

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527
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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: 02/16-17/16</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>At this Life Safety Code survey, Greencroft Healthcare 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, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The existing one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors except for the Therapy wing and the Gables nursing unit and all spaces open to the corridors. Hard wired</p>	K 0000	<p>F 000 InitialComments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.</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 0018 SS=E Bldg. 01	<p>smoke detectors that provide a visual and audible signal at the nurses' station were provided in all resident rooms. The new two story addition was determined to be of Type II (111) construction and fully sprinklered. A 2-hour fire wall is provided on each side of the corridor dividing the facility into two separate buildings. The new building is subdivided into two smoke compartments on both floors. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 256 and had a census of 184 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to the kitchens in Cove and Haven open to the corridor and is in compliance.</p> <p>Quality Review on 02/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other</p>			

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	<p>than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 East Gable Shower Room door, 1 of 1 Therapy door, and 1 of 1 Central Unit Soiled Utility door was capable of resisting smoke for at least 1/2 hour. This deficient practice could affect staff and at least 7 residents.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 between 1:18 p.m. and 2:44 p.m., the following corridor doors were not smoke resistive due to unsealed penetrations:</p> <ul style="list-style-type: none"> a) two separate quarter inch penetrations in the East Gables Shower room door b) two separate quarter inch penetrations in the Therapy door c) a quarter inch penetration in the Central Unit Soiled Utility room door 	K 0018	<p>K018 A walk through was completed to determine if other areas were effected. All smoke-resistant doors were filled with 3M Fire Caulk. A Preventative Maintenance will be scheduled annually to check the integrity of fire barriers and doors by Maintenance using assistance from outside contractors when appropriate. The Director of Maintenance will review the Preventative Maintenance schedule on a monthly basis for compliance. He will address issues and report to QI quarterly for review and recommendation. Alleged compliance 3/10/16</p>	03/10/2016	

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K 0025 SS=E Bldg. 01	<p>Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage corridor doors closed and positively latched into the door frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:13 p.m., one of the two corridor doors to the oxygen storage room was provided with a latching device that required manual operation. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in</p>				

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	<p>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 5 of 10 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires 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 staff and at least 41 residents.</p> <p>Findings include:</p> <p>Based on observations with the Health Care Maintenance #1 and Director of Environmental Services on 02/17/16</p>	K 0025	<p>K025</p> <p>Repairs have been completed on the unsealed ceilingpenetrators. Fire caulk, mortar, 5/8" drywall and/or ceiling tile have been added or replaced to seal allpenetrators. Att. A (1 of 5) A walk-thru was completed to determine other integrityissues. A PM will be scheduled annually to check the integrity offire barriers and doors by Maintenance using assistance from outsidecontractors when appropriate.</p> <p>The Director of Maintenance will review the PM schedule on amonthly basis for compliance and will address issues and report to QI quarterlyfor review and recommendation.</p> <p>Alleged compliance 3/10/16</p>	03/10/2016	

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	<p>between 9:50 a.m. and 10:50 a.m., the following smoke barriers had unsealed penetrations:</p> <ul style="list-style-type: none"> a) a three inch by twelve inch gap in the smoke barrier near resident room 321 b) an eighteen inch by ten inch gap and two separate six inch by twelve inch gaps in the smoke barrier attic by resident room 221 c) a quarter inch gap around conduit in the smoke barrier near office "Door 33" d) a five inch by three inch piece of drywall was hanging off the Gables East Hall smoke barrier e) five separate penetrations ranging from two and a half inches to one foot by three foot gaps in the Gables attic smoke barrier <p>Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledge the aforementioned condition and provided the measurements.</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 was maintained to provide a one half 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 staff only.</p>			

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K 0029	<p>Findings include:</p> <p>Based on observations with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 from 12:42 p.m. to 3:24 p.m., the following unsealed ceiling wall penetrations were discovered:</p> <ul style="list-style-type: none"> a) one inch by one inch ceiling penetration outside the Admissions office b) a three inch ceiling penetration in the Old Info Center c) one inch by four and a half feet ceiling penetration in the Terrace Oxygen supply storage room d) two separate two inch by two inch ceiling penetrations in the West Gable Housekeeping office e) a quarter inch ceiling penetration in West Hall South Unit Housekeeping office f) two of thirty ceiling tiles were missing in the Basement Activities Storage room <p>Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			

