

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/18/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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K 000  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: 05/18/15</p> <p>Facility Number: 000439 Provider Number: 155716 AIM Number: 100275070</p> <p>At this Life Safety Code survey, Good Samaritan Home Inc. 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 with two separate basements was determined to be of Type II (222) construction for the original portion of the facility and Type V (111) construction for the remainder of the facility, including the Pathways 1, Pathways 2, and Pavilion. The facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke</p>	K 000	<p>Please accept the following Plan of Correction for the annual Life Safety Survey conducted on May 18, 2015</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies This Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws This facility appreciated the time and dedication of the Surveyor, and the facility will accept the survey as a tool for use in continuing to better the quality of care provided to the residents of our community</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 025 SS=E Bldg. 01	<p>detectors in the corridors, spaces open to the corridors, both basements, and all resident sleeping rooms. The facility has a capacity of 212 and had a census of 184 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds used for facility storage and one plastic shed used for bio hazard waste.</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 1 of 14 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect any number of residents, as well as staff and visitors while in the Administrative Wing and the corridor between the Lobby and Dining Room.</p>	K 025	There were no residents found to be affected to date by the cited deficient practice Between the dates of Tuesday, May 26, 2015 and Wednesday, June 3, 2015, the facility maintenance staff conducted a survey of each corridor and closed all opening/penetration through a fire wall with a fire-rated material The material used (White Lightning - Flame Buster) Intumescent	06/03/2015

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K 047 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation on 05/18/15 at 12:45 p.m. during a tour of the facility with Director of Facility Operations, the smoke barrier wall above the smoke barrier doors between the Administrative Wing and the corridor between the Lobby and Dining Room had a four inch gap through the wall. This was acknowledged by the Director of Facility Operations at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was provided for 1 of 3 ways of exit from Pathways III. LSC 19.2.10.1 refers to 7.10. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect 15 residents, as well as staff and visitors in Pathways III.</p>	K 047	<p>Silicone Sealant is manufactured specifically for this purpose The corrective action taken to ensure that the deficient practice does not recur is that all future contractors will be required to complete a checklist and provide documentation and product information for any repair work done on ALL firewalls that have been penetrated No further action is needed at this time, as this is a structural issue</p> <p>There were no residents found to be affected to date by the cited deficient practice On Wednesday, May 27, 2015, an exit sign that is connected to an emergency generator was installed in the Pathways II Therapy Kitchen Testing of this new device and regular maintenance will be conducted in the same manner as required by all emergency exit lighting devices A list of all exit signs is kept in the Maintenance Department, and this new device has been added to that list [See attachment] No further action is needed, as</p>	05/27/2015			

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	<p>Findings include:</p> <p>Based on observation on 05/18/15 at 11:15 a.m. during a tour of the facility with the Director of Facility Operations, there was no illuminated exit sign at the south end of the Pathways III corridor. This was acknowledged by the Director of Facility Operations at the time of observation.</p> <p>3.1-19(b)</p>		this is a structural issue		