

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
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K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/27/15</p> <p>Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400</p> <p>At this Life Safety Code survey, Golden Living Center-Mishawaka was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke</p>	K 000	<p>Disclaimer Statement: Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal and State Law. This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement.</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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K 022 SS=E Bldg. 01	<p>detectors are provided all resident sleeping rooms. The facility has a capacity of 87 and had a census of 66 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered garage and storage shed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 10 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect residents in the 100 Hall smoke compartment.</p> <p>Findings include:</p>	K 022	<p>1. A sign stating "push until alarm sounds door can be opened in 15 seconds" was placed at the 100 hall exit door. 2. No other residents are affected. 3. A monthly check will be added to our preventative maintenance plan. 4. Preventative maintenance work order inspections will be monitored by the ED for compliance. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>	05/27/2015

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K 025 SS=E Bldg. 01	<p>Based on observation with the Maintenance Supervisor on 04/27/15 at 2:16 p.m., the 100 Hall exit door was equipped with an electromagnetic lock that released after 15 seconds. This exit door lacked a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." Based on interview at the time of observation, the Maintenance Supervisor acknowledged the deficiency.</p> <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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires</p>	K 025	1. The area above the ceiling tile was sealed. The brown caulk was removed and red caulking was used which has the proper documentation. The maintenance office ceiling was also sealed to prevent smoke penetration. 2. No other residents were affected. 3. All	05/27/2015

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	<p>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 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 residents, as well as staff and visitors in the 100 Hall smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director on 04/27/2015 at 2:44 p.m. the 100 Hall smoke barrier wall had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a four inch by 6 inch hole in the drywall. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor.</p> <p>b. Based on observation with Maintenance Director on 04/27/2015 at 2:44 p.m., above the ceiling tile in the 100 Hall smoke barrier wall was sealed with brown caulk. Based on interview at the time of observation, the Maintenance</p>		<p>work by outside vendors will be monitored and checked after completion by the maintenance supervisor to ensure any areas needing sealing or caulking will be completed. 4. Maintenance Supervisor will share any areas needing sealing or caulking with Executive Director for vendor following up. Results will be shared during QAPI for further monitoring for compliance on an ongoing basis as needed.</p>	

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K 029 SS=D Bldg. 01	<p>Supervisor was unable to provide documentation for the caulk used.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect mostly staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 04/27/15 at 12:19 p.m., the Maintenance Office had a one inch unsealed ceiling penetration. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the unsealed ceiling penetration.</p> <p>3.1-19(b)</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</p>						

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	<p>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 deficient practice could affect residents, as well as staff and visitors while in the Main Dining Room.</p> <p>Findings include: Based on observation with the Maintenance Supervisor on 04/27/15 at 1:44 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview at the time of observation, the Maintenance Supervisor was unable to provide documentation to show that the rolling fire door was inspected/tested within the past twelve months.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 kitchen doors latched into the door frame. This deficient practice could affect residents, as well as staff and visitors while in the</p>	K 029	<p>1. The rolling fire doors are now self closing upon activation of the fire alarm system. 2. No additional people were affected. 3. They will be tested once a quarter during fire drills and inspected yearly by an outside vendor. 4. The Maintenance Supervisor will report any non compliance of activation of the fire alarm system to the Execurtive Director. Adverse results will be shared during monthly QAPI meetings on a continual basis.</p>	05/27/2015

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K 039 SS=E Bldg. 01	<p>main dining room and at least 16 residents, staff and visitors while in the smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 1:52 p.m., two kitchen tray doors going in and out of the kitchen to an exit corridor did not latch into the door frame when tested. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 exit access corridors in the 100 Hall were readily accessible and unobstructed at all times. This deficient practice could affect 16 residents, as well as staff and visitors on 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 2:22 p.m., a food serving cart was stored</p>	K 039	<p>1. The serving cart was moved to another area to have a clear exit path. 2. No additional people are affected. 3. All staff were inserviced on storing the serving cart in the new area and why this is necessary. 4. Rounds will be done seven times per week by the Executive Director and/or designee. Results will be shared during QAPI to determine if further education and/or monitoring is needed.</p>	05/27/2015

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K 044 SS=E Bldg. 01	<p>outside the Dietary/Food Service Room reducing the clear unobstructed width to 36 inches. Based on interview at the time observation, the Maintenance Supervisor stated the serving cart is stored in the corridor after meals are served. The Maintenance Supervisor acknowledged this deficiency.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4. 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect residents, as well as staff and visitors while in the Main Dining Room.</p> <p>Findings include:</p>	K 044	<p>1. The doors were repaired so they latch when closed. 2. All are affected equally. 3. Doors will be tested once a month during fire alarm drills. 4. Results of drills will be shared with Executive Director. ED will share adverse results at QAPI meeting for follow up repairs and increase monitoring.</p>	05/27/2015

