

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
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NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514
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K 0000 Bldg. 02	<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: 01/05/16</p> <p>Facility Number: 002661 Provider Number: 155783 AIM Number: 201056540</p> <p>At this Life Safety Code survey, Greenleaf Health Campus 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) 2000 Edition, Chapter 18, New 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 building was constructed in 2010, is adjacent to an assisted living unit and separated by a two hour rated fire wall. The facility has a fire alarm system with smoke detection in corridors, in areas open to the corridors and hard wired smoke detectors in the</p>	K 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on 1/5/2016. Please accept this Plan of Correction as Greenleaf Health Campuscresdible allegation of compliance effective June 18, 2014. Greenleaf respectful requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0018 SS=D Bldg. 02	<p>resident rooms. The facility has a capacity of 60 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance supplies.</p> <p>Quality Review completed 01/06/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 60 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observation and interview with the Director of Environmental Service and the Maintenance on 1/5/16 at 11:56 a.m., the corridor door to resident room 217 had a wooden door stop that prevented the resident room door from closing and latching into the door frame.</p>	K 0018	<p>Resident room 217 door stop was removed. No other resident room was found with a door stop. Director of Plant Operations will make monthly audits of doors to ensure the absence of door stops. This action has been added to the monthly inspection forms. Monthly inspections forms are turned into the Quality Assurance committee and are reviewed for completeness and compliance. Any concerns regarding door stops will be immediately addressed by the Director of Plant Operations and/or the Executive Director.</p>	01/19/2016

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K 0022 SS=E Bldg. 02	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation, the facility failed to ensure 1 of 1 200 Hall exit discharge paths was marked with directional indicators to make the direction of travel to reach the public way obvious. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect staff, visitors, and at least 25 residents in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Service and the Maintenance on 01/05/15 at 11:59 a.m., the 200 Hall exit discharge sidewalk goes</p>	K 0022	A directional sign was placed at the 200 hall discharge path.No other exit was identified as needing additional signage.The Director of Plant Operations will review appropriate fire exit signage as a part of the monthly inspections. The inspection form now includes ensuring signs are easily readable in in the correct locations.The Plant Operations Director will provide monthly inspection reports to the Quality Assurance committee. Any concerns regarding signage will be immediately corrected and reported to the Executive Director	01/19/2016

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K 0050 SS=C Bldg. 02	<p>left and right shortly after exiting the door. No sign is visible to indicate the direction to the public way. If the right path leads back into the building. The left path leads to the public way. Based on interview at the time of observation, the Director of Environmental Service and the Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review, the facility failed to insure fire drills included the transmission of a fire alarm signal in 6 of 8 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires that fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a</p>	K 0050	<p>Transmission of the fire drill alarm is now documented each of three shifts. Other shifts were found to have documented alarm transmission responses. The fire drill audit sheet has been altered to include the transmission recording and is maintained by the Director of Plant Operations or designee. The fire alarm drill documentation is provided to the Quality Assurance committee. Each audit form will be reviewed</p>	01/19/2016

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K 0051 SS=E Bldg. 02	<p>coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Record of Drills" with the Director of Environmental Service and the Maintenance Assistant at on 1/5/16 at 10:14 a.m., the only transmission of fire alarm signal documentation provided was for fire drills performed on 10/17/15 at 10:45 a.m. and 11/7/15 7:55 p.m. fire drills.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire</p>		by the committee for completeness and accuracy including the fire alarm transmission.		

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K 0056 SS=D Bldg. 02	<p>alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 smoke detectors in the Town Square area were installed in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72 2-3.4.3.1 Spot-type smoke detectors shall be located between 4 in. and 12 in. (100 mm and 300 mm) down from the ceiling to the top of the detector. This deficient practice could affect up to 19 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Service and the Maintenance on 1/5/16 at 11:21 a.m., the Town Square open area has a ceiling that goes up quite a bit higher than the one story facility. Two separate smoke detectors that were roughly 10 feet from the ceiling. Based on interview at the time of observation, the Director of Environmental Service and the Maintenance acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system,</p>	K 0051	A smoke detector was placed in the Town Square area as directed.No other area of the community was found to be in need of additional smoke detectors.Korson Fire Systems has been notified to place a perminant smoke detector in the identified area and to inspect the community for additional compliance.Any concerns documented by Korson Fire Systems will be addressed through the Quality Assurance Committee and immediately remedied.	01/19/2016			

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	<p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 2 of 3 sprinklers in the 300 Hall Nurse's supply room was 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, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Service and the Maintenance on 1/5/16 at 11:26 a.m., the</p>	K 0056	The spray pattern for the two identified sprinklers was made unobstructed by relocating the light fixture. No other sprinkler heads were found to be at risk for obstruction of sprinkler spray pattern. Korson Fire Systems have been contracted to inspect all areas of the community on an annual basis for compliance with the latest of NFPA standards. Any concerns as identified by the Korson Fire Systems of internal inspection will be immediately addressed for compliance.	01/19/2016

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K 0072 SS=E Bldg. 02	<p>spray pattern for the two separate sprinkler heads were obstructed by separate ceiling lights. One ceiling light was two inches away and below the deflector. Another ceiling light was six inches away and below the deflector. Based on interview at the time of observation, the Director of Environmental Service and the Maintenance acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 1 of 5 exits. This deficient practice could affect up to 16 residents close enough to use the exit.</p> <p>Findings include:</p> <p>Based on observation with the the</p>	K 0072	<p>Snow was removed by the Director of Enviromental Services in the identified area.No other exits were found to be without snow removal.The Director of Plant Operations reviewed the contract/agreement with the snow revoval company and reinforced the clearing of the identified area as part of the agreement understanding.The Director of Plant Operations, Director of Environemtal Services or designees will monitor for snow clearing to include the identified</p>	01/19/2016

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K 0144 SS=C Bldg. 02	<p>Director of Environmental Service and the Maintenance on 1/5/16 at 12:17 p.m., the exit discharge for the Sunroom was obstructed by a two inch accumulation of snow. Based on interview at the time of observation, the Director of Environmental Service and the Maintenance said the facility has a contract with a landscaping company who had not been out yet to remove the snow and acknowledged the aforementioned condition.</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 record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the</p>	K 0144	<p>area. Any noncompliance will be called through the Directors and the the outside agent. This audit will be communicated through the Quality Assurance committee and the Vendor Account Review.</p> <p>The cool down period is a part of the automatic generator program. The run period is 45 minutes with 30 minutes under load with 15 minutes of cool down. Only one generator exist on the property. The generator test form now includes documentation of the cool down period established by the manufacturer. The Director of Plant Operations will provide monthly testing with the test form being forwarded to the Quality Assurance Committee. The test audit form will be reviewed by the Quality Assurance Committee via the Direct of Plant Operations. Any</p>	01/19/2016

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	<p>Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Director of Environmental Service and the Maintenance on 1/5/16 at 10:45 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the the Director of Environmental Service and the Maintenance acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>failure in the cool down period will be called to the vendor for immediate correction.</p>		