STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. BUILDING 02 B. WING	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENCROFT HEALTHCARE	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
K 0000 Bldg. 02	An Initial Life Safety Code Certification and State Licensure Survey for a new addition with 60 certified Comprehensive beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/13/15 Facility Number: 000112 Provider Number: 155205 AIM Number: 100288710 At this Initial Life Safety Code and Environmental survey, the addition of Greencroft Healthcare which will be certified, the first and second floor, 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 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. This two story facility was determined to	K 0000	**F000 Initial Comments** 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 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. We respectfully request a desk review of this Plan of Correction.	

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

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	be of Type II (111) construction and fully sprinklered. A 2-hour fire wall is provided on each side of the corridor dividing the facility into two separate buildings. The new building is subdivided into two smoke compartments on both floors. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The new addition has a capacity of 60 Comprehensive beds and had a census of 0 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.			
K 0025 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3,			

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	18.3.7.5, 18.1.6.3 1. Based on observation, the facility failed to ensure the passage of wire and/or pipe through 2 of 2 vertical 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 could affect staff only. Findings include: Based on observation with the Director of Maintenance on 08/13/15 at 1:41 p.m. and then again at 3:00 p.m., the 1st floor Data room had eight penetrations in the drop ceiling ranging from a quarter inch to an inch and a half. There were two separate three inch pipes penetrating the floor that were not sealed. Then again the 2nd floor Data room had nine penetrations in the drop ceiling ranging from a quarter inch to an inch and a half. Based on interview at the time of each observation, the Director of Maintenance acknowledged the aforementioned conditions.	K 0025	The maintenance lead person in charge of the Healthcare building filled the 2 conduits noted in the new building data rooms (2) with Hilty Fire Putty. The lower level beneath these data rooms were also checked for open conduits. None were found to be out of compliance.As this is new construction, in the future all staff and sub-contractors working for the facility in these rooms will be reminded to fire seal any changes to wiring using the conduits. The lead maintenance person for Healthcare will take this responsibility.The director of maintenance or designee will monitor for compliance based on when subcontractor have been in the building or other projects that require conduit. This will be reported to Corporate Compliance.Compliance Date: 9/2/2015	09/02/2015

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect at least 30 residents and staff. Findings include: Based on observations with the Director of Maintenance on 08/13/15 at 1:18 p.m. and then again at 2:49 p.m., a quarter inch penetration gap around a pipe in the smoke barrier near the Haven Center elevator access point door. Then again an eight square inch penetration of drywall cut out of the smoke barrier by Oasis Center Elevator door. Based on interview at the time of each observation, the Director of Maintenance acknowledged the aforementioned condition and provided the measurements for each unsealed penetration. 3.1-19(b)			

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K 0029 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 4 hazardous areas, all kitchens with cooking facilities were protected in accordance with 8.4 unless otherwise permitted by 18.3.2.5.2, 18.3.2.5.3 or 18.3.2.5.4. LSC 18.3.2.5.3 allows a cooking facility to be open to the corridor within a smoke compartment where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons provided all the requirements of 18.3.4.5.3 are met. This deficient practice is in all four smoke compartments and could affect all staff, residents, and visitors within the new addition. Findings include: Based on interview during the record review on 08/13/15 at 11:16 a.m., the Director of Maintenance requested a categorical waiver to allow for the kitchens to be open to the corridor but was not able to provide evidence the	K 0029	The facility is requesting a categorical waiver per CMS 2012 Life Safety Code 18.3.2.5.3 that allows cooking facilities open to the corridor for less than 30 persons or fewer in each household.The new Healthcare addition is a two story building with four households of 16 residents each. Two households are on each floor. Each 16 bed household is in a separate smoke compartment and has a smoke barrier wall separating it from the other household on the same floor.The gas range in each household is protected with a Denlar model D1000 UL 300A rated that is the width of the range and is ducted to the outside. It has an automatic heat activated startup of the exhaust fan, provides an extinguishing system for the range through either fuseable links or a manual release located in the path of egress in accordance with NFP 96 10.5. There is an interlock with a gas valve supply in the range that shuts off the gas whenever the temperature rises above 190	09/02/2015