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K 045 SS=E Bldg. 01	<p>Based on observation on 04/27/15 between 12:42 p.m. and 1:44 p.m.. the following was discovered.</p> <p>a. Fire doors near resident room 211 failed to latch when tested.</p> <p>b. Fire doors separating the Main Dining room from resident rooms failed to latch when tested.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged both sets of doors were fire doors and would not latch into their frames.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting for 2 of 2, 200 Hall 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 residents, as well as staff and visitors in the 200 Hall if evacuated through these exits.</p> <p>Findings include:</p>	K 045	<p>1. Exterior lighting was installed to the emergency exit near rooms 216 and 230. 2. No additional people were affected. 3. The lights were added to our preventative maintenance check list for exterior lighting. 4. Any adverse results will be shared with Executive Director for follow up in QAPI meetings. It will then be determined if more frequent monitoring is needed for compliance.</p>	05/27/2015			

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K 050 SS=F Bldg. 01	<p>Based on observation on 04/27/15 at 12:26 p.m. during a tour of the facility with the Maintenance Supervisor the facility lacked exterior lighting to the public way at the exit discharges near resident rooms 216 and 230. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each deficiency.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview the facility failed to document the simulation of emergency fire conditions for 12 of 12 fire drills. This deficient practice could affect all occupants in the facility including residents, staff, and visitors.</p> <p>Findings included:</p> <p>Based on record review on 04/27/2015 at</p>	K 050	<p>1. Going forward the maintenance director will indicate on the "Report of Fire Drill Exercise" where the simulated fire conditions occurred. 2. No additional residents, staff or visitors affected. 3. Maintenance Supervisor was educated by the surveyor on adding this additional detail to Fire Drill Exercises. 4. Executive Director will monitor monthly by reviewing Fire Drill Exercise report. Results will</p>	05/27/2015

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K 062 SS=E Bldg. 01	<p>10:53 a.m., the document titled "Report of Fire Drill Exercise" revealed all 12 of the fire drills conducted during the past 12 months lacked documentation of the fire drill simulation of emergency fire conditions. Based on interview at the time of review, this deficient practice was confirmed by the Maintenance Supervisor.</p> <p>3.1-19(b) 3.1-51(c)</p> <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 replace 6 of 6 sprinkler heads outside the employee entrance which were covered with green corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall 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, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect residents, staff and</p>	K 062	<p>be shared during QAPI meeting to determine if further education is needed.</p> <p>1. The six sprinkler heads will be replaced. 2. No additional people affected. 3. Sprinkler heads will be visually checked weekly by Maintenance Supervisor during his rounds. Any concerns will be shared with Executive Director for further follow up. 4. Sprinkler heads will be visually checked every six months by our contracted vendor. Findings will be shared at QAPI meeting to determine further action.</p>	05/27/2015			

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K 064 SS=D Bldg. 01	<p>visitors in and near the employee entrance which enters the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 2:33 p.m., six of six automatic sprinklers outside the employee entrance were covered with green corrosion. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the six sprinkler heads were covered with corrosion.</p> <p>3.1-19(b)</p> <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 portable fire extinguisher in the Beauty Shop was readily accessible. NFPA 10, 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. NFPA 10, 1-6.6 requires fire extinguishers shall not be obstructed or obscured from view. This deficient</p>	K 064	<p>1. The shelving was moved to allow easy access to fire extinguisher.2. No additional people affected.3. Maintenance will observe all locations and accessibility of fire extinguishers during monthly checks. Beautician was instructed on regulation regarding accessibility.4. Maintenance Supervisor will report findings to Executive Director for further follow up. Information will be shared at QAPI meeting to determine if education and/or monitoring is needed.</p>	05/27/2015

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K 066 SS=D Bldg. 01	<p>practice could affect up to 2 residents and staff in the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 1:22 p.m., access to the portable fire extinguisher located in the Beauty Shop was blocked by shelving. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the inaccessibility of the fire extinguisher.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
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K 068 SS=D Bldg. 01	<p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 areas where smoking was permitted for staff and residents were maintained, and the metal containers with self-closing covers were used for ashtrays. This deficient practice could affect at least 3 residents and facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/27/15 at 1:14 p.m. the Maintenance Supervisor acknowledged the designated smoking area called the "Back Patio" had a smoking container without a lid.</p> <p>Based on observation and interview on 04/27/15 there were 18 cigarette butts on the ground in the non-designated resident smoke area near the employee entrance.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for</p>	K 066	<p>1. A new cigarette container with cover was placed in "Back Patio".</p> <p>2. No additional people affected.</p> <p>3. Staff inserviced on designated areas to smoke. Sign stating no smoking within 8 feet in place. 4. Maintenance Supervisor will monitor weekly on an ongoing basis. Results will be shared with Executive Director to be reviewed during QAPI to determine if education and/or increased monitoring is needed.</p>	05/27/2015
		K 068	<p>1. A fresh air intake was placed in the laundry room. 2. No residents are affected. 3. No other areas noted to need a fresh air intake. 4. Environmental</p>	05/27/2015