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SS=D Bldg. 01	<p>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 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 the corridor door to 1 of 1 "Across from the Sideboard" storage room greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 12:47 p.m., the storage room "Across from the Sideboard" contained storage such as six mattresses, three drawer stands, and other miscellaneous storage. The corridor door did not have a self-closer. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of</p>	K 0029	<p>K029</p> <p>1. Stored items in storage room across from the Sideboard have been removed. The cipher lock code on door has been changed to a code not provided to most staff that would have interest in storing items. The room will remain empty. Att. B (1 of 2)</p> <p>2. Corridor to Laundry had missing strike plate replaced. The door now latches securely. The Environmental Services Director will monitor door latching and operations monthly for compliance as well as in appropriate storage. He will submit this audit findings to Administrator and will report how issue was resolved. QI will monitor for compliance and make adjustments. Alleged compliance 3/10/16</p>	03/10/2016			

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K 0038 SS=E Bldg. 01	<p>Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Laundry, a hazardous area, would positively latch into the frame. This deficient practice could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:04 p.m., the Laundry room contained fuel fired appliances. The corridor door failed to latch when tested. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 exterior South Dining exit discharge paths was readily accessible at all times. This</p>	K 0038	<p>K038 The panic mechanism was disassembled and repaired. Door now opens with push of panic bar.</p>	03/10/2016

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K 0044 SS=E Bldg. 01	<p>deficient practice could affect staff and up to 43 residents using the South Dining Hall.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 2:32 p.m., the left South Dining exit door crash bar failed to release the latch in the bottom frame and the door would not open. Based on an interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</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 11 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 and 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</p>	K 0044	<p>A walk-thru was completed todetermine if other exterior panic bars were affected. The panic door bar was added to monthly auditsheet. The Environmental ServicesDirector will report findings to Administrator, including the plan to correctthe issue. Corrections will be monitored by QI. Alleged compliance 3/10/16</p> <p>K044 The mechanism was adjusted to open, close and latchcorrectly. A walk-thru was completed todetermine if other interior doors were effected. Interior door operations were added to auditsheet for monthly walk-thru audits. TheEnvironmental Services Director will report findings to Administrator. The</p>	03/10/2016	

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K 0062 SS=E Bldg. 01	<p>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 staff and at least 7 residents.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:16 p.m., the fire doors entering Gables from Terrace failed to close and latch when tested. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace corroded sprinkler heads. LSC 33.2.3.5.2 refers to</p>	K 0062	<p>report will include plan to correct the issue. QI will monitor and make adjustments. Alleged compliance 3/10/16</p> <p>K062 The wet fire sprinkler heads with corrosion were identified. Shambaugh & Son Fire Protection</p>	03/10/2016			

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	<p>LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 staff and at least 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 between 12:45 p.m. to 3:02 p.m., the following sprinkler heads were corroded:</p> <ul style="list-style-type: none"> a) 2 of 4 corroded sprinkler heads in the Old Info Center b) 1 of 1 corroded sprinkler head by Door 3 c) 3 of 4 corroded sprinkler heads outside at Gables North Entrance d) 2 of 2 corroded sprinkler heads in the South Unit East Hall Bathing Room e) 1 of 33 corroded sprinkler heads in the Kitchen near the Dish Area <p>Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged</p>		<p>Division replaced the fire sprinkler heads affected. Att. C Dry sprinkler heads were ordered. Att. D (1 of 3) To prevent future issues with sprinklers, Shambaugh will annually inspect heads throughout the building. Corroded heads identified will be replaced. Escutcheons were added where missing. Shambaugh will inspect annually whenscheduled. Director of Maintenance will report to Administrator/QI Shambaugh annual report of repair compliance Alleged compliance 3/10/16</p>	

