

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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 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: 01/24/13</p> <p>Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist &amp; Robert Sutton, Life Safety Code Specialist Trainee.</p> <p>At this Life Safety Code survey, Golden Living Center-Mishawaka 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</p>	K0000	<p><b>Disclaimer Statement</b> Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal &amp; State Law.</p> <p><b>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirement."</b></p>	
-------	---	-------	---	--

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:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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>and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in forty one resident sleeping rooms. The facility has a capacity of 85 and had a census of 55 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except an unsprinklered garage and shed used for storage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
	following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
K0018 SS=E	<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 regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 41 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 22 residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on observation on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., the corridor door to resident room 110 would not latch into its frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the door to resident room 110 would not latch in its frame.</p>	K0018	<p><b>K018/E</b></p> <p>1) The corridor door to resident room 110 was adjusted to latch into its frame. 2) All residents on the 100 hall have the potential to be affected by this practice. 3) A Preventative Maintenance work order will be added to computer to remind maintenance staff to check that all resident corridor doors latch into their frames on a routine basis. 4) Compliance of Preventative Maintenance work order inspections will be monitored by the Executive Director for compliance. Adverse results will be shared during monthly QA meetings on a continual basis.</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
	3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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	
K0025 SS=E	<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 openings through 1 of 4 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 had the potential to affect 22 residents on the 100 hall, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., there were three, one half inch holes in the</p>	K0025	<p><b>K025/E</b></p> <p>1) The three one-half inch holes in the smoke barrier on both sides of the smoke barrier wall in the 100 hall adjacent to room 109 and 107 were sealed with the appropriate fire/smoke prevention material.</p> <p>2) All residents on the 100 hall, as well as staff and visitors have the potential to be affected by this practice.</p> <p>3) A Preventative Maintenance work order will be added to computer to remind maintenance staff to check that there are no holes on smoke barrier on a routine basis.</p> <p>4) Compliance of Preventative Maintenance work order inspections will be monitored by the Executive Director for compliance. Adverse results will be shared during monthly QA meetings on a continual basis.</p>	02/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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>smoke barrier on both sides of the smoke barrier wall in the 100 hall adjacent to room 109 and 107. Based on interview with the Maintenance Supervisor at the time of observation, the penetrations in the smoke barrier were done by contractors and he would make sure the penetrations were sealed.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient had the potential to affect residents on the 200 hall, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., the set of smoke barrier doors in the 200 hall had a three and a half inch gap between the doors when they were closed which</p>	K0027	<p><b>K027/E</b> 1) The smoke barrier doors in the 200 hall were adjusted to the minimum clearance necessary for proper operation to restrict the movement of smoke (1/8") when closed. 2) All residents on the 200 hall, as well as staff and visitors have the potential to be affected by this practice. 3) A Preventative Maintenance work order will be added to computer to remind maintenance staff to check that smoke barrier doors meet the minimum clearance of 1/8" when closed. 4) Compliance of Preventative Maintenance work order inspections will be monitored by the Executive Director for compliance. Adverse results will be shared during monthly QA meetings on a continual basis.</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
	would allow the passage of smoke. Based on interview with the Maintenance Supervisor on 01/24/13 between 9:00 a.m. and 1:30 p.m., he acknowledged the smoke barrier doors did not completely close, leaving a three and a half inch gap between the doors.  3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
K0074 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 1 of 2 dining rooms were flame retardant. This deficiency had the potential to affect resident, staff and visitors who use this dining room.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., the window coverings in the dining room adjacent to the director of nursing office lacked attached documentation confirming they were inherently flame retardant. Based on</p>	K0074	<p><b>K074/B</b></p> <p>1) Flame retardant certification for the window curtains in the fireside dining room is now on file.</p> <p>2) All residents, staff and visitors have the potential to be affected by this practice.</p> <p>3) Maintenance staff has been educated regarding ensuring flame retardant certification is on file for all newly introduced window coverings.</p> <p>4) Certificate was in facility in ED's office. Compliance will be monitored by ED, DNS and Maintenance Director. Each will keep copies of flame retardant certifications on file so certifications will be accessible during survey. Adverse results will</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
	interview with the Maintenance Supervisor on 01/24/13 between 9:00 a.m. and 1:30 p.m., he stated there was no documentation regarding flame retardancy for the window coverings available for review.  3.1-19(b)		be shared during monthly QA meetings on a continual basis.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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
K0144 SS=F	<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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage</li> </ol>	K0144	<p><b>K144/F</b></p> <ol style="list-style-type: none"> <li>1) A remote alarm annunciator for the generator will be added to the nurses station fire panel.</li> <li>2) All residents, staff and visitors have the potential to be affected by this practice.</li> <li>3) Per LSC inspection, this was the only issue not to be connected to nurses station fire panel.</li> <li>4) The system will be monitored during weekly generator checks. Any issues will be corrected and reported to the QA committee for further follow up on a continual basis.</li> </ol>	02/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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>tank contains less than a 3-hour operating supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficiency had the potential to affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., a remote alarm annunciator for the generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station. Based on interview with the Maintenance Supervisor on 01/24/13 between 9:00 a.m. and 1:30 p.m., there was no remote alarm annunciator for the generator in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544		
(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	
	3.1-19(b)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544			
(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			
K0147 SS=D	<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 flexible cords such as an extension cord was not used as a substitute for fixed wiring. 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, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/24/13 with the Maintenance Supervisor during the tour from 9:00 a.m. to 1:30 p.m., a heavy weight extension cord was plugged in and providing power to a power strip for an air conditioner in the housekeeping room. Based on interview with the Maintenance Supervisor on 01/24/13 between 9:00 a.m. and 1:30 p.m., he was not aware the fifteen foot orange extension cord was being used to plug in an air conditioner.</p> <p>3.1-19(b)</p>	K0147	<p><b>K147/D</b></p> <p>1) Permanent power has been installed in the housekeeping office and the extension cord has been removed.</p> <p>2) All staff have the potential to be affected by this practice.</p> <p>3) Staff will be educated regarding policy that no extension cords will be used as permanent power source. Building will be monitored during rounds to ensure no extension cords are being utilized as permanent power source.</p> <p>4) Compliance will be monitored by Maintenance Director during weekly rounds and by Executive Director during monthly environmental rounds. Adverse results will be shared during monthly QA meetings on a continual basis.</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 811 E 12TH ST MISHAWAKA, IN 46544
--	---

(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