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K 072 SS=E Bldg. 01	<p>rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 04/27/15 at 2:26 p.m., the laundry room had fuel fired dryers with no fresh air intake. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect 16 residents, as well as staff and visitors on 100 Hall.</p> <p>Findings include:</p>	K 072	<p>Supervisor will monitor weekly to be sure intake work has fixed the issue. Any adverse issues will be shared with Executive Director for follow up during QAPI to determine if another solution is needed.</p> <p>1. Cart and lift were removed immediately. 2. No additional residents or staff affected. 3. Staff inserviced on importance of keeping exit paths clear. Managers will be monitoring daily. 4. Any instances of equipment blocking exit doors will be reported to Executive Director and/or designee. Information will be</p>	05/01/2015			

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K 076 SS=E Bldg. 01	<p>Based on observation with the Maintenance Supervisor on 04/27/15 at 2:11 p.m., a lift and linen cart was stored in front of an exit door near resident room 100. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the storage in front of the exit door.</p> <p>3.1-19(b)</p> <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 2 of 5 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff in the Oxygen Supply</p>	K 076	<p>shared during QAPI to determine if further education and/or monitoring is needed.</p> <p>1. Chains were added to room to secure all cylinders. 2. All residents, staff and visitors equally affected. 3. Oxygen rooms will be monitored for compliance by the Maintenance Supervisor 3 times a week. 4. Any instances of non compliance will be reported to Executive Director for follow up. Findings will be shared during QAPI to determine if monitoring needs increased and/or education provided.</p>	05/27/2015

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K 147 SS=D Bldg. 01	<p>Room and any resident near this room in the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 1:37 p.m., two oxygen cylinders were standing in the Oxygen Supply Room without support. The Maintenance Supervisor agreed at the time of observation, the cylinders should have been in properly secured stands or carts.</p> <p>3.1-19(b)</p> <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 1 of 1 flexible cords such as extension cord power strips were 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</p>	K 147	<p>1. a. Extension cord power strip was removed.b. Extension cord was removed.c. One extension cord power strip was removed.d. Multiplug adapter was removed. e. Both multiplug adapters were removed.f. Both items plugged into wire plug mold installed by licensed electrician.g. Air conditioner plugged directly into electrical socket.Face plate was replaced in bookkeepers office. The junction box in Fire Sprinkler Riser Room now has a cover. Removed wire and conduit from junction box.2. Staff equally affected.3. Power and extension cords and other</p>	05/27/2015

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	<p>affect at least 12 residents, as well as staff and visitors in the 100 Hall, plus staff and visitors throughout the rest of the facility.</p> <p>Findings include: Based on an observations with the Maintenance Supervisor on 04/27/15 between 12:37 p.m. and 2:07 p.m., the following was discovered:</p> <ul style="list-style-type: none"> a. an extension cord power strip was plugged in and providing power to another extension cord power strip in the Medical Records room. b. an extension cord was powering a radio in the Social Services office. c. an extension cord power strip was plugged in and providing power to another extension cord power strip at the nurses' station in the 100 Hall. d. a multiplug adapter was powering a meat slicer and radio in the Main Kitchen. e. two separate multiplug adapters in use in the Receptionist office. f. a multiplug adapter powering a refrigerator and all-in-one printer in the Executive Director office. g. an extension cord power strip powering an air conditioner in the 		<p>electical items will be checked during monthly preventative maintenance 4. Issues found will be reported to Executive Director and shared during QAPI meeting. It will be determined if further education and/or increased rounds is needed.</p>	

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	<p>Executive Director office.</p> <p>At the time of each observation the Maintenance Supervisor acknowledged each deficiency.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 electrical outlets in the Business Office which was located in the 100 Hall. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect mostly staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 1:41 p.m., an electric receptacle in the Business Office in the 100 Hall was not provided with a cover. The Maintenance Supervisor acknowledged at the time of observation, the wiring should have been protected by a face plate.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview,</p>			