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	<p>each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads in the West Hall South Unit and 1 of 1 sprinkler head in the Education Room Storage Closet was maintained. This deficient practice could affect staff and at least 9 residents.</p> <p>Findings include:</p> <p>Based on observations the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 2:27 p.m. then again at 2:51 p.m., one sprinkler head in the West Hall South Unit corridor was missing one escutcheon outside resident room 225 and one sprinkler head in the Education Room Storage Closet was missing one escutcheon. Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each missing escutcheon at the time of each observation.</p> <p>3.1-19(b)</p>			
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K 0064 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure 1 of 1 Gable North Hall fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff and up to 19 residents.</p> <p>Findings include:</p> <p>Based on observation and interview with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:37 p.m., the Gable North Hall fire extinguisher maintenance tag indicated the last six year test was completed 01/10. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of 4 K class kitchen fire extinguishers was maintained</p>	K 0064	<p>K064 M & M Security checked all extinguishers for compliance. They cleaned nozzles and hoses for operational function. Director of Maintenance has added nozzle checks to annual service plan. Greencroft Goshen security checks K type extinguishers in building monthly. Their report is submitted to Maintenance Director for work orders when needed. Maintenance Director reviews reports and submits report to QI quarterly. Att. E (1 of 3) Alleged compliance 3/10/16</p>	03/10/2016			

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K 0069 SS=E Bldg. 01	<p>as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 2:55 p.m., four separate type K class kitchen fire extinguishers were corroded on the nozzles. Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to protect cooking equipment with a range hood extinguishing system in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations in 1 of 1 Gables Patio Pantry kitchen. NFPA 96, 7-1.2 requires cooking equipment that produces grease laden vapors (such as but</p>	K 0069	<p>K069 The pantry areas affected will have food items that produce grease laden vapors prepared in the main kitchen which has a hood extinguisher system for cooking. Staff members were educated on the food prep. changes. The Culinary Director will monitor for compliance and report concerns to QI quarterly for review and recommendation. Alleged compliance 3/10/16</p>	03/10/2016

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K 0072 SS=D Bldg. 01	<p>not limited to deep fat fryers, ranges, griddles, broilers, woks, tilting skillets, and braising pans) shall be protected by fire extinguishing equipment. This deficient practice could affect staff, visitors, and at least 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:25 p.m., The Gables Patio Pantry contained a stovetop and oven. Based on interview at the time of observation, the Dining Assistant #1 was asked what foods were cooked in the Gables Patio Pantry kitchen under a range hood that lacked an extinguishing system. She confirmed that ground beef was cooked. The Health Care Maintenance #1 and Director of Environmental Services acknowledged the oven's range hood was not provided with an extinguishing system.</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.</p>						

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K 0076 SS=D Bldg. 01	<p>7.1.10 Based on observation and interview, the facility failed to ensure the corridor width for 1 of 1 Basement Ramp exit corridors was readily accessible at all times. This deficient practice affects any of the staff only.</p> <p>Findings include:</p> <p>Based on an observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 3:22 p.m., the Basement Ramp exit door had storage in front of it. Storage included a large cardboard box and a table saw. Based on an interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged these items were being stored in the corridor in front of the exit.</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</p>	K 0072	<p>K072 The Maintenance Dept. has moved several items and were in-serviced on maintaining 4' corridors at all times. A walk-thru was completed to determine if any items obstructed exit paths in building. Environmental Services Director will audit corridors weekly. Maintenance Director to review condition of basement quarterly and correct findings immediately. A report will be submitted to QI quarterly noting findings and adjustments made. Alleged compliance 3/10/16</p>	03/10/2016			

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	<p>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 3 of 3 cylinders in the Terrace oxygen storage room and 1 of 1 cylinder in the Basement Parts Room of nonflammable gases such as oxygen or carbon dioxide 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 only.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 1:13 p.m. then again at 3:18 p.m., the Terrace oxygen storage room had three oxygen cylinders that were freestanding on the floor. Then again the Basement Parts Room had one carbon dioxide cylinder that was freestanding on the floor. Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</p>	K 0076	<p>K076</p> <p>In the Oxygen room the bottleholders have been fastened in place. Noother hazardous gas containers were found to be unsecured. The Director of Environmental Services willmonitor the placement of bottles in correct holders weekly during rounds.</p> <p>The cylinders stored in thebasement have been permanently removed from building.</p> <p>Director of Maintenance willinclude review of hazardous gas containers in his monitoring of basement. He will correct future risks and reportfindings to QI quarterly for review and recommendation.</p> <p>Alleged compliance 3/10/16</p>	03/10/2016			

