

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155303	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST JASONVILLE, IN 47438
---	--

(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
K0000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/30/12 and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/06/12</p> <p>Facility Number: 000200 Provider Number: 155303 AIM Number: 100367980</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk-thru survey, Good Samaritan Society Shakamak Retirement Community 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</p>	K0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155303	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST JASONVILLE, IN 47438
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>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 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms were not provided with smoke detection. The facility has a capacity of 75 and had a census of 61 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for two detached garages, one used for a maintenance shop and maintenance storage, and the other used for facility storage. Neither garage was provided with sprinkler coverage.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155303	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST JASONVILLE, IN 47438
---	--

(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>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/17/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155303		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/06/2012	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM				STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST JASONVILLE, IN 47438			
(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			
K0029 SS=E	<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 1 of 10 hazardous area room doors to rooms such as a kitchen would latch into the door frame. This deficient practice could affect any of the 61 residents, as well as staff and visitors while in the dining room.</p> <p>Findings include:</p> <p>Based on observation on 08/06/12 at 10:00 a.m. during a tour of the facility with Maintenance Supervisor, the kitchen door to the main part of the kitchen was not provided with a positive latch, only a deadbolt. This was acknowledged by the Maintenance Supervisor at the time of observation.</p>	K0029	<p>Submission of this plan of correction shall not constitute or be construed as an admission by Shakamak Good Samaritan Center that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Shakamak Good Samaritan Center.</p> <p>Survey Event: ID ZOU521 Survey Date: 05/30/2012</p> <p>RE: K029 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>1. The kitchen door now has a positive latch.</p> <p>Completion Date: Aug. 24, 2012</p>	08/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155303	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SHAKAMAK RETIREMENT COMM	STREET ADDRESS, CITY, STATE, ZIP CODE 800 E OHIO ST JASONVILLE, IN 47438
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>3.1-19(b)</p> <p>This deficiency was cited on 05/30/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			