on 07/20/12 at 12:20 p.m. with the director of plant operations, the healthcare nurses'</p>	K0029	<p>K 029</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the corridor door to 2 hazardous areas such as a kitchen and soiled linen room to ensure they are provided with smoke tight doors: 1. A face plate will be installed to cover the hole in the service hall kitchen door. 2. The door to the nurse's station soiled linen room door will be properly adjusted to ensure it latches into the door frame, preventing the gap along the latching side of the door.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This alleged deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen, and any residents near the healthcare</p>	08/19/2012			

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	<p>station soiled linen room door failed to latch into the door frame, leaving a one half inch gap along the latching side of the door. This was verified by the director of plant operations at the time of observations and confirmed at the exit conference on 07/20/12 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>nurses' station.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: 1. will observe the kitchen door to the service hall to ensure the face plate remains in place to provide a smoke tight door. 2. Will observe the door to the nurse's station soiled linen room to ensure it latches into the door frame, preventing the gap along the latching side of the door to ensure a smoke tight door is provided.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: 1. will observe the kitchen door to the service hall to ensure the face plate remains in place to provide a smoke tight door. 2. Will observe the door to the nurse's station soiled linen room to ensure it latches into the door frame, preventing the gap along the latching side of the door to ensure a smoke tight door is</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 78 room sprinkler heads in the facility were maintained. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 07/20/12 at 11:25 a.m. with the director of plant operations, the kitchen sprinkler above the automatic dishwashing machine had the escutcheon not tight fitting to the drywall ceiling leaving a two inch gap around the area where the sprinkler penetrated the ceiling into the attic space above. This was verified by the director of plant operations at the time of observation and confirmed at the exit conference on 07/20/12 at 1:30 p.m.</p> <p>3.1-19(b)</p>	K0062	<p>K 062</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The following corrections were made to the 1 sprinkler head located in the kitchen to ensure a tight fit to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling into the attic space above: the Escutcheon will be adjusted to a tight fit to the drywall.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: This alleged deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The following audit observation will be conducted by the Director of Plan Operations or designee weekly</p>	08/19/2012	

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			<p>times 4 weeks, then monthly times 5 months to ensure compliance: observe the sprinkler head in the kitchen to ensure a tight fit remains to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling into the attic space above.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur The following audit observation will be conducted by the Director of Plan Operations or designee weekly times 4 weeks, then monthly times 5 months to ensure compliance: observe the sprinkler head in the kitchen to ensure a tight fit remains to the dry wall without leaving a gap around the area where the sprinkler penetrates the ceiling into the attic space above.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	