STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155783	A. BUILDING -- B. WING	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY AVE ELKHART, IN 46514

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/22 Facility Number: 002661 Provider Number: 155783 AIM Number: 201056540 At this Emergency Preparedness survey, Greenleaf Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 54. Quality Review completed on 09/08/22	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/30/22 Facility Number: 002661 Provider Number: 155783 AIM Number: 201056540 At this Life Safety Code survey, Greenleaf Health	K 0000	Preparation or execution of this plan of correction by Greenleaf health Campus does not constitute admission to or agreement with the truth of the facts alleged in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of the Federal and State Law. The Plan of Correction is submitted to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 Fire Wall with a two-hour Fire Resistive Rating. 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 resident rooms. The facility is partially protected by a 150 kW Natural Gas Generator. The facility has a capacity of 60 beds and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance supplies. Quality Review completed on 09/08/22		respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Survey on August 30, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance. With this, we the provider respectfully request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0131 SS=E Bldg. 02	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by			

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	construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observation with the Facility Maintenance Support, Environmental Service	K 0131	**K131** **What corrective actions will be accomplished for those residents found to have been affected the deficient practice?** · There were no negative outcomes for this deficient practice. **How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** · There were potentially 25 residents that had the potential for being affected in one smoke compartment. /p> **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** · An in-service was completed with the DPO. The wires were caulked and sealed,	09/22/2022

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	Director, and Administrator on 08/30/22 at 09:40 a.m., above the drop ceiling of the separation fire barrier to Assisted Living had an unsealed hole around wires. Based on interview at the time of observation, the Facility Maintenance Support agreed the separation fire barrier had an unsealed hole through the wall. This finding was reviewed with the Administrator, Facility Maintenance Support, and Environmental Service Director during the exit conference. 3.1-19(b)		leaving no hole through the wall. See attachment photo k131. **How the corrective action(s) will be monitored to ensure the deficient practice will no recur?** · Monthly audits will be conducted and reviewed by QA for completion for a minimum of 6 months.	
K 0331 SS=E Bldg. 02	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls in 1 of 1 common areas met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. and 10.2.3.4 LSC 101 (2012 edition). This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observation with the Facility	K 0331	**K331** **What corrective actions will be accomplished for those residents found to have been affected the deficient practice?** · There were no negative outcomes for this deficient practice. **How other residents have the potential to be affected by the same deficient practice will be**	09/22/2022

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	Maintenance Support, Environmental Service Director, and Administrator on 08/30/22 at 10:00 a.m., in the town square area there were two walls covered in vinyl siding. Based on records review at 11:55 a.m., no documentation of the flame spread rating for the wall coverings was available for review. Based on interview at the time of observation, the Administrator and the Facility Maintenance Support stated the flame spread documentation for the siding could not be located. This finding was reviewed with the Administrator, Facility Maintenance Support, and Environmental Service Director during the exit conference. 3.1-19(b)		**identified and how will corrective action be taken?** · There were potentially 25 residents that had the potential for being affected in one smoke compartment. /p> **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** · After surveyor exited, flame spread rating for the wall coverings was located and reviewed by ED and DPO. See attached k331. **How the corrective action(s) will be monitored to ensure the deficient practice will no recur?** · Documentation of the flame spread rating was placed in the Life Safety book and will be discussed in QA along with Life Safety audits and follow up.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section	K 0355	**K355** **What corrective actions will be accomplished for those residents found to have been affected the deficient practice?**	09/22/2022

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	6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could staff on the service hall. Findings include: Based on observation with the Facility Maintenance Support, Environmental Service Director, and Administrator on 08/30/22 at 10:00 a.m., the portable fire extinguisher located in the maintenance shop was mounted on the wall with the top of the extinguisher 6 feet above the floor. Based on interview at the time of observation, the Facility Maintenance Support stated the top of the extinguisher was 6 feet above the floor This finding was reviewed with the Administrator, Facility Maintenance Support, and Environmental Service Director during the exit conference. 3.1-19(b)		· There were no negative outcomes for this deficient practice. **How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** · There were no residents that had the potential to be affected but could have affected staff in the maintenance office. No harm occurred as a result. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** · An in-service was completed with the DPO and DES. The fire extinguisher has now been properly secured at the right height on a hanger intended for fire extinguishers in the maintenance office. The DPO will round weekly to ensure all fire extinguishers are properly secured. Results will be shared at QA. See attached photo k355. **How the corrective action(s) will be monitored to ensure the deficient practice will no recur?** · Monthly audits will be conducted and reviewed by QA for completion for a minimum of 6 months.	

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K 0363 SS=D Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 16 resident room corridor doors on the 200-hall were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 217. Findings include: Based on observation with the Facility Maintenance Support, Environmental Service Director, and Administrator on 08/30/22 at 09:48 a.m., the corridor door to resident room 217 did not latch into the frame when tested. Based on interview at the time of observation, the Administrator stated the corridor door would not latch into the door frame because the latch was misaligned. This finding was reviewed with the Administrator, Facility Maintenance Support, and Environmental Service Director during the exit conference. 3.1-19(b)	K 0363	**K363** **What corrective actions will be accomplished for those residents found to have been affected the deficient practice?** · There were no negative outcomes because of this deficiency. **How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** · This practice had the potential to affect staff, visitors and residents on the 200 hall. No harm occurred because of this deficiency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** · The door to room 217 has been fixed. The latch and strike plate are now aligned. An in-service was completed with the DPO. DPO will round weekly to ensure all resident doors latch appropriately. See attachment k363	09/22/2022

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur? · Monthly audits will be conducted and reviewed by QA for completion for a minimum of 6 months.	
K 0923 SS=E Bldg. 02	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage			

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	room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen trans-filling rooms. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Facility Maintenance Support, Environmental Service Director, and Administrator on 08/30/22 at 09:40 a.m., ten plastic containers containing supplies were stored within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Based on interview at the time	K 0923	**K923** **What corrective actions will be accomplished for those residents found to have been affected the deficient practice?** · There were no negative outcomes because of this deficiency. **How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** · There were potentially 20 residents that had the potential for being affected in one smoke compartment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** · The fill tanks were marked to ensure a five feet distance from	09/22/2022

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	of observation, the Administrator agreed combustible materials were stored within five feet of stationary liquid oxygen containers. 2. Based on observation and interview, the facility failed to ensure 10 of 10 cylinders were segregated from full and empty cylinders and were marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observation with the Facility Maintenance Support, Environmental Service Director, and Administrator on 08/30/22 at 09:40 a.m., the oxygen storage area contained 10 oxygen cylinders that were not marked or separated as full and empty cylinders. Based on interview at the time of observation, the Administrator agreed the oxygen cylinders were not marked as full and empty cylinders. This finding was reviewed with the Administrator, Facility Maintenance Support, and Environmental Service Director during the exit conference. 3.1-19(b)		combustible materials. Full oxygen takes were separated from empty oxygen tanks and marked accordingly. The DPO and all nursing staff were in-serviced. See attachments k923a, k923b and k923c. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** · Monthly audits will be conducted and reviewed by QA for completion for a minimum of 6 months.	