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	facility meets all requirements of 18.3.2.5.3 of the 2012 Edition of NFPA 101, the Life Safety Code. Based on observation during the observation tour between 12:11 p.m. and 3:50 p.m., four separate kitchens were observed open to the corridor. Based on interview at the time of observation, the Director of Maintenance confirmed the facility's intent to cook sausage, bacon, and other grease laden-vapor producing foods. 3.1-19(b)		degrees at the hood or the extinguisher within the hood is activated.There is also a timed switch in a restricted location near the range that limits the gas "on" time to 120 minutes. This is a staff only access timer that requires a specific sequence of steps to allow gas flow to the range.A K type fire extinguisher is located close to the cooking area in each household.Maintenance procedures in accordance with Denlar's instructions and NFPA 96 Chapter 11 are written into the Greencroft Healthcare Preventative Maintenance system (Attachment A). Ducts for these hoods are cleaned semi-annually by a service company contracted to do all the Healthcare hoods. There are two photo electric smoke detectors in the area. They are interconnected, AC powered and equipped with a "silence" button. Both are approximately 20 feet from the range.	
K 0044 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire doors would latch into the door frame. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the	K 0044	The door in question was adjusted at the hinge point by an employee of the general contractor that built the new addition. It now has adequate clearance at the point the twin doors meet to prevent rubbing and assure latching when closing.All other fire doors in the	08/26/2015

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	Standard for Fire Doors and Fire Windows at 2-.1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires all fire doors to be closed and latched at the time of a fire. This deficient practice affects staff and any resident leaving the facility. Findings include: Based on observation with the Director of Maintenance on 08/14/15 at 12:17 p.m. the fire doors separating the D Building from the pedestrian corridor failed to latch when tested. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition. 3.1-19(b)		new construction were checked to assure they all latch correctly.All doors in the new construction area have been added to the Preventative Maintenance schedule for quarterly check of proper latching. The Environmental Services Directors audits doors for proper latching and will write work orders as needed.The Preventative Maintenance program is monitored monthly by the supervisor of building maintenance to keep current. Program deficiencies identified will be assigned to maintenance staff via the work order permit. The Director of Maintenance or designee will report to Corporate Compliance.Date of Compliance : 8/26/2015	
K 0048 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms	K 0048	See emergency evacuation plans (Attachment C thru C.5) and procedures attached to this report.	08/31/2015

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	(2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review and interview on 08/13/15 at 12:04 p.m., the Director of Maintenance acknowledged the "General Evacuation Plan Procedure" did not address (6) evacuation of smoke compartment nor (7) preparation of floors and building for evacuation. 3.1-19(b)			
K 0067 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A			
	Based on observation and interview, the facility failed to ensure 100 % of fire dampers throughout the new addition were installed in accordance with NFPA	K 0067	All dampers in the 3 levels of new construction area were identified on the print by a representative from the sheet metal subcontractor for the building	08/28/2015

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	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, 3-4.6.2 requires that fire dampers, including their sleeves; smoke dampers; and ceiling dampers shall be installed in accordance with the conditions of their listings and the manufacturer ' s installation instructions. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance on 08/14/15 at 12:10 p.m., the facility has installed fire dampers located in the HVAC return air plenum above the ceiling tiles in the corridors throughout the new addition. Based on interview at the time of observation, the Director of Maintenance was unable to provide documentation of installation in accordance with the conditions of their listings and the manufacturer ' s installation instructions and acknowledged the aforementioned condition.		along with the job site foreman from the general contractor. They tested each detector for proper closure and opening. All dampers were listed with an associated reference number on a form for future use in Preventative Maintenance (Attachment D).All locations of dampers were shown to facility maintenance staff likely working in this area including the lead maintenance person for the Healthcare building.The Preventative Maintenance for Dampers form has been updated to include all dampers in healthcare. The Preventative Maintenance program is monitored monthly by the supervisor of building maintenance. Deficiencies identified are assigned to maintenance staff via the work order system.The Director of Maintenance or designee will report non-compliance to Corporate Compliance.Date of Compliance: 8/28/2015	

