

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0000	<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: 05/01/12 and 05/02/12</p> <p>Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Courtyard Healthcare Center 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) and 410 IAC 16.2. The original section of the building consisting of the A Wing, B Wing, the C wing and the main dining room was surveyed with Chapter 19, Existing Health Care</p>	K0000	<p>Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conducted on 5/2/2012. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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			
	<p>Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident rooms. The facility has a capacity of 188 and had a census of 140 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/11/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0025 SS=E	<p>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 1 of 3 smoke barrier walls was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. Penetrations caused by the passage of wire and/or conduit through the smoke barrier wall were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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</p>	K0025	<p>K025 NFPA LIFE SAFETY CODE STANDARD Facility will continue to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Corrective Actions: The Cedar Wing smoke barrier wall, noted in the CMS 2567, has been repaired so as to ensure compliance with the Life Safety Code Standard. Additional drywall has been installed atop the drop down ceiling and the penetrations noted have been sealed. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been trained on the requirements relating to smoke barriers. Monitoring: Future work in and above the ceiling, completed by contractors, will be signed off my maintenance staff to ensure that smoke barriers have not been breached.</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>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. This deficient practice could affect any resident in C wing common area and C wing 3 hall.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 10:40 a.m., the dry wall stopped six inches short of the roof deck above the drop down ceiling at the C wing 3 hall smoke barrier wall. The remaining six inches were stuffed with fiberglass insulation. Seven of seven penetrations ranging in size from one foot to one inch were unsealed around conduit lines and the main sprinkler. Measurements were provided by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		Date of Completion: June 1, 2012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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			
K0029 SS=E	<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 roll down doors at the openings in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect all residents in the main hall dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 11:50 a.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the</p>	K0029	<p>K029 NFPA LIFE SAFETY CODE STANDARD Facility will continue to ensure that an automatic fire extinguishing system protects hazardous areas by separating hazardous areas by the use of smoke resisting partitions and doors. Corrective Actions: The roll down door at the openings in the kitchen wall has been tied into the fire system, ensuring that the window will close upon activation of the fire system. The dish machine room corridor door has been equipped with a latch and panic hardware to allow access in and out of the dishroom. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Inspection of the kitchen window and assurance of its proper operation has been added to the list of items inspected regularly by the fire and sprinkler inspection company. Monitoring: Fire Drill</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling fire door with a fusible link. Based on interview with Director of Maintenance Director at the time of observation, the rolling fire door does not close upon activation of the fire alarm.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 dish machine room corridor doors on the service hall closed and latched into the door frame. This deficient practice was in the service hall and could affect any of staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 1:20 p.m., the corridor door to the dish machine room in the service hall lacked latching hardware and did not latch into the door frame. The</p>		<p>form has been amended to include visual verification that the roll down door closed upon activation of the fire system. The monthly Fire Drill Reports will be forwarded to the facility's Safety and Performance Improvement Committee for review for the next six months. Date of Completion: June 1, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	dish machine room was open to the rest of the kitchen. This was acknowledged by the Director of Maintenance observation. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 7 of 13 doors in the path of egress equipped with a magnetic locking system remained unlocked with activation of the building fire alarm system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect any number of residents in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observations with the Administrator in Training and the Director of Maintenance on 05/02/12 from 2:00 p.m. to 2:12 p.m., the C wing 1 hall, 2 hall and lounge exit doors; the B wing 3 hall and the lounge exit doors;</p>	K0038	<p>K038 NFPA 101 LIFE SAFETY CODE STANDARD Facility will continue to have its exits arranged so as to be readily accessible at all times.</p> <p>Corrective Actions: The magnetically locked doors noted in the CMS 2567 have been tied to the fire system to ensure they unlock with the activation of the building fire alarm system. A concrete pad has been poured, linking the activity courtyard sidewalk to the parking lot, thus ensuring access to a public way.