

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  02/13/2014
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/09/13 and 12/10/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/13/14</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 PSR survey, Golden Living Center-Elkhart was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building (North, East and South Units) was</p>	K010000		
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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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	<p>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 148 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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=B	<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 were protected to maintain the smoke resistance of each smoke barrier. LSC 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 and interview with the Maintenance Supervisor on 02/13/14</p>	K010025	<p>K-251. The Primrose center smoke barrier has had the expandable foam removed and approved fire caulked has been used to meet this requirement. B. The primrose north smoke barrier has had the expandable foam removed and replaced with approved fire caulk and are now sealed . C. The Primrose Units south smoke barrier has had the expandable foam removed and replaced with approved fire caulk.D. The smoke barrier near 425 has had the expandable foam removed and replaced with approved fire caulked to meet this requirement. 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. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3.The Director of Maintenance is</p>	03/10/2014			

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	<p>from 8:30 a.m. to 10: 30 a.m., there were penetrations through the smoke barriers above the ceiling tiles at the following locations that were sealed with expandable foam which is not an approved material for maintaining the smoke resistance of a smoke barrier:</p> <p>a. The Primrose Unit center smoke barrier had a sprinkler pipe penetration sealed with expandable foam.</p> <p>b. The Primrose Unit north smoke barrier had three penetrations sealed with expandable foam.</p> <p>c. The Primrose Unit south smoke barrier had three wire penetrations sealed with expandable foam.</p> <p>d. The smoke barrier near room 435 had one wire penetration sealed with expandable foam.</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 Maintenance Supervisor acknowledged the openings through the smoke barriers had been sealed with expandable foam that was thought to be an approved material. The ceiling smoke barrier had not been repaired due to a frozen sprinkler pipe that delayed repair which is scheduled.</p> <p>This deficiency was cited on 12/10/13. The facility failed to implement a</p>		<p>no longer at the facility and the maintenance tech has been in-serviced on the life safety requirement as it relates to sealed smoke barriers by March 2, 2014. 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&amp;A committee monthly for 6 months and then the QA&amp;A committee will determine the need for additional auditing until compliance is achieved. 5. Date of Compliance March 10, 2014</p>		

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	systemic plan of correction to prevent recurrence.  3.1-19(b)				