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K 0069 SS=E Bldg. 02	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 4 of 4 cooking facilities were protected in accordance with 9.2.3 unless otherwise permitted by 18.3.2.5.2, 18.3.2.5.3 or 18.3.2.5.4. LSC 18.3.2.5.3 allows a cooking facility to be open to the corridor within a smoke compartment where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons provided all the requirements of 18.3.4.5.3 are met. This deficient practice is in all four smoke compartments and could affect all staff, residents, and visitors within the new addition. Findings include: Based on interview during the record review on 08/13/15 at 11:16 a.m., the Director of Maintenance requested a categorical waiver to allow for the kitchens to be open to the corridor but was not able to provide evidence the facility meets all requirements of 18.3.2.5.3 of the 2012 Edition of NFPA 101, the Life Safety Code. Based on observation during the observation tour between 12:11 p.m. and 3:50 p.m., four	K 0069	The facility is requesting a categorical waiver per CMS 2012 Life Safety Code 18.3.2.5.3 that allows cooking facilities open to the corridor for less than 30 persons or fewer in each household.The new Healthcare addition is a two story building with four households of 16 residents each. Two households are on each floor. Each 16 bed household is in a separate smoke compartment and has a smoke barrier wall separating it from the other household on the same floor.The gas range in each household is protected with a Denlar model D1000 UL 300A rated that is the width of the range and is	09/02/2015

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	separate kitchens were observed open to the corridor. Based on interview at the time of observation, the Director of Maintenance confirmed the facility's intent to cook sausage, bacon, and other grease laden-vapor producing foods. 3.1-19(b)		ducted to the outside. It has an automatic heat activated startup of the exhaust fan, provides an extinguishing system for the range through either fuseable links or a manual release located in the path of egress in accordance with NFP 96 10.5. There is an interlock with a gas valve supply in the range that shuts off the gas whenever the temperature rises above 190 degrees at the hood or the extinguisher within the hood is activated.There is also a timed switch in a restricted location near the range that limits the gas "on" time to 120 minutes. This is a staff only access timer that requires a specific sequence of steps to allow gas flow to the range.A K type fire extinguisher is located	

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			close to the cooking area in each household.Maintenance procedures in accordance with Denlar's instructions and NFPA 96 Chapter 11 are written into the Greencroft Healthcare Preventative Maintenance system (Attachment A). Ducts for these hoods are cleaned semi-annually by a service company contracted to do all the Healthcare hoods. There are two photo electric smoke detectors in the area. They are interconnected, AC powered and equipped with a "silence" button. Both are approximately 20 feet from the range.	
K 0130 SS=D Bldg. 02	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 2 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier.	K 0130	The general contractor for the new building provided labor to check all penetrations within the fire barrier between smoke compartments. Where missing,	08/26/2015

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	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 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect residents in 2 of 5 smoke compartments.		approved fire caulk was added to any open conduits, caulked around pipe and conduits if needed and covered any "orange foam" that may or may not be approved with an Hilty Inc fire caulk to correct depths. This was completed on both sides of the fire barrier above ceilings.Future work that requires penetration or reuse of existing sealed conduits or pipes within this fire barrier will be monitored by the healthcare lead maintenance person for compliance with fire barrier maintenance.The general maintenance staff that may work in the area have been shown examples of correct fire sealing and told to contact the lead maintenance person if they find it necessary to reseal this wall.The director of maintenance or designee will audit compliance based on conduit works. This will be reported to Corporate Compliance.Compliance Date 8/26/2015	

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	Findings include: Based on an observation with the Director of Maintenance on 08/13/15 at 12:21 p.m. then again at 12:24 p.m., the fire barrier wall separating C Building from the pedestrian corridor had three penetrations, two separate quarter inch gaps around pipe and a quarter inch gap around conduit. Then again in the fire barrier wall separating D Building from the pedestrian corridor had one pipe with a quarter inch gap inside a pipe with wires passing through. Based on interview at the time of each observation, the Director of Maintenance acknowledged the aforementioned conditions. 3.1-19(b)			