

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 08/17/12</p> <p>Facility Number: 000622 Provider Number: 15G079 AIM Number: 100272170</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-North Willow was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.470(j), 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 and 410 IAC 16.2.</p> <p>This three story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the</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.

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	<p>corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 208 and had a census of 162 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage. The facility was found not in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility services including storage which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/22/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0052	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K0052	<p>K 0521. The fire alarm system breaker in basement next to kitchen is now locked. This deficient practice could effect all residents at North Willow. The fire alarm system breaker in basement next to kitchen being locked is now on a preventive maintenance schedule and checked at least monthly. Maintenance Director will inform ED whenever this system is found not to be locked on the Preventive Maintenance check for further follow up.</p> <p>2. Number 48 smoke detector by back elevator has been replaced and documentation shows test passed on</p> <p>This deficient practice could effect all residents at North Willow.</p> <p>When repair is scheduled by an outside contract, the Maintenance Director will assure that the work is completed as ordered.</p> <p>Maintenance Director will inform ED when work is incomplete and progress of obtaining completion of work.</p>	09/16/2012

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	<p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 08/17/12, access to the fire alarm system breaker located in the basement hallway next to the kitchen was not locked. Based on interview at the time of observation, the Director of Maintenance acknowledged access to the fire alarm system breaker located in the basement hallway next to the kitchen was not locked.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 73 smoke detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused</p>						

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	<p>nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect 30 residents, and any staff and visitors on the third floor in the vicinity of the back elevator.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Sensitivity Test & Inspection Report" documentation</p>						

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	<p>dated 01/31/12 with the Director of Maintenance during record review from 10:20 a.m. to 12:10 p.m. on 08/17/12, the smoke detector identified as "# 48 (by back elevator)" was listed as "FAIL" for the sensitivity test. In addition, Koorsen's "Service Call Report" follow up documentation dated 02/02/12 stated "could not replace smoke # 48 (near back elevator) as it has a special elevator relay." Based on interview at the time of observation, the Director of Maintenance Director stated no documentation of smoke detector # 48 passing a subsequent sensitivity test was available for review and acknowledged smoke detector # 48 was not recalibrated, retested or replaced following 01/31/12 sensitivity testing for the facility.</p> <p>3.1-19(b)</p>				

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K0069	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure hydrostatic testing for 1 of 1 hood extinguishing systems in the kitchen was performed. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable.</p> <p>a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems NFPA 17, Standard for Dry Chemical Extinguishing Systems 9-5 requires hydrostatic testing shall be performed by persons trained in pressure testing procedures and safeguards and having available suitable testing equipment, facilities, and an appropriate service manual(s). The following parts of dry chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years:</p>	K0069	<p>K069 1. Fire system, for kitchen exhaust, has had its 12 year maintenance completed.</p> <p>This deficient practice could effect all residents at North Willow.</p> <p>Maintenance Director will document needed contract maintenance in the building engine computer system for close out when completed.</p> <p>Maintenance Director will inform ED when work is incomplete and progress of obtaining completion of work. Work incomplete after 30 days prompts an automated e-mail to ED.</p>	09/16/2012			

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	<p>(a) Dry chemical containers (b) Auxiliary pressure containers (c) Hose assemblies This deficient practice in the staff only kitchen in the basement would not directly affect residents.</p> <p>Findings include:</p> <p>Based on review of Allied Safety Services "Fire Equipment Systems Report" documentation dated 10/04/11 with the Director of Maintenance during record review from 10:20 a.m. to 12:10 p.m. on 08/17/12, the kitchen range hood suppression system report stated "Recommend system upgrade. System tank is due for hydrostatic test." In addition, Allied's subsequent semiannual kitchen range hood suppression system report dated 04/05/12 stated "Fire system past due for required 12 year maintenance." Based on interview at the time of record review, the Director of Maintenance stated the twelve year maintenance referenced in Allied's reports had not been performed and acknowledged the kitchen range hood fire suppression system hydrostatic testing had not been done and was past due for the twelve year maintenance.</p> <p>3.1-19(b)</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in 1 of 89 resident sleeping rooms before July 1, 2012. This deficient practice could affect at least 2 residents in the facility.</p> <p>Findings include:</p>	K9999	<p>K9999</p> <p>1. Room 203 smoke detector has been adjusted to between 4 and 12 inches as per regulations.</p> <p>This deficient practice could effect all residents at North Willow.</p> <p>All smoke detectors have been checked to assure they are installed between 4 and 12 inches as per regulations.</p> <p>During monthly preventive maintenance check the installation will be checked to assure it is between 4 and 12 inches as per regulations.</p>	09/16/2012			

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	<p>Based on observation with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 08/17/12, the wall mounted, battery operated smoke detector in resident sleeping room 203 was installed thirteen inches from the ceiling and was not installed according to manufacturer's recommendations. The manufacturer's recommendations indicate wall mounted, battery operated smoke detectors should be installed four to twelve inches from the ceiling. Based on interview at the time of observation, the Director of Maintenance acknowledged the wall mounted, battery operated smoke detector was installed more than twelve inches from the ceiling.</p> <p>3.1-19(ff)</p>				