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K 154 SS=F Bldg. 01	<p>the facility failed to provide a covered junction box for electrical wiring in 1 of 1 sprinkler riser rooms. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/15 at 2:15 p.m., two wire wing nuts with wires were exposed outside of conduit in the Fire Sprinkler Riser Room. The Maintenance Supervisor acknowledged at the time of observation, the wires and wing nuts should have been protected. 3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be</p>	K 154	1. The Indiana State Department of Health was added to policy containing procedures to be	05/27/2015			

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K 155 SS=F Bldg. 01	<p>followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 66 of 66 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 04/27/15 at 11:55 a.m., the facility had a document titled "Fire Plan" for a sprinkler system failure, but did not address all components of LSC Section 9.7.6.1. Specifically, the plan did not include notification of the outage to the Indiana State Department of Health as an authority having jurisdiction.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour</p>		<p>followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period. 2. All residents are affected. 3. After adding ISDH to policy, no further monitoring is needed. 4. Polycys will be reviewed yearly for needed updates. Any changes will be reviewed in Safety Committee and QAPI meetings.</p>	

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K 000	<p>period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to protect 66 of 66 clients by providing a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Fire Plan" with the Maintenance Supervisor on 04/27/2015 at 11:55 a.m., the facility had a written policy and procedure for an impaired fire alarm system. The policy did not include notifying the Indiana State Department of Health. Based on an interview with the Maintenance Supervisor at the time of record review, he acknowledged the procedure did not indicate the facility shall contact the Indiana State Department of Health.</p> <p>3.1-19(b)</p>	K 155	<p>1. The Indiana State Department of Health was added to our policy containing procedures for an impaired fire alarm system. 2. All residents are affected. 3. After adding ISDH to policy, no further monitoring is needed. 4. Polycys will be reviewed yearly for needed updates. Any changes will be reviewed in Safety Committee and QAPI meetings.</p>	05/27/2015

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Bldg. 02	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/27/15</p> <p>Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400</p> <p>At this Life Safety Code survey, Golden Living Center-Mishawaka was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke detectors are provided all resident</p>	K 000	<p>Disclaimer Statement: Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal and State Law. This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement.</p>	
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K 050 SS=F Bldg. 02	<p>sleeping rooms. The facility has a capacity of 87 and had a census of 66 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered garage and storage shed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview the facility failed to document the simulation of emergency fire conditions for 12 of 12 fire drills. This deficient practice could affect all occupants in the facility including residents, staff, and visitors.</p> <p>Findings included:</p> <p>Based on record review on 04/27/2015 at 10:53 a.m., the document titled "Report of Fire Drill Exercise" revealed all 12 of the fire drills conducted during the past 12 months lacked documentation of the</p>	K 050	<p>1. Going forward the maintenance director will indicate on the "Report of Fire Drill Exercise" where the simulated fire conditions occurred. 2. No additional residents, staff or visitors affected. 3. Maintenance Supervisor was educated by the surveyor on adding this additional detail to Fire Drill Exercises. 4. Executive Director will monitor monthly by reviewing Fire Drill Exercise report. Results will be shared during QAPI meeting to determine if further education is needed.</p>	05/27/2015			

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K 154 SS=F Bldg. 02	<p>fire drill simulation of emergency fire conditions. Based on interview at the time of review, this deficient practice was confirmed by the Maintenance Supervisor.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 66 of 66 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and</p>	K 154	<p>1. The Indiana State Department of Health was added to policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period. 2. All residents are affected. 3. After adding ISDH to policy, no further monitoring is needed. 4. Policys will be reviewed yearly for needed updates. Any changes will be reviewed in Safety Committee and QAPI meetings.</p>	05/27/2015	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
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(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
K 155 SS=F Bldg. 02	<p>other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 04/27/15 at 11:55 a.m., the facility had a document titled "Fire Plan" for a sprinkler system failure, but did not address all components of LSC Section 9.7.6.1. Specifically, the plan did not include notification of the outage to the Indiana State Department of Health as an authority having jurisdiction.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to protect 66 of 66 clients by providing a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient</p>	K 155	<p>1. The Indiana State Department of Health was added to our policy containing procedures for an impaired fire alarm system. 2. All residents are affected. 3. After adding ISDH to policy, no further monitoring is needed. 4. Polycys will be reviewed yearly for needed updates. Any changes will be reviewed in Safety</p>	05/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155109	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/27/2015
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	<p>practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Fire Plan" with the Maintenance Supervisor on 04/27/2015 at 11:55 a.m., the facility had a written policy and procedure for an impaired fire alarm system. The policy did not include notifying the Indiana State Department of Health. Based on an interview with the Maintenance Supervisor at the time of record review, he acknowledged the procedure did not indicate the facility shall contact the Indiana State Department of Health.</p> <p>3.1-19(b)</p>		Committee and QAPI meetings.		