

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/28/2014
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NAME OF PROVIDER OR SUPPLIER  GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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K010000	<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: 08/28/14</p> <p>Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Glen Oaks 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), 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The healthcare portion</p>	K010000	<p><b>Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Code Survey on August 28, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</b></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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K010029 SS=F	<p>of the facility has a capacity of 68 and had a census of 51 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/02/14.</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 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</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of 4 hazardous areas, such as a combustible storage room over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect all residents in the</p>	K010029	<p><b>K 029</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p>	09/27/2014

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	<p>healthcare center based on the central location of the nursing supply room and the healthcare central supply room.</p> <p>Findings include:</p> <p>Based on observations on 08/28/14 at 11:55 a.m. with the director of plant operations, the center nurses' station nursing supply room and healthcare central supply, which measured one hundred twenty square feet each and stored twenty four shelves of cardboard boxes of nursing supplies, paper, and plastic adult briefs, each lacked a self closing device on the doors. The lack of self closing devices on the center nurses' station nursing supply room door and healthcare central supply room door was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 08/28/14 at 1:25 p.m.</p> <p>3.1-19(b)</p>		<p>A self-closing device which causes the doors to automatically close and latch into the door frames was installed on all nursing and healthcare central supply rooms.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Plant Operations will review all storage areas to ensure self-closing devices are installed and operating properly.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Plant Operations will complete an audit and or observations to ensure that hazardous areas are provided with self-closing devices which would cause the doors to</p>	

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K010038 SS=F	<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 4 of 5 healthcare exit door electromagnetic locks remained unlocked while the fire alarm was activated and silenced. LSC 18.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of</p>	K010038	<p>automatically close and latch into door frames. The audits are conducted 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>K 038 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Repairs were completed to 4 of 5 healthcare exit door electromagnetic locks so that the doors remain unlocked while the fire alarm is activated and silenced. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The Director of Plant</p>	09/27/2014

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K010046 SS=A	<p>egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect all health care residents in the facility.</p> <p>Findings include:</p> <p>Based on observations during a test of the fire alarm system on 08/28/14 with the director of plant operations at 1:00 p.m., the electromagnetic lock on the 100 Hall exit door, the 200 Hall exit door, the Service Hall exit door, and the 400 Hall exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the director of plant operations at the time of observations and acknowledged by the administrator at the exit conference on 08/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly and annually for 90 minutes over the past</p>	K010046	<p>Operations will monitor all healthcare exit doors to ensure they remain in proper operation. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Director of Plant Operations will complete an audit and or observations to ensure that all healthcare exit doors remain in proper operation. The audits conducted 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>K 046 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> A testing log was</p>	09/27/2014			

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	<p>year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice does not affect any residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 08/28/14 at 9:35 a.m. with the director of plant operations, the maintenance office had one battery backup light mounted on the north wall near the exit door.</p> <p>Based on an interview with the director of plant operations on 08/28/14 at 9:40 a.m., the facility does not have a monthly battery backup testing log nor an annual 90 minute testing log for the maintenance office battery backup light. The lack of a monthly test log and an annual ninety</p>		<p>instituted to record visual inspections and test for monthly battery backup testing and annual 90 minute testing for battery backup lighting. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> No residents are affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b>The Director of Plant Operations will monitor the testing log for completion.<b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Director of Plant Operations will audit the testing log to record the results of monthly battery backup testing and annual 90 minute testing. The audits will be conducted 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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K010062 SS=E	<p>minute test log on the maintenance office battery backup light was verified by the director of plant operations at the time of interview and acknowledged by the administrator at the exit conference on 08/28/14 at 1:40 p.m.</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>1. Based on observation and interview, the facility failed to replace 10 of over 300 sprinklers in the facility covered in corrosion and rust. 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 28 health care residents who use the main dining room, located near the main entrance.</p> <p>Findings include:</p>	K010062	<p><b>K 062 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Repairs were completed to main entrance overhang sprinklers. The private fire hydrant was inspected, tested, operated, and maintained.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The Director of Plant Operations will monitor all sprinklers to ensure they are</p>	09/27/2014

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	<p>Based on observation on 08/28/14 at 12:10 p.m. with the director of plant operations, the main entrance overhang had eight sprinklers completely covered in green corrosion and two sprinklers completely covered in brown rust. This was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 08/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 08/28/14 at 1:00 p.m. with the director of plant operations,</p>		<p>maintained in reliable operating condition. The Director of Plant Operations will inspect, test, and maintain, and periodically operate the private fire hydrant. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Director of Plant Operations will complete an audit and or observations to ensure that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The Director of Plant Operations will complete an audit and or observations to ensure that the fire hydrant is maintained in reliable operating condition, inspected and tested. The audits will be conducted 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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K010143 SS=F	<p>the facility had one private fire hydrant on the south side of the facility's property. Based on an interview with the director of plant operations on 08/28/14 at 1:05 p.m., there is no documentation of an annual inspection for the fire hydrant. The lack of an annual inspection for the one fire hydrant was acknowledged by the administrator at the exit conference on 08/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</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 1 oxygen storage/transfer location was provided with a sign indicating that transferring is occurring and the door was equipped</p>	K010143	<p><b>K 143</b></p> <p><b>Corrective actions</b></p>	09/27/2014

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	<p>with a self closing device. This deficient practice could affect all health care residents based on the central location of the liquid oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation with the director of plant operations on 08/28/14 at 12:05 p.m., the center nurses' station liquid oxygen storage room, where seven full liquid oxygen containers were stored, lacked a sign outside the door indicating that the transferring of oxygen occurs in the room. Furthermore, the liquid oxygen storage room lack a self closing device on the door. Based on an interview with the director of plant operations on 08/28/14 at 12:15 p.m., the nursing staff transfers liquid oxygen into small containers for resident use in the liquid oxygen storage room. The lack of a sign indicating that transferring of oxygen is occurring and a self closing device on the liquid oxygen room door was verified by the director of plant operations at the time of observation and acknowledged by the administrator at the exit conference on 08/28/14 at 1:40 p.m.</p> <p>3.1-19(b)</p>		<p><b>accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p>A sign indicating transferring of oxygen is occurring and that smoking is not permitted was posted. A self-closing device which causes the door to automatically close and latch into the door frames was installed on all nursing and healthcare central supply rooms.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Plant Operations will monitor oxygen storage to ensure the sign indicating transferring of oxygen is occurring and that smoking is not permitted remains posted. The Director of Plant Operations will monitor oxygen storage to ensure the self-closing device is installed and operating properly.</p>	

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			<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Plant Operations will complete an audit and or observations to ensure the sign indicating transferring of oxygen is occuring and that smoking is not permitted remains posted; ensure self-closing device is installed and operating properly. The audits will be conducted 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		