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| 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 12/10/2014 |
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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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| K010000 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/10/14</p> <p>Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This 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</p> | K010000 | <p>F 000 Initial Comments</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 of 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. The facility has a capacity of 196. 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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| K010018 SS=E | <p>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 facility has a capacity of 196 and had a census of 187 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 was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code-Medical Surveyor on 12/15/14.</p> <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 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</p> | | | |

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| K010025 SS=E | <p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Central Unit soiled utility room doors closed and latched into the door frame. This deficient practice could affect at least 10 residents throughout the Central Unit as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services on 12/10/14 at 12:55 p.m., the Central Unit soiled utility room door lacked a functioning latching device. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the aforementioned condition, indicating the room was formally a shower room.</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</p> | K010018 | <p>K018 A walk-thru audit of areas with similar functions was completed. We purchased a sipher latch lock for the door. Installation is scheduled for 12/22/14. When areas change purpose or function the Director of Maintenance will inspect for correct lock hardware and door function. Work orders will be written to correct deficient locks.</p> <p>Alleged date of compliance 1/6/2015</p> | 01/06/2015 | | | |

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| | <p>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 2 of 3 smoke barriers within the Gables unit 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 30 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 Maintenance Lead II and the Director of Environmental Services on 12/10/14 from 11:30 a.m. to 11:45 a.m., there were exposed penetrations through the attic smoke barriers at the following locations that were not firestopped:</p> <p>a) The attic smoke barrier near exit door 6 had eight penetrations that were not sealed with gaps ranging from one to three inches. Six of the penetrations were</p> | K010025 | <p>K025 Areas for potential smoke barrier violations were inspected. Maintenance staff will complete drywall repair and fire caulk repair for these smoke barrier areas.</p> <p>Each time a contractor and/or staff complete work that affects a smoke barrier wall, an inspection will be completed by Maintenance supervisor or designee. Results will be reported to Maintenance Director and work orders written to remedy compromised smoke barrier walls.</p> <p>Alleged date of compliance 1/6/2015</p> | 01/06/2015 |

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| K010038 SS=E | <p>pipe sleeves; one was a sprinkler pipe and the other was a two inch diameter hole.</p> <p>b) The attic smoke barrier in Pod 1 by room 523 had four penetrations that were not sealed with gaps ranging from one to two inches. Three of the penetrations were pipe sleeves and the other was a 2" by 4" wood stud.</p> <p>Based on interview during the times of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the unprotected openings through the attic smoke barriers.</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>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 26 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of</p> | K010038 | <p>K038 A walk-thru audit was completed. A keypad was added next to card reader at door #6 (Att.1). The key pad code will be posted at the #6 door as well. This type of egress hardware will not be added in this building in the future.</p> <p>Alleged date of compliance 1/6/2015</p> | 01/06/2015 |

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| K010062 SS=A | <p>health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects at least 30 residents and visitors.</p> <p>Findings include:</p> <p>Based on interview on 12/10/14 at 11:10 a.m. with the Maintenance Lead II and the Director of Environmental Services, all exit doors were magnetically locked and could be opened by staff by swiping an electronic keycard. Based on observation, each door with the exception of exit door #6, was also provided with a keypad next to the card reader. Based on interview with Maintenance Lead II and the Director of Environmental Services at 11:10 a.m., the facility did not want residents or visitors using exit # 6.</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>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler</p> | K010062 | K062 Director of Maintenance completed a walk-thru to | 01/06/2015 | | | |

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| K010064 | <p>systems was continuously maintained in reliable operating condition. 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 staff in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services at 12:45 p.m. on 12/10/14, paint was noted on the sprinkler deflector in the basement billing records room and the pendant sprinkler in the basement hallway near activity storage was improperly oriented in an upright position. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the aforementioned sprinkler conditions.</p> <p>3.1-19(b) NFPA 101</p> | | <p>identify sprinkle head deficiencies. The sprinkle deflector heads identified were changed 12/12/14. Sprinkle deflector heads will be audited following ceiling painting. When a sprinkler head must be changed for any reason the Maintenance Supervisor and/or designee will complete an audit for proper head. Finding will be reported at the weekly maintenance meeting and work orders written.</p> <p>Alleged date of compliance 1/6/2015</p> | | | | |

