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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/10/2013 |
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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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| 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 Dates: 12/09/13 and 12/10/13</p> <p>Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Elkhart 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 was determined to be of Type V (111) construction and was fully sprinklered except for an enclosed area with exterior access off of the closed North Unit. The original</p> | K010000 | | |

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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| | <p>building (North, East and South Units) was constructed in 1968 with an addition (Primrose and Southwest Units) 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 146 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 an enclosed area with exterior access off of the closed North Unit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | |

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| K010014 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A or Class B in order to protect 50 of 146 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke</p> | K010014 | K-14 1. The South Unit has had the siding treated with appropriate flame retardant treatment to ensure it meets the NFPA requirement. B. The Carpeting located at the East Nurses station has had the carpeting treated with an approved flame retardant spray. There were no residents affected by this alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice 3. The Maintenance Departments have been informed to the life safety code requirement as it relates to flame retardant materials and will perform inspections of these areas every 6 months.4. Inspection reports as it relates to flame retardant materials will be forwarded to the QA&A committee for review The results of these audits will be reported by the Director of Maintenance every 6 months and then the QAA team will determine the need for additional auditing. | 01/09/2014 | | | |

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| | <p>test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident on the South or East Units as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. The central area of the South Unit (Alzheimer) had siding used as an interior finish on the walls and medication room. Interview with the Executive Director and Maintenance Supervisor after the time of observation revealed no documentation was immediately available to demonstrate the siding exhibited a flame spread classification of Class A or B.</p> <p>b. The East Unit nurses station had carpeting used as an interior finish. Interview with the Executive Director and Maintenance Supervisor after the time of observation revealed no documentation was immediately</p> | | | | | | |

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| K010017 SS=E | <p>available to demonstrate the carpeting exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 use areas were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same</p> | K010017 | <p>1. The Prim Rose Cafe, Golf Area and the Vending area have had smoke detectors installed to meet this requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents' residing at the facility have to potential to be affected by the alleged deficient practice. 3. The Maintenance Director and support staff has been in-serviced on the Life Safety code as it relates to smoke detector coverage. 4. The Maintenance Supervisor will</p> | 01/09/2014 | |

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| | <p>smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any number of residents using the Primrose Park Cafe and the Golf Course Lounge and staff or visitors in the vicinity of these two areas.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the Primrose Park Cafe and the Golf Course Lounge were open to the corridor and the corridor was protected by an electrically supervised automatic detection system but the individual spaces were not. Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the aforementioned observation.</p> <p>3.1-19(b)</p> | | perform audits on the smoke detectors monthly. Monthly audits will be forwarded to the QA&A team for 6 months and then the QA&A committee will determine the need for additional Audits until compliance is achieved . | | |

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| K010018 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 and interview, the facility failed to ensure 6 of 109 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 30 of 146 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m. and on 12/10/13 from 9:15 a.m. to 11:15 a.m., the doors to resident room 306, 326, 408, 418, 428 and 521 did not latch into the frame. Based on interview at the times of observation, the Executive</p> | K010018 | K-181.The doors identified rooms 306,326,408,418,428,and 521 have had the door latches repaired to ensure proper latching to meet this requirement. The wood wedge was immediately removed for the Housekeeping supply room door. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Director of Maintenance has been in-serviced by the Executive Director on the Life Safety Requirement related to Proper door latching as well as the utilization of wooden wedges for door propping by 1/9/144. The Director of Maintenance will perform audits on resident room doors monthly for 6 months. The | 01/09/2014 | | | |

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| | <p>Director and Maintenance Supervisor acknowledged the doors to the aforementioned resident rooms would not latch in their frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 200 corridor doors did not have an impediment to closing. This deficient practice would not directly affect residents but had the potential to affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the housekeeping storage closet door was propped open with a wooden wedge under the door. Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the the door should not be propped open and that wedges were not allowed.</p> <p>3.1-19(b)</p> | | <p>results of those audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A committee will determine the need for additional auditing until compliance is achieved.</p> | | | | |

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| K010021 SS=B | <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 15 doors serving hazardous areas such as a storage room for combustibles which was over 50 square feet in size was held open only by a device arranged to automatically close the door upon activation of the fire alarm system. This deficient practice would not directly affect residents but had the potential to affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the housekeeping supply room door was held open by a device, a wooden wedge</p> | K010021 | <p>K-211. The wooden door prop was immediately removed during the survey tour. There were no residents affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice 3. The Director of Housekeeping has been in-serviced by the Executive Director on the life safety requirement as it relates to utilizing wooden door props by 1/9/14 4. The Director of Maintenance will perform audits on the use of wooden or any other door props monthly for 6 months. Results of those audits will be forwarded to the QA&A</p> | 01/09/2014 |

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| K010025 SS=E | <p>under the door, which would not allow the door to close automatically upon activation of the fire alarm system. Combustible storage in this room that measured over 50 square feet included included large quantities of housekeeping supplies wrapped and packaged in paper, plastic and cardboard boxes. Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the door was blocked open with a wedge under the door and would not automatically close upon activation of the fire alarm system.</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 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>Based on observation and interview, the facility failed to ensure the passage of cable through 5 of 16 smoke barriers was protected to maintain the smoke resistance of each smoke barrier. LSC</p> | K010025 | <p>K-251. The Primrose smoke barrier has had the area fire caulked to meet this requirement. B. The primrose penetrations are now sealed . C. The smoke barrier near 425 has been fire</p> | 01/09/2014 | | | |

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| | <p>Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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 at least 100 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., there were exposed penetrations through the smoke barriers above the ceiling tiles at the following locations that were not firestopped:</p> <p>a. The Primrose Unit center smoke barrier had a sprinkler pipe penetration that was not sealed and had a one inch gap.</p> <p>b. The Primrose Unit north smoke barrier had three penetrations that were not sealed. Two of the penetrations were by water lines with one inch annular space around each water line that was unsealed and the third</p> | | <p>caulked to meet this requirement.</p> <p>D. The In-service Education room has had the hole around the sprinkler head replaced to meet this requirement. There were no residents directly affected by the alleged deficient practice.</p> <p>2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.</p> <p>3. The Director of Maintenance has been in-serviced on the life safety requirement as it relates to sealed smoke barriers by 1/9/144. The Director of Maintenance will perform monthly audits of the sprinklers pipes monthly for 6 months. The results of those audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A committee will determine the need for additional auditing until compliance is achieved.</p> | | | | |

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| | <p>penetration was a sprinkler pipe with a one inch annular space around it.</p> <p>c. The Primrose Unit south smoke barrier had three wire penetrations that were not sealed with a one inch annular space around each wire.</p> <p>d. The smoke barrier near room 435 had one wire penetration that was not sealed with a one inch annular space around the wire.</p> <p>e. The ceiling smoke barrier in the Inservice Education room had a four inch hole around a sprinkler head. Based on interview during the times of observation, the Executive Director and Maintenance Supervisor acknowledged the unprotected openings through the smoke barriers.</p> <p>3.1-19(b)</p> | | | | |

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| K010029 SS=B | <p>NFPA 101 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>Based on observation and interview, the facility failed to ensure 3 of 15 doors serving hazardous areas such as rooms larger than 50 square feet and storing combustible materials closed and latched to prevent the passage of smoke. This deficient practice would not directly affect residents but had the potential to affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the following was noted:</p> <p>a. The dining services office which exceeded 50 square feet had at least 30 cardboard boxes and the corridor door to this room lacked a door closer.</p> | K010029 | <p>K-291. a. The dining services office has had a self closer installed on the door. b. The Central Supply Door has had a self closer installed. c. The Maintenance Room has had a self closer installed on the door as well as an automatic flush bolt. There were no residents directly affected by the alleged deficient practice. 2. Resident residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department have been educated on the life safety requirement as it relates to hazardous areas by 1/9/14. The Maintenance Supervisor will perform monthly inspection of doors that have self closers and will report on these doors monthly to the QA&A committee for a period of 6-months then the QA&A committee will determine the need for add itional auditing until a threshold of 100% is</p> | 01/09/2014 |

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| K010038 SS=E | <p>b. The service corridor central supply room which exceeded 50 square feet had at least 30 cardboard boxes and the corridor door to this room lacked a door closer.</p> <p>c. The maintenance room which exceeded 50 square feet had at least 20 cardboard boxes and the double set of corridor door to this room lacked door closers. Additionally, one of the doors was provided with a manual flush bolt instead of an automatic flush bolt. Based on interview during the times of observation, the Executive Director and Maintenance Supervisor acknowledged the aforementioned hazardous area corridor doors did not have a self closer to ensure the doors automatically closed and latched into the door frame.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 27 exit doors were accessible. This deficient practice could affect at least 15 residents using the Primrose main dining room and any visitors.</p> <p>Findings include:</p> | K010038 | <p>achieved</p> <p>K-381. The primrose exit door has been repaired to ensure proper exit operation. 2. A NO-EXIT sign has been placed on the closed unit doors to ensure its not mistaken as an exit. There were no residents directly affected by the alleged deficient practice 2. Residents and/or visitors residing at the facility</p> | 01/09/2014 |

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| | <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the Primrose unit center hall exit door was magnetically locked and provided with a posted code on the keypad. When the code was entered, the door did not release. Based on interview during the time of observation, the Executive Director and Maintenance Supervisor acknowledged the aforementioned door should have released.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 doors was identified as not an exit. NFPA 101, Section 7.10.8 Special Signs. Any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign reading "NO EXIT." Such sign shall have the word "NO" in letters 2 inches high with stroke width of 3/8 inch and the word "EXIT" in letters 1 inch high, with the word "EXIT" below the word "NO." This deficient practice could affect at least 15 residents using the Primrose main dining room and any visitors.</p> | | <p>have the potential to be affected by the alleged deficient practice.</p> <p>3. The Director of Maintenance & Director of Housekeeping serviced have been in-serviced on the life safety requirement related to exit areas by 1/9/144. The Director of Maintenance will perform monthly audits of exit areas for 6 months. The results of those audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A team will determine the need for additional auditing until compliance is achieved.</p> | | | | |

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| K010046 SS=F | <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the North unit center hall exit door was provided with an exit sign above the door; was magnetically locked and provided with a posted code on the keypad. Exit access was not available within the closed North unit due to storage in the corridors. Based on interview during the time of observation, the Executive Director and Maintenance Supervisor acknowledged the storage in the corridors of the closed North unit and indicated the path of egress through the closed unit no longer exists.</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 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to provide exterior emergency lighting for 27 of 27 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could</p> | K010046 | K-461. The Exterior Exit Lights has been connected to the Generator and are functioning properly Documentation of the emergency lighting has been obtained. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility | 01/09/2014 |

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| | <p>affect all residents as well as staff and visitors throughout the facility if forced to evacuate.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m. and on 12/10/13 from 9:15 a.m. to 11:15 a.m., there were exterior lights available at the exit discharges. Based on interview on 12/09/13 during the time of observation with the Executive Director and Maintenance Supervisor, it could not be verified the exterior lighting was connected to the generator.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to document annual testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections</p> | | <p>have the potential to be affected by the alleged deficient practice 3. The Director of Maintenance has been in-serviced by the Executive Director on the life safety requirement related to Exterior lighting by 1/9/14 4. The Director of Maintenance will perform audits on the documentation reports for emergency lighting tests, these will be presented to QA&A committee monthly for 6 months and the quarterly there after. 5. Date of Compliance 1/9/14</p> | | |

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| | <p>and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of battery operated emergency lighting testing documentation with the Maintenance Supervisor from 10:30 a.m. to 12:15 p.m. on 12/09/13, documentation of an annual ninety minute test for the two battery operated emergency lights located at the generator interior locations were not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged annual testing documentation for each of two battery operated emergency lights installed inside the facility was not available for review. Based on observations with the Executive Director and Maintenance Supervisor during the tour of the facility, the two battery operated emergency lights functioned when their respective test button was pressed.</p> <p>3.1-19(b)</p> | | | | |

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| K010048 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 109 of 109 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Plan" documentation with the Executive Director and Maintenance Supervisor during record review from 10:30 a.m. to 12:15 p.m. on 12/09/13, the facility's written fire safety plan did not include</p> | K010048 | <p>K-481. The policy as it relates to staff response to battery operated smoke detectors has been revised to meet this requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Staff have been in-serviced on staff response to battery operated smoke detectors by 1/9/14.4. The Executive Director will audit the policy on an annual basis and report the findings to the QA&A Team for review. The results of this policy will be updated on an annual basis.</p> | 01/09/2014 | | | |

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| | <p>staff response to the activation of battery operated smoke detectors installed in each of 109 resident sleeping rooms. Based on observations with the Executive Director and Maintenance Supervisor during tours of the facility from 1:00 p.m. to 4:15 p.m. on 12/09/13 and from 9:15 a.m. to 11:15 a.m. on 12/10/13, battery operated smoke detectors were installed in each resident sleeping room. Based on interview at the exit conference, the Executive Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> | | | | | | |

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| K010051 SS=C | <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, 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 in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. 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 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system's components and devices such as smoke detectors was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.</p> | K010051 | <p>1. a. The smoke detector located in the main lobby has been replaced to meet the requirement. b. The smoke detector located in the therapy room has been replaced to meet the requirement. c. the smoke detector located in the laundry room has been tested and is in full operation. There were no residents directly affected by the alleged deficient practice. 2. Residents' residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department has been in-serviced on the life safety code as it relates to documentation required for smoke detectors by 1/9/144. The sensitivity Test and</p> | 01/09/2014 | | | |

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| | <p>Findings include:</p> <p>Based on review of the facility's fire alarm system Inspection and Testing Forms dated 03/14/13 with the Maintenance Supervisor on 12/09/13 from 10:30 a.m. to 12:15 p.m., the following was noted on the Sensitivity Test and Inspection Report:</p> <p>a. The photoelectric smoke detector # 12 located in the main lobby had a factory setting of 1.5-4.40 % and had a measured setting of 1.46 % but was listed as "Pass" on the inspection report.</p> <p>b. The photoelectric smoke detector # 50 located in Therapy lacked a factory setting and a measured setting but was listed as "Pass" on the inspection report.</p> <p>c. The ion smoke detector # 101 located in the laundry had a factory setting of 1.9-3.00 V and had a measured setting of 2.32 but the "Pass/Fail " section was blank on the inspection report.</p> <p>Based on interview at the time of review, the Maintenance Supervisor acknowledged the results of documentation on the Sensitivity Test and Inspection Report were not complete.</p> <p>3-1.19(b)</p> | | <p>Inspection reports will be reviewed by the Maintenance Supervisor. Results of the inspection will be forwarded to the QA&A committee for review monthly for a period of 6-months and then the QA&A committee will determine the need for additional monitoring until a threshold of 100% is achieved.</p> | | | | |

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| K010056 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains are provided were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems in 2 of 109 resident rooms and one office. This deficient practice could affect at least four residents, visitors or staff.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., and on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. Resident room 419 was provided with two privacy curtains but one had a mesh</p> | K010056 | <p>K- 561. Room 419, 309 and the restorative nursing offices curtains have been replaced with mesh style tops to ensure adequate sprinkler coverage. There were no residents directly affected by the alleged deficient practice B. The area East area lacking adequate sprinkler coverage has had a new sprkinkler head installed. C. The Sprinkler heads have been relocated to meet the 4 inches from the wall. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Director of Maintenance & Director of Housekeeping serviced have been in-serviced on the life safety requirement related to adequate sprinkler coverage and the types of curtains needed by 1/9/14 4. The Director of Maintenance will</p> | 01/09/2014 | | | |

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| | <p>top panel less than 70 percent open weave and the the other had no mesh top panel at all.</p> <p>b. Resident room 309 had a privacy curtain with no mesh top panel.</p> <p>c. The restorative nursing office had a privacy curtain that had less than a 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector.</p> <p>Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the cubicle curtains with no mesh or inappropriate size mesh should not have been in use.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 exterior enclosed rooms on the closed North Unit. This deficient practice would not directly affect residents but could affect staff accessing the North unit.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., a room</p> | | <p>perform monthly audits of the shower curtains for 6 months. The results of those audits will be forwarded to the QA&A committee monthly for 6 months and then the QA&A team will determine the need for additional auditing until a threshold of 100% is achieved.</p> | | | | |

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| | <p>with exterior access on the closed North unit on the east hall lacked a sprinkler head to provide sprinkler coverage. The room was enclosed with wood construction and had combustible materials stored inside. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the exterior room lacked a sprinkler head.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the automatic sprinkler system was installed in accordance with NFPA 13, The 1999 Edition Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 5-6.3.3 requires sprinklers be located a minimum of 4 inches from a wall. This deficient practice could affect any staff using the first floor nourishment pantry behind the nurses station.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the two Primrose Unit north hall linen closets</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/10/2013 | |
| 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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| K010062 SS=E | <p>each had a sprinkler head that was one inch from the wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the sprinkler heads in the linen closets were one inch from the wall.</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 4 of 4 sprinklers in the facility which had paint on them. 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 at least 20 residents, staff and visitors on the South Unit.</p> <p>Findings include:</p> | K010062 | <p>1. The three automatic sprinkler heads were replaced in the south activity storage area, and the sprinkler head in the puzzle room by the Maintenance Director. A. The sprinkler head in the primrose clean utility has been relocated to ensure appropriate spray pattern of activated. B. The sprinkler head in the Primrose soiled utility room has been relocated to ensure appropriate spray pattern. C. The sprinkler head in the Southwest medication room was relocated to ensure appropriate spray pattern if activated. There were no residents affected by the alleged deficient practice. 2. Residents' residing at the facility have to potential to be affected by the alleged deficient practice. 3. The Maintenance Director will perform</p> | 01/09/2014 | | | |

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| | <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. Three sprinkler heads in the South Unit activity supply room had paint on the sprinkler deflector or fusible link</p> <p>b. A sprinkler head in the Puzzle room had paint on the sprinkler deflector.</p> <p>Based on interview at the time of the observations, the Executive Director and Maintenance Supervisor acknowledged the sprinklers had paint on the deflector or fusible link.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads in 1 of 1 sprinkler systems were unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or</p> | | <p>environmental/life safety rounds which will include sprinkler heads on a monthly basis. 4. Environmental/Life Safety inspection reports will be forwarded to the QA&A committee for review. The results of these audits will be reported by the Director of Maintenance monthly for 6 months and then the QAA team will determine the need for additional auditing until a threshold of 100% is achieved.</p> | | | | |

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| | <p>additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice does not directly affect residents since these areas are accessible to only staff members.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. The sprinkler head in the Primrose clean utility room was obstructed by a light fixture in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the room.</p> <p>b. The sprinkler head in the Primrose soiled utility room was obstructed by a light fixture in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the room.</p> <p>c. The sprinkler head in the Southwest Unit medication room was obstructed by a light fixture in such a way the spray pattern of the sprinkler head would not provide adequate coverage of the room.</p> <p>Based on interview at the time of observation it was acknowledged by the Executive Director and Maintenance Supervisor, the spray pattern of the sprinkler head would not provide adequate coverage of the rooms.</p> | | | |

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| K010064 SS=E | <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure 1 of 50 portable fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect at least 10 residents and staff using the Southwest Unit lounge.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the gauge on the portable fire extinguisher located in the Southwest Unit lounge with a</p> | K010064 | <p>1. The fire extinguisher located in the southwest lounge has been replaced to ensure proper operation. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department have been in-serviced on the life safety code as it relates to Fire extinguishers by 1/9/144. Monthly Fire Extinguisher audits will be forwarded to the QA&A team for review. The results of those audits will be reported by the Maintenance supervisor monthly for a period of 6-months. Then the QA& A team will determine the need for additional auditing until a threshold of 100% is achieved.</p> | 01/09/2014 | | | |

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| K010066 SS=E | <p>pool table indicated the extinguisher was undercharged. The Executive Director and Maintenance Supervisor agreed at the time of observation, the gauge reading was not in the normal operating range and did not know if it would affect the operation of the fire extinguisher.</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>(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 trash and cigarette butts in 1 of 1 areas where</p> | K010066 | 1. The co-mingled trash was immediately removed upon the discovery of the co-mingled trash. The Terra Cotta pot was removed | 01/09/2014 | | | |

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| K010070 SS=E | <p>smoking was permitted for residents staff were not commingled. This deficient practice could affect residents using the smoking area.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., three containers contained cigarette butts commingled with the paper trash. Two containers were metal buckets and the third was a terra cotta pot. Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the commingled trash and cigarette butts. Additionally, based on interview, the facility is nonsmoking with eight residents who have been grandfathered being allowed to smoke.</p> <p>3.1-19(b)</p> <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) 19.7.8 Based on observation, record review, and interview; the facility failed to</p> | K010070 | <p>from the area. There were no residents directly affected. 2. Residents who reside at the facility have the potential to be affected by the alleged deficient practice. 3. Residents who smoke have been informed of the requirement as it relates to trash in smoking areas., The Maintenance Department will complete rounds on a daily basis to ensure no co-mingled trash exists. 4. The Maintenance Supervisor will perform rounds/audits of the smoking area for residents. The results of those audits will be forwarded to the QA&A committee for review monthly for a period of 6-months and then quarterly thereafter.</p> <p>1. The space heaters in the training center and the activity</p> | 01/09/2014 | | | |

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| | <p>enforce the policy for the use of 3 of 3 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect at least 30 residents, staff or visitors on the Southwest or East Units.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., and on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. Two space heaters were observed in use in the Training Center which is a non-resident area.</p> <p>b. A space heater was observed but not in use in the East Unit activity office.</p> <p>Based on review of the space heater policy with the Executive Director at the exit conference at 11:15 a.m. on 12/10/13, the facility does allow space heaters in nonsleeping staff and employee areas with the heating element not exceeding 212 degrees Fahrenheit.</p> <p>Based on interview at the time of record review, the facility does not have documentation that the heating elements of the three space heaters will not exceed 212 degrees Fahrenheit.</p> <p>3.1-19(b)</p> | | <p>office were immediately removed at the time of the discovery of their use. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential3. Staff were in-serviced on the regulation as it relates to space heater use by 1/9/14. The Maintenance Department will complete random monthly rounds to ensure no further space heaters are being utilized.4. Space Heater audits will be performed by the Maintenance Supervisor on a monthly basis for a period of 6-months. The results of those audits will be forwarded to the QA&A monthly for 6-months and then quarterly there after.</p> | | | | |

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| K010072 SS=E | <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. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 27 exits. This deficient practice could affect at least 15 residents as well as staff and visitors in the South Unit kitchen lounge area.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the South unit kitchen lounge exterior exit door could not be readily opened due to the door hitting the threshold. Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the door could not be opened.</p> <p>3.1-19(b)</p> | K010072 | <p>1. The South Unit Kitchen Door has been repaired to ensure proper exit operation. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department as well as facility staff have been in serviced on the requirement related to exit egress by 1/9/13. Staff were informed to place doors that have not opened properly into the Building Engines Maintenance program for appropriate follow up.4. The Maintenance Department will perform monthly exit egress tests. The results of those tests will be forwarded to the QA&A committee on a monthly basis for a period of 6-months and quarterly thereafter until a threshold of 100% is achieved.</p> | 01/09/2014 | | | |

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| K010074 SS=B | <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 3 of 200 rooms were flame retardant. This deficient practice could affect at least 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., the following was noted:</p> <p>a. Window curtains in the Training Center lacked attached documentation that they were inherently flame retardant.</p> | K010074 | K-741. The training center curtains have been removed to meet this requirement. B. The curtains in the southwest lounge 1. A. The window curtains in have been removed to meet this requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department have been in-serviced on the requirement as it relates to flame retardant materials by 1/9/144. The Maintenance Department will complete rounds on a monthly basis. The results from those rounds will be forwarded to the QA&A committee for a period of | 01/09/2014 | | | |

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| K010130 SS=D | <p>b. Window curtains in both of the Southwest Unit lounges lacked attached documentation that they were inherently flame retardant.</p> <p>Based on interview at the time of observation with the Executive Director and Maintenance Supervisor, there was no documentation regarding flame retardancy for these window curtains available for review.</p> <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 1 of 4 boilers had current certificates of inspection. NFPA 101, 19.1.1.3 requires all health care facilities be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. This deficient practice would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/10/13 from 9:15 a.m. to 11:15 a.m., the facility's certificate of inspection for the</p> | K010130 | <p>6-months and then quarterly there after until a threshold of 100% is achieved.</p> <p>K-1301. The Boiler inspection has been performed and now is in compliance with the mentioned requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department have been in-serviced on the requirement as it relates to boiler inspections by 1/9/14. The Maintenance Department will perform audits of the Boiler inspections monthly for a period of 6-months. The results of those inspections will be forwarded to the QA&A committee on a monthly basis for 6-months and quarterly there after.</p> | 01/09/2014 | | | |

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| K010143 SS=B | <p>boiler with State of Indiana registration number 290623 had expired on 10/17/13. Based on interview at the time of observation with the Executive Director and Maintenance Supervisor, there was no documentation regarding a current inspection of the boiler available for review.</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 2 of 4 liquid oxygen storage areas where oxygen transferring takes place were enclosed by 1 hour fire resistive enclosures. This deficient practice could affect any residents, staff and visitors in the vicinity of the oxygen storage rooms on</p> | K010143 | <p>K-1431. The Oxygen Room Doors have been replaced and have the appropriate fire rating.2. Residents' residing at the facility have the potential to be affected by the alleged deficient practice. 3.Environmental/Life Safety rounds which will include Oxygen storage rooms will be performed by the Director of Maintenance on</p> | 01/09/2014 | | | |

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| K010144 SS=C | <p>the Primrose and Southwest Units.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/10/13 from 9:15 a.m. to 11:15 a.m., the Primrose and Southwest Units' oxygen storage room door labels were painted over and the ratings could not be determined. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the fire rated door labels for the oxygen storage room doors were painted.</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>Based on interview and record review, the facility failed to ensure the off site fuel source for 2 of 2 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be</p> | K010144 | <p>a monthly basis and changes in door structure will be repaired as needed. 4. Environmental/Life Safety inspection reports will be forwarded the QA&A committee monthly for 6 months and then the QAA committee will determine the need for additional auditing until a threshold of 100% is achieved.</p> <p>K-1441. The Natural Gas Letter has been updated to meet the life safety requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3.The Maintenance Department have been educated on the requirement as it relates to the reliable source for natural gas by</p> | 01/09/2014 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155685 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/10/2013 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-ELKHART | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W HIVELEY AVE ELKHART, IN 46517 | | | |
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| | <p>permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure</p> <p>b) Liquefied petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the | | 1/9/134. The Maintenance Department will forward the Natural Gas Letter to the QA&A committee for review. The letter will be reviewed on a quarterly basis in the QA&A meetings. | | | | |

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| | <p>statement regarding the low probability of interruption,</p> <p>5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Executive Director and Maintenance Supervisor during record review from 10:30 a.m. to 12:15 p.m. on 12/09/13, the fuel source for the two emergency generators was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) which was dated August 4, 2008 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas and the low probability of interruption of the natural gas service.</p> <p>This was acknowledged by the Executive Director and the Maintenance Supervisor during the time of record review.</p> <p>3.1-19(b)</p> | | | | | | |

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| K010147 SS=E | <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>1. Based on observation and interview, the facility failed to ensure ground fault circuit interrupter (GFCI) receptacles in staff areas in 2 of 4 units were provided and operated properly to protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. These deficient practices were not in a resident area and would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m., and on</p> | K010147 | <p>K-1471. A. The East Unit Outlet has been replaced with a GFI outlet to meet the requirement.B. The Primrose Medication room has had the outlet changed to a GFI outlet to meet the requirement.C. The Nebulizer was removed from the power strip in room 419 upon the discovery of its use. The power strip was removed from rooms 429, 430, the secondary activity office, the Clinical Education office and the MDS office. The refrigerator for all locations are plugged into the wall directly. There were no residents affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice.3. Staff have been in-serviced by the Director of Clinical education on the use of power strips and the life safety requirement by 1/9/14*Guardian Angels will monitor residents rooms 5 x per week to ensure no power cords are being utilized. Any areas found will be corrected immediately. 4. The Director of Maintenance will perform rounds on a monthly basis to audit power strip usage. The results of those rounds will be forwarded to the QA&A committee monthly for 6 months and then the QA&A</p> | 01/09/2014 | | | |

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| | <p>12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. There was a GFCI electrical receptacles on the wall within two feet of the sink in the East Unit medication room. When tested with the test button on the receptacle, power was not interrupted.</p> <p>b. There was an electrical receptacle on the wall within two feet of the sink in the Primrose Unit medication room. The outlet was not identified as being protected by a GFCI.</p> <p>Based on interview at the times of observation, the Director of Plant Services acknowledged the aforementioned wet location areas were not provided with GFCI protection.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute</p> | | committee will determine the need for additional auditing until compliance is achieved. | | | | |

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| | <p>for fixed wiring of a structure. This deficient practice could affect least 20 residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and Maintenance Supervisor during a tour of the facility on 12/09/13 from 1:00 p.m. to 4:15 p.m. and on 12/10/13 from 9:15 a.m. to 11:15 a.m., the following was noted:</p> <p>a. A nebulizer was plugged into a powerstrip in resident room 419.</p> <p>b. Refrigerators were plugged into power strips in resident rooms 429, 430, in the secondary activity office, in the gift shop, in the Clinical Education office and in the MDS office.</p> <p>Based on interview at the time of observation, the Executive Director and Maintenance Supervisor acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> | | | |