</p> <p>How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been trained on the requirements for doors unlocking when the building fire alarm system has been activated and the requirements for exits leading to a public way.</p> <p>Monitoring: Fire Drill form has been amended to include the magnetic unlocking of doors upon activation of the fire alarm system. The monthly Fire Drill Reports will be forwarded to the facility's Safety and Performance Improvement Committee for review for the next six months.</p> <p>Date of Completion: June 1, 2012</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>and the main dining room and therapy room exit doors which were equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence mode. This was acknowledged by the Administrator in Training and the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 13 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affects any occupants evacuated through the main dining room and the activity room exits.</p> <p>Findings include:</p> <p>Based on observations with Administrator in Training and the Director of Maintenance on 05/02/12 at 11:35 a.m., the main dining room and the activity room exited onto the same sidewalk. This sidewalk ended at a path of grass measuring fifteen feet to the public way. Measurements were provided by the Director of Maintenance at the time of observation. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0046 SS=E	<p>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> <p>Based on observation and interview, the facility failed to provide exterior emergency light for 1 of 13 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants evacuated through the corridor exit across from the therapy room.</p> <p>Findings include:</p> <p>Based on observations with the Administrator in Training and the Director of Maintenance on 05/02/12 at 12:35 p.m., exterior lights were observed under the canopy at the exit across from the Therapy room and there were no battery operated exterior emergency lights provided. Based on an interview with the Director of Maintenance at the time of observation, he could not confirm the exterior lights were on emergency power.</p>	K0046	<p>K046 NFPA 101 LIFE SAFETY CODE STANDARD Facility will continue to ensure that exterior emergency lighting of at least 1 ½ hours is provided at exists as per 7.9. Corrective Actions: The lighting noted in the CMS 2567, that outside the corridor exit across from the therapy room, has been tied to the emergency generator, thus meeting the requirement. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been trained on what the requirements for exit lighting. Monitoring: Exit lighting at all exits, including the exit noted in the CMS 2567, will be checked monthly to ensure its proper functioning. Said checks will be submitted to the facility's Performance Improvement Committee monthly for review for each meeting conducted in the next six months. Date of Completion: June 1, 2012</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 2 sprinkler heads was unobstructed in the C wing lounge. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any resident in the C wing lounge.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/01/12 at 2:55 p.m., a ceiling mounted sprinkler head was located within one inch of a book case. The book case obstructed</p>	K0062	<p>K062 NFPA 101 LIFE SAFETY CODE STANDARD The facility will continually to maintain required automatic sprinkler systems in reliable operating condition and have them inspected and tested periodically. Corrective Actions: Sprinkler head noted in CMS 2567 has been moved so as to ensure the spray pattern. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been re-trained on sprinkler head placement requirements. Monitoring: Sprinkler system will be inspected as per the requirement and the documentation of all said inspections occurring will be reviewed by the facility's Performance Improvement Committee for the next six months. Date of Completion: June 1, 2012</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>the sprinkler spray pattern. Measurements were provided by the Administrator in Training at the time of observation.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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			
K0064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 K-class portable fire extinguisher was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 1:30 p.m., the annual maintenance tag on the kitchen K-class portable fire extinguisher indicated the last annual inspection occurred in November 2010. This was acknowledged by the Administrator in Training and the Director of Maintenance at the</p>	K0064	<p>K064 NFPA 101 LIFE SAFETY CODE STANDARD The facility will continue to provide portable fire extinguishers. Corrective Actions: The K-class fire extinguisher noted in the CMS 2567 has been inspected and a new tag has been placed on the extinguisher. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance staff has been re-trained on the maintenance of fire extinguishers, as has the company that regularly inspects the facility's fire extinguishers. Monitoring: The facility's preventive maintenance for fire extinguishers has been amended to include the date of the fire extinguisher's last inspection. These preventive maintenance records will be submitted to the facility's Performance Improvement Committee for review at each P.I. meeting held in the next six months. Date of Completion: June 1, 2012</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	time of observation. 3.1-19(b)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen cylinders in the B wing oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any resident near the B wing oxygen storage room.