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K 0130 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 8 of 11 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the</p>	K 0130	<p>K130</p> <p>Fire barrier walls location were repaired with double layer 5/8" drywall and/or sealed with 3M FireCaulk. The facility hired a contractor to complete a building inspection of all fire and smoke door penetrators and repair as appropriate. Att. F This was added to Preventative Maintenance list. Annually, the maintenance dept. will hire a contractor to inspect all fire barriers for repairs that maybe needed to maintain their fire barrier integrity. The report will be reviewed by Director of Maintenance and submitted to QI for recommendations. Alleged compliance 3/10/16</p>	03/10/2016

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	<p>following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and at least 44 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/17/16 between 9:43 a.m. to 10:59 a.m., the following fire wall penetrations were discovered:</p> <p>a) an eighteen inch by fourteen inch and a one inch by one inch penetration in the Door 50 fire barrier</p> <p>b) a quarter inch penetration in the Household Door-to-the-Vista Fire barrier</p> <p>c) a three quarter inch penetration in the Activities fire barrier</p> <p>d) four separate penetrations ranging from three quarters of an inch to a twelve inch by twelve inch block was removed in the Lea fire barrier</p> <p>e) a three quarter inch by one inch penetration in the Door 16 fire barrier</p> <p>f) a six inch by four inch penetration in the Door 28 fire barrier</p> <p>g) three separate quarter inch penetrations</p>			

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K 0144 SS=F Bldg. 01	<p>in the Door 11 fire barrier h) multiple gaps were the fire wall bricks meet the corrugated roof was not sealed along the ridges in the fire barrier near resident room 207. Based on interview at the time of each observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure 3 of 3 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to</p>	K 0144	<p>K144 F Cool down period documentation was added. Staff were educated on documenting cool down and 30 min. run documentation. Att. G Director of Maintenance will monitor generator logs monthly to make sure documentation is accurate and complete. He will report to QI quarterly for and recommendations and follow-thru. Alleged compliance 3/10/16</p>	03/10/2016

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	<p>shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Health Care Maintenance #1 and Director of Environmental Services of the facility's Emergency Generator monthly testing log on 02/16/16 at 10:18 a.m., the generator log form failed to include documentation that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 3 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2 requires Diesel-powered exercised monthly with supplemental loads at 30 percent of nameplate rating for 30 minutes. This deficient practice could</p>			

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K 0147 SS=D Bldg. 01	<p>affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 10:18 a.m., the Kitchen generator and the Gables generator documentation indicated both generators failed to run for at least 30 minutes for 9 of 12 months and 1 of 2 months respectively. Based on interview at the time of record review, the Health Care Maintenance #1 and Director of Environmental Services acknowledged the aforementioned condition.</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>Based on observation and interview, the facility failed to ensure 2 of 2 multiplug adapters and 6 of 6 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p>	K 0147	<p>K147</p> <p>Flexible cords, multi-plugadapters and surge protectors have been addressed for compliance. They were removed and receptacles installed (Att. H 1-4) An audit of offices was completed. Electrical audits were added to weekly audit sheet. Staff were educated on protocol. Director of Environmental Services will</p>	03/10/2016

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K 0000 Bldg. 02	<p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 between 1:06 p.m. to 3:08 p.m. the following was discovered:</p> <p>a) a surge protector was powering another surge protector powering computer equipment in the Kitchen Scheduler's office</p> <p>b) a surge protector was powering another surge protector powering computer equipment in the Food Manager's office</p> <p>c) a surge protector was powering another surge protector powering computer equipment in the Food Services office</p> <p>d) a multiplug powering computer equipment in the Gables Electrical Room</p> <p>e) a multiplug powering light bulbs in the North Mechanical Room</p> <p>Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>monitor offices during rounds for electrical Life Safetycodes. Correction of non-compliance will be completed immediately. Director of Environmental Services will report written findings to QI quarterly for compliance and recommendations. Alleged compliance 3/10/16</p>				

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	<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: 02/16-17/16</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>At this Life Safety Code survey, Greencroft Healthcare 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, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The existing one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors except for the Therapy wing and the Gables nursing unit and all spaces open to the corridors. Hard wired smoke detectors that provide a visual and audible signal at the nurses' station were provided in all resident rooms. The new</p>	K 0000	<p>F 000 InitialComments</p> <p>This plan of correction constitutes Greencroft Healthcare's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission or that a deficiency exists, or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a desk review of this Plan of Correction.</p>		

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K 0022 SS=E Bldg. 02	<p>two story addition was determined to be of Type II (111) construction and fully sprinklered. A 2-hour fire wall is provided on each side of the corridor dividing the facility into two separate buildings. The new building is subdivided into two smoke compartments on both floors. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 256 and had a census of 184 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to the kitchens in Cove and Haven open to the corridor and is in compliance.</p> <p>Quality Review on 02/25/16 - DA</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</p>			

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K 0051 SS=E Bldg. 02	<p>Based on observation and interview, the facility failed to ensure 2 of 2 Cove/Haven set of doors likely to be mistaken for a way of exit from the Cove/Haven dining rooms was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect staff and up to 15 residents. Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 12:03 p.m., the door leading from the Cove/Haven dining rooms contained an exit sign next to the doors leading to the courtyard. Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services confirmed that the courtyard doors are not to be used as an exit and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved</p>	K 0022	<p>K022</p> <p>"No Exit" signage has been added. The building was audited for existing compliance signage. Director of Environmental Services will audit exit signage weekly for compliance and correct violations. He will submit a written report to QI quarterly for review and recommendation.</p> <p>Alleged compliance 3/10/16</p>	03/10/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155205	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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	<p>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 smoke detectors in 1 of 1 new construction building was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and 15 residents.</p> <p>Findings include:</p> <p>Based on observation with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 between 11:45 a.m. and 12:40 p.m., the</p>	K 0051	<p>K051 Smoke detectors located too close to HVAC vents were moved to a minimum of 3 ft. from vent. An audit was completed. Whenever a vent repair location or smoke detector change occurs the Maintenance Director or designee will inspect for compliance and report to QI as appropriate. Alleged compliance 3/10/16</p>	03/10/2016

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K 0144	<p>following smoke detectors were next to air vents:</p> <ul style="list-style-type: none"> a) Terrace Connecting Link twelve inches away b) Fire Place Area in Haven twelve inches away c) Fire Place Area in Cove twelve inches away d) Cove Dining twelve inches away e) Fire Place Area in Oasis twelve inches away f) In the corridor outside resident room 728 twelve inches away g) Elevator Hallway in Oasis twenty four inches away h) In the corridor outside resident room 711 twenty four inches away i) In the corridor outside resident room 703 twenty four inches away j) In the Terrace corridor twenty four inches away <p>Based on interview at the time of observation, the Health Care Maintenance #1 and Director of Environmental Services acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>			

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SS=C Bldg. 02	<p>LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Health Care Maintenance #1 and Director of Environmental Services on 02/16/16 at 10:18 a.m., the Household/Terrace Generator documentation indicated that generator failed to meet 30% of the total load for the last 12 months and the last annual load bank was performed on 10/20/14. Based on interview at the time of record review, the Health Care</p>	K 0144	<p>K144 F Cool down period documentation was added. Staff were educated on documenting cool down and 30 min. run documentation. Att. G Director of Maintenance will monitor generator logs monthly to make sure documentation is accurate and complete. He will report to Ql quarterly for and recommendations and follow-thru. Alleged compliance 3/10/16</p>	03/10/2016

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	Maintenance #1 and Director of Enviornmental Services acknowledged the aforementioned condition. 3-1.19(b)				