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| SS=B | <p>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>Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers were maintained in accordance with NFPA 10, 1998 Edition, the Standard for Portable Fire Extinguishers. NFPA 10, Section 4-4.4.2 requires each extinguisher that has undergone maintenance that includes internal examination or that has been recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. This deficient practice could any of the kitchen staff and resident or visitor using the adjacent Sideboard dining area.</p> <p>Findings include:</p> <p>Based on observation on 12/10/14 at 12:30 p.m. with the Maintenance Lead II</p> | K010064 | <p>K064 The four (4) portable fire extinguishers were serviced by the facility fire protection vendor on 12/10/14. (Att. 2) Six-year service collars were attached with the month and year it was serviced. (Att. 3) The fire protection vendor monitors fire extinguisher PM service for this facility. (Att. 4: 1-5) The vendor monitors and services annually. Following their inspection the Maintenance department will audit the completed work and report findings to the Maintenance Director or designee. Alleged date of compliance 1/6/2015</p> | 01/06/2015 | | | |

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| K010066 SS=D | <p>and the Director of Environmental Services, the four K class fire extinguishers located in the main kitchen and Sideboard kitchen all had a six year maintenance tag affixed to them but did not have a "Verification of Service" collar. A six year maintenance procedure involves an internal examination that requires the extinguisher to be recharged. Based on interview at the time of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the aforementioned condition but did not know why the service collars were not provided.</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> | | | |

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| K010067 SS=E | <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 cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 1 outside areas where smoking was permitted. This deficient practice could affect one resident, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Lead II and the Director of Environmental Services at 11:10 a.m. on 12/10/14, there was a 5-gallon bucket outside in the North Unit courtyard outdoor smoking area with at least 30 extinguished cigarette butts commingled with banana peels and dried leaves. Based on interview at the time of the observation, the facility has one resident who smokes and the Maintenance Lead II and the Director of Environmental Services acknowledged the extinguished cigarette butts were deposited in the 5-gallon bucket.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning</p> | K010066 | <p>K066 The facility purchased a metal container with lid for the resident smokers 12/19/14. Sand was added and it is being used as the residents smoking receptacle. The Environmental Services Director will monitor three times a week to assure smoke materials are being disposed of properly. As of 1/1/15 the organization will be a smoke-free campus. Alleged date of compliance 1/6/2015</p> | 01/06/2015 |

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| | <p>comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 80 of 80 fire dampers throughout the Gables Unit and the Orchard dining room were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects any residents staff and visitors throughout the Gables Unit and the Orchard dining room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Lead II at 11:00 a.m. on 12/10/14, the facility had at least 80 fire dampers located in the HVAC supply air vents throughout the Gables Unit resident</p> | K010067 | <p>K067 An audit of dampers has been completed. We will replace fusible links and lubricate sliding mechanisms to make sure the smoke dampers close properly. Alleged compliance 1/6/15.</p> <p>A new PM was written for the four-year inspection cycle (Att. 7). The PM cycle is monitored by the Maintenance Director and/or his designee for compliance.</p> <p>Documentation of work will be submitted via fax 1/7/15 to ISDH.</p> <p>Alleged date of compliance 1/6/2015</p> | 01/06/2015 | | | |

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| K010147 SS=E | <p>rooms and the Orchard dining room and no documentation regarding fire damper inspection and service within the past four years.</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 1 of 1 pieces of medical equipment and high current draw electrical devices were not plugged into powers strips or extension cords 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 that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Lead II and the Director of Environmental Services from 11:00 a.m.</p> | K010147 | K0147 The Environmental Services Director will in-service and reeducate housekeeping and nursing staff on the use of power strips and 3-way adapters and the non-use of extension cords (Att. 5). An audit of rooms was completed by the Environmental Services Director and 3-way adapters and extension cords were removed and inappropriate use of power strips was corrected. The ESD or designee will complete weekly audits of the building for extension cord violations, 3-way adapter violations and/or power strip violations Att.6). Correction will be completed immediately and documented by the EDS or designee. The ESD or designee will submit audit documentation to the Administration weekly to include violations. The ESD will report violations to QAPI routinely. Alleged date of compliance 1/6/2015. | 01/06/2015 |

| 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 12/10/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GREENCROFT HEALTHCARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1225 GREENCROFT DR GOSHEN, IN 46527 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>to 1:30 p.m. during a tour of the facility on 12/10/14, the following was noted:</p> <p>a) The air conditioner in resident room 143 was plugged into a powerstrip.</p> <p>b) An air mattress in resident room 127 by the window was plugged into a powerstrip.</p> <p>c) A toaster was plugged into a powerstrip in the Central Unit storage room.</p> <p>Based on interview at the times of observation, the Maintenance Lead II and the Director of Environmental Services acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> | | | | |