

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155561	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME & REHABILITATIVE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660
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K 0000  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: 10/13/15</p> <p>Facility Number: 000327 Provider Number: 155561 AIM Number: 100273920</p> <p>At this Life Safety Code survey, Good Samaritan Home and Rehabilitative 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with two separate basements was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors on both levels including the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident</p>	K 0000	<p><b>Plan of Correction for Good Samaritan Home 2015 Life Safety Annual Survey</b></p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 26 2015</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0062 SS=D Bldg. 01	<p>sleeping rooms. The facility has a capacity of 103 and had a census of 83 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except a detached garage used as a maintenance shop and maintenance storage.</p> <p>Quality Review completed on 10/16/15 - DA</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 ensure 2 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect one to two staff while in the housekeeping room.</p> <p>Findings include:</p>	K 0062	<p>K062 Required automatic sprinkler systems</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by this deficient practice? ·Sprinkler heads were scheduled to be immediately changed out</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ·All residents have the potential to be affected by this alleged deficient practice</p>	10/26/2015

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K 0066 SS=E Bldg. 01	<p>Based on observation on 10/13/15 at 1:00 p.m. during a tour of the facility with Maintenance Supervisor, the two sprinkler heads in the housekeeping room were covered with green corrosion. This was acknowledged by Maintenance Supervisor at the time of observation.</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>3.What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not occur?</p> <ul style="list-style-type: none"> <li>·The maintenance supervisor will conduct fullhouse audit on all sprinkler heads and make sure free of corrosion</li> <li>·The executive director will check off that the audit was completed</li> </ul> <p>4.How the corrective actions will be monitored to ensure the deficient practice will not resure, i.e, what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> <li>·A CQI tool will be used to track the audits of sprinkler heads weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters.</li> </ul> <p>5.Date completion : October 26, 2015</p>		

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	<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> <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 cigarette butts were properly disposed of at 1 of 2 areas where cigarettes were smoked. This deficient practice could affect up to 10 residents, as well as staff and visitors at a time while in the courtyard smoking area.</p> <p>Findings include:</p> <p>Based on observation on 10/13/15 at 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, two of five metal containers under the courtyard carport where smoking occurs had a mixture of combustible trash and cigarette butts. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K 0066	<p>K066 Smoking regulations</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> <li>·All smoking cans were immediately emptied and cleaned out</li> </ul> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by this alleged deficient practice</li> </ul> <p>3.What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not occur?</p> <ul style="list-style-type: none"> <li>· Maintenance supervisor will complete a daily check off to ensure all smoking containers are free of trash</li> <li>·All staff in service on smoking policy and proper protocol for discarding trash and cigarettes</li> </ul> <p>4.How the corrective actions will</p>	10/26/2015	

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K 0161 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 dumbwaiter elevator shafts were provided with sprinkler coverage at the top of the shaft. NFPA 13, Standard for the Installation of Sprinkler Systems at 5-13.2.1 states "One sprinkler shall be installed at the top of the shafts." This deficient practice could affect up to 21 residents, as well as staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/13/15 at 1:10</p>	K 0161	<p>be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place.</p> <p>A CQI tool will be used to track the audits daily times 4 weeks, weekly times one month, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.</p> <p>5.Date completion: October 26, 2015</p> <p>K 161 Existing escalators/dumbwaiters</p> <p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The dumbwaiter was immediately measured and scheduled for installation for new sprinkler coverage</p> <p>2.How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice</p> <p>3.What measures will be put in</p>	10/26/2015

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	p.m. during a tour of the facility with the Maintenance Supervisor, the top of the shaft of the laundry dumbwaiter was not provided with sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observation.  3.1-19(b)		place or what systemic changes will be made to ensure that deficient practice does not occur? ·The maintenance director will do a visual inspection to ensure sprinkler coverage is in place ·The executive director will check off that the audit was completed 4.How the corrective actions will be monitored to ensure the deficient practice will not recure, i.e, what quality assurance program will be put into place? ·A CQI tool will be used to track the audits weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 5.Date completion: October 26, 2015		