

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155685	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELY AVE ELKHART, IN 46517
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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
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K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/02/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Dates: 04/22/16</p> <p>Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130</p> <p>At this PSR survey, Golden Living Center-Elkhart was found in substantial 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 V (111) construction and was fully sprinklered except for the electrical room in the maintenance shop. The original building (North, East and South Units) was constructed in 1968 with an addition (Primrose and Southwest Units)</p>	K 0000		
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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 0143 SS=B Bldg. 01	<p>built in 1975. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 175 and had a census of 144 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with the exception of the electrical room in the maintenance shop. Quality Review completed on 04/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 liquid oxygen storage areas where oxygen</p>	K 0143	IT is the policy of this facility that all oxygen storage areas where oxygen is transferred and stored are equipped with continuous	04/22/2016

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	<p>transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/22/16 at 11:41 a.m., the Primrose oxygen transfill room fan was not working when it was checked with a piece of paper. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 03/02/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>mechanical ventilation Necessary corrections for this citation was completed on 4-1-1, which at that time all oxygen storage area fans were in workable condition As part of the facilities quality assurance checks, the maintenance director was performing daily inspections in accordance to our plan of correction and the unit was found to be working up to the day before 4-22-16 when it was found that the Primrose oxygen storage unit was not functioning 1) Corrective action: The fan motor was replaced. 2) Identification of others: The remainder of the oxygen storage units was inspected and found to have working exhaust systems. 3) Measures in place: Inspection rounds targeting the oxygen storage areas has been added to the maintenance department's daily required routines. 4) Monitoring system in place: The maintenance director will turn in dly inspection results to the ED for review The results will be discussed monthly times 3 months during QAPI, then once a quarter until facility has reached threshold of 100% compliance and maintained for a total of 3 months.</p>		