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 11:50 a.m., there was an unsupported "E" cylinder of</p>	K0076	<p>K076 NFPA LIFE SAFETY CODE STANDARD Facility will continue to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. Corrective Actions: The e-cylinder noted in the CMS 2567 has been removed from the facility. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance, Central Supply, Administrative, and Nursing Administrative staff has been trained on the oxygen storage requirement. Nursing staff training is in process and will be completed before June 1, 2012. Monitoring: Oxygen storage rooms will be visually inspected weekly for adherence to this requirement. These inspections will be submitted to the facility's Performance Improvement Committee for review at each P.I. meeting held</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>compressed oxygen in the B wing oxygen storage room. This was acknowledged by the Administrator in Training at the time of observation.</p> <p>3.1-19(b)</p>		<p>in the next six months. Date of Completion: June 1, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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			
K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 29 penetrations of the fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item</p>	K0130	<p>K130 NFPA 101 MISCELLANEOUS Facility will continue to ensure compliance with K130 relating to boiler inspections. Corrective Actions: The Dogwood Unit boilers have been inspected by the Department of Homeland Security certifying that they were in safe operating condition. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been trained on boiler inspection/certificate requirements. Monitoring: Fire Drill form has been amended to include visual verification that the roll down door closed upon activation of the fire system. The monthly Fire Drill Reports will be forwarded to the facility's Safety and Performance Improvement Committee for review for the next six months. Date of Completion: June 1, 2012</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all occupants near the main entrances and common area and near the fire walls in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Director of Maintenance on 05/02/12 from 11:10 a.m. to 11:18 a.m., the following fire barrier walls had unsealed penetrations:</p> <p>a. one of thirteen penetrations above the drop down ceiling at the fire barrier wall entering C wing was unsealed measuring three inches around a conduit line,</p> <p>b. one of ten penetrations above</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>the drop down ceiling at the fire barrier wall entering B wing was unsealed around a three inch sleeve,</p> <p>c. two of six penetrations above the drop down ceiling at the fire barrier wall entering D wing were unsealed around conduit lines. Measurements were confirmed by the Director of Maintenance. Based on an interview with the Director of Maintenance at the time of observations, these were fire barrier walls.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 12:18 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview with the Director of Maintenance 05/02/12 at 12:30 p.m., there was no documentation of an annual inspection for the rolling fire door.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 emergency generators were equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p>	K0144	<p>K144 NFPA 101 LIFE SAFETY CODE STANDARD The facility will continue to ensure that generators are inspected weekly and exercised under load for 30 minutes per month. Corrective Actions: A remote manual stop has been installed for each of the two generators noted in the CMS 2567. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance staff has been retrained on the generator requirements of K144. Monitoring: Generators have been placed on a weekly preventive maintenance schedule. Results of these checks will be submitted to the facility's Performance Improvement Committee for review for the next six months. Date of Completion: June 1, 2012</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Administrator in Training on 05/01/12 from 11:00 a.m. to 3:00 p.m. and 05/02/12 from 10:40 a.m. to 3:10 p.m., the facility did not have a remote manual stop for the emergency generators. Based on an interview with the Director of Maintenance on 05/02/12 at 1:40 p.m., both of the generators are new. One was installed 2010 and the other in 2011.</p> <p>3-1.19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
(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			
K0147 SS=E	<p>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 6 of 6 flexible cords such as an extension cord was not used as a substitute for fixed wiring. 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 could affect 8 of 140 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Director of Maintenance on 05/02/12 from 11:35 p.m. to 12:15 p.m., extension cords were noted in the following locations:</p> <p>a) resident room 130 to a TV box and a clock b) resident room 117 to a lamp and another heavy duty extension cord was providing power to a TV</p>	K0147	<p>K147 NFPA 101 LIFE SAFETY CODE STANDARD The facility will continue to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electric Code. Corrective Actions: Extension cords have been removed from rooms 103, 111, 117, and 130. In rooms where power strip usage is prohibited and electrical access was inadequate, facility has installed additional outlets to accommodate electrical devices. The GFCI outlet in Cedar Wing storage room has been replaced. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Admissions, Maintenance, Administrative, and Nursing Administrative staff has been trained on the prohibition of extension cords & multi-plug outlets and the limited usage of power strips. Admission Agreement has been amended to include language prohibiting the use of extension cords in resident rooms. Monitoring: Resident rooms will be inspected to ensure that extension cords are not being used and that power strip usage is congruent with the requirement. One hallway will be</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>and another extension cord was providing power to a light.</p> <p>c) resident room 111 to a microwave and a refrigerator</p> <p>d) resident room 103 to a chair</p> <p>This was acknowledged by the Administrator in Training and the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 staff wet locations such as C wing storage room was provided with ground fault circuit interrupter (GFCI) against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body,</p>		<p>inspected weekly for each of the next 24 weeks so each room will be inspected at least twice during that period of time to ensure compliance with K147.</p> <p>Results of these checks will be submitted to the facility's Safety & Performance Improvement Committee for review for the next six months.</p> <p>Date of Completion: June 1, 2012</p> <p>Resident rooms will be inspected to ensure that extension cords are not being used and that power strip usage is congruent with the requirement. One hallway will be inspected weekly for each of the next 24 weeks so each room will be inspected at least twice during that period of time to ensure compliance with K147. Results of these checks will be submitted to the facility's Safety & Performance Improvement Committee for review for the next six months.</p> <p>Date of Completion: June 1, 2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>and electrical insulation is more subject to failure. This deficient practice could affect any staff in the C wing storage room.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator in Training and the Director of Maintenance on 05/01/12 at 2:38 p.m., an electrical receptacle on the wall was within three feet of a sink in the C wing storage room. The receptacle was provided with GFCI protection at the breaker but when the test button was pressed by the Director of Maintenance, power was not interrupted at the receptacle. Based on an interview with the Director of Maintenance at the time of observation, the breaker was not working properly.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0000	<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: 05/01/12 and 05/02/12</p> <p>Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Courtyard Healthcare Center 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) and 410 IAC 16.2. The new 2011 addition of the building consisting of the D Wing was surveyed with Chapter 18, New Health Care Occupancies.</p>	K0000	<p>Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conducted on 5/2/2012. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident rooms. The facility has a capacity of 188 and had a census of 140 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 D wing boilers had a current inspection certificate to ensure the boilers were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect any number of occupants entering the D wing.</p> <p>Findings include:</p> <p>Based on observation with the Administrator in Training and the Director of Maintenance on 05/02/12 at 12:40 p.m., the two D wing boilers lacked a certificate of inspection. Based on an interview with the Director of Maintenance at the time of observation, he does not believe these two boilers have been inspected.</p> <p>3.1-19(b)</p>	K0130	<p>K130 NFPA 101 MISCELLANEOUS Facility will continue to ensure compliance with K130 relating to boiler inspections. Corrective Actions: The Dogwood Unit boilers have been inspected by the Department of Homeland Security certifying that they were in safe operating condition. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance Supervisor has been trained on boiler inspection/certificate requirements. Monitoring: Fire Drill form has been amended to include visual verification that the roll down door closed upon activation of the fire system. The monthly Fire Drill Reports will be forwarded to the facility's Safety and Performance Improvement Committee for review for the next six months. Date of Completion: June 1, 2012</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526
---	---

(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
K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 emergency generators were equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p>	K0144	<p>K144 NFPA 101 LIFE SAFETY CODE STANDARD The facility will continue to ensure that generators are inspected weekly and exercised under load for 30 minutes per month. Corrective Actions: A remote manual stop has been installed for each of the two generators noted in the CMS 2567. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Maintenance staff has been retrained on the generator requirements of K144. Monitoring: Generators have been placed on a weekly preventive maintenance schedule. Results of these checks will be submitted to the facility's Performance Improvement Committee for review for the next six months. Date of Completion: June 1, 2012</p>	06/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526		
(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	
	<p>Findings include:</p> <p>Based on observation with the Director of Maintenance and the Administrator in Training on 05/01/12 from 11:00 a.m. to 3:00 p.m. and 05/02/12 from 10:40 a.m. to 3:10 p.m., the facility did not have a remote manual stop for the emergency generators. Based on an interview with the Director of Maintenance on 05/02/12 at 1:40 p.m., both of the generators are new. One was installed 2010 and the other in 2011.</p> <p>3-1.19(b)</p>				