

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 LYN-MAR DR MUNCIE, IN 47304
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K010000	<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: 09/16/14</p> <p>Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Muncie 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 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, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of correction is not an admission 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.</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.

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K010038 SS=E	<p>has a capacity of 117 and had a census of 103 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage for facility storage which was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 public restrooms were not equipped with slide bolts to latch the doors from the inside. This deficient practice could affect any resident as well as visitors and staff if the occupants were inaccessible when the doors were latched from the inside.</p> <p>Findings include:</p>	K010038	No residents were identified to have been affected by the alleged deficient practice. The two public restrooms on Main hall had one slide bolt on the inside of each door to ensure privacy. The slide bolt mechanisms found on the inside door of each public restroom were removed. The Maintenance Director and his assistant conducