

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2013
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NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
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K020000	<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: 12/30/13</p> <p>Facility Number: 002661 Provider Number: 155783 AIM Number: 201056540</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist; Liberty Fruth, Life Safety Code Specialist; and Brett Overmyer Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Greenleaf Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) 2000 Edition, Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The building was constructed in 2010, is adjacent to an</p>	K020000	<p>Please accept the enclosed information as Greenleaf Health Campus's Plan of Correction for the annual Life Safety survey conducted on December 30, 2013. Please contact me if there are any questions. Thank you for your time. Judy Plantinga Administrator Greenleaf Health Campus.</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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K020018 SS=E	<p>assisted living unit and separated by a two hour rated fire wall. The facility has a fire alarm system with smoke detection in corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 50 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/02/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the</p>	K020018	1. There were no residents	01/27/2014			

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K020029 SS=E	<p>facility failed to ensure 2 of 70 doors protecting corridor openings did not have an impediment to the closing. This deficient practice could affect approximately 15 of 50 residents.</p> <p>Findings include:</p> <p>Based on observations made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, the corridor door to the Private/Restorative dining room was provided with a door closer and was held open by a folding walker and the door to room 317 was blocked open by a dumbbell weight. Based on interview during the times of observation, the Director of Plant Operations acknowledged the doors should not be blocked open.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the</p>	K020029	<p>negatively affected when the corridor door to the private/restorative dining was held open by a folded up walker and the door to room 317 was blocked by a dumb bell weight. 2. The walker and the dumb bell weight were removed. The resident in room 317 understood about not using it to hold door open. All staff will be inserviced on not blocking or obstructing the doors from closing.3. During Maintenance rounds daily these items will be checked to ensure they are not blocked open with any type of device. 4. Monthly x 3 months the maintenance director and or his designee will present audits to the Quality Assurance Committee and the committee will review and decide to continuing monitoring or resolve it.</p> <p>1. No residents were negatively</p>	01/27/2014			

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	<p>facility failed to ensure the doors to 1 of 5 hazardous areas such as soiled linen rooms automatically closed and latched into their door frames. Doors to hazardous areas are required to automatically latch in the door frame when closed to keep the door tightly closed. These deficient practices could affect at least 10 residents and staff on the 200 hall.</p> <p>Findings include:</p> <p>Based on observations made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, the 200 hall spa shower room had one 32 gallon size container full of soiled linen and two plastic bags of soiled linen stored on the floor in the shower room. The spa shower room was not provided with a door closer. Based on interview at the time of observation, the Director of Plant Operations acknowledged the spa shower room was not to be used for storage of soiled linen and the soiled linen should not be there.</p> <p>3.1-19(b)</p>		<p>affected at this time.2. The soiled linen has been removed from the spa area.3. All staff have been inserviced on where the soiled utility room is and that this is where the soiled linen bags and barrels need to be taken to. Maintenance Director and or Nursing supervisors will monitor daily during rounds for compliance. 4. The Maintenance Director and or Nursing supervisor will bring report to monthly Quality Assurance x 3 months to discuss compliance or if issue continues to need monitoring.</p>				

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K020038 SS=B	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks was provided with signage. LSC 7.2.1.6.1(d), states, "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 at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, the service hall east exit door was not provided with signage next to the door stating the door can be opened in 15 seconds by pushing on the door release device. Based on interview at the time of observation, the Director of Plant Operations acknowledged a sign on the door was not provided.</p>	K020038	<p>1. No staff were negatively affected by the signage not being there.2. Signage installed on service hall east exit door and does read:"Emergency Exit Push until alarm sounds and door can be opened in 15 seconds". 3. This was the only door affected.4. Signage up on door.</p>	01/13/2014			

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K020050 SS=F	<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. 18.7.1.2</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Record of Fire Drills" documentation with the Director of Plant Operations from 9:30 a.m. to 11:15 a.m. on 12/30/13, a fire drill was not documented for the first shift of the fourth quarter of 2012. Based on interview of the Director of Plant Operations, the fire drill on 10/23/12 at 10:05 a.m. in the Life Safety Code book actually occurred in the assisted living building which has a separate fire alarm</p>	K020050	<p>1. No residents, staff or visitors were negatively affected. 2. Education of the Director of Plant Operations that Assisted Living fire drills cannot be counted in the required 1 per shift per quarter requirement for Health Care Campus. The transmission of the fire alarm to the monitoring company will be documented on every fire drill conducted between the hours of 9pm and 6am. Education of the Director of Plant Operations to ensure fire drills will be held at various random times and conditions.3. Administrator will audit monthly to ensure that fire drills on Health Care Campus are being done at random times and that the ones conducted between the hours of 9pm and 6am have documentation from the fire alarm company of notification for the record. 4. Administrator will bring audit</p>	01/27/2014			

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	<p>system. Additionally, per interview during the record review, there was no other documentation available for review to verify a first shift, fourth quarter fire drill in the health center was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 5 of 7 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Record of Fire Drills" documentation with the Director of Plant Operations from 9:30 a.m. to 11:15 a.m. on 12/30/13, the</p>		findings to monthly Quality Assurance Meeting monthly x 6 months and if no issues they will decide if resolved or not.		

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	<p>documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. on 04/18/138 at 10:23 a.m., on 01/20/13 at 7:30 p.m., on 05/30/13 at 2:45 p.m. and on 08/31/13 at 1:45 p.m. did not indicate the fire alarm system had been activated. Based on interview at the time of record review, the Director of Plant Operations acknowledged the transmission of alarm was not documented on the fire drill forms.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>3. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 4 of 12 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include: Based on review of "Record of Fire Drills" documentation with the Director of Plant Operations from 9:30 a.m. to 11:15 a.m. on 12/30/13, four of four first shift fire drills were conducted between 10:00 a.m. and 11:00 a.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the fire drills for the first</p>						

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K020051 SS=D	<p>shift were not held randomly. 3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 smoke detectors connected to the fire alarm system in the kitchen was properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the</p>	K020051	<p>1. No residents or staff were negatively affected. 2. The smoke detector and air vent in the kitchen is scheduled to be relocated to a minimum of 36 inches apart. This was the only smoke detector affected. 3. This is scheduled to be done on 1/15/14.</p>	01/20/2014	

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K020062 SS=D	<p>detectors. This deficient practice would not directly affect residents but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, one smoke detector located in the kitchen dishwasher area was 12 inches from an air vent. Based on interview at the time of observation, the Director of Plant Operations acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the kitchen janitors closet which had paint on the deflector. LSC 9.7.5</p>	K020062	<p>1. No residents or staff were negatively affected by this. 2. The sprinkler head will be replaced on 01/15/14. All other sprinkler heads will be inspected during</p>	01/27/2014
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	<p>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 would not directly affect residents but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, an upright automatic sprinkler head in the janitors closet had paint on the underside of the deflector. Based on interview at the time of observation, the Director of Plant Operations acknowledged the presence of paint on the sprinkler deflector.</p> <p>3.1-19(b)</p>		<p>quarterly sprinkler systems inspections. 3. Maintenance Director to bring quarterly sprinkler inspections to review in Quality Assurance x 6 months and if no issues noted it will be decided if issue is resolved.</p>		

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K020070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8</p> <p>1. Based on observation and interview, the facility failed to ensure a portable space heater was not used in 1 of 5 lounge areas accessible to residents. This deficient practice could affect 10 to 15 residents using the Jazz Cafe lounge.</p> <p>Findings include:</p> <p>Based on observation made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, the Jazz Cafe lounge had a portable electric fire place that produced heat. Based on interview at the time of observation, the Director of Plant Operations acknowledged the portable electric fire place produced heat.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview; the facility failed to ensure 1 of 1 space heaters used in an office was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient</p>	K020070	<p>1. No residents or staff were negatively affected by this practice. 2. The electrical cord was removed from the portable electric fire place in the Jazz Cafe lounge. 3. The Social Service Director took home her portable heater and was educated on the facility's space heater policy. No other offices have portable electric heaters in them.</p>	01/17/2014	

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	<p>practice would not directly affect residents but could affect staff in the Social Services office.</p> <p>Findings include:</p> <p>Based on observation made with the Director of Plant Operations from 12:30 p.m. to 2:15 p.m. on 12/30/13, an unplugged portable space heater was in the Director of Social Services office. Based on interview at the time of observation, the Director of Social Services acknowledged the space heater is used when it is very cold outside. Based on review of the facility's space heater policy at 2:30 p.m., "space heaters are permitted in offices as long as the heating element does not exceed 200 degrees." Based on interview at the time of observation, the Director of Plant Operations was not aware of the presence of the space heater nor aware of the maximum temperature of the heating element.</p> <p>3.1-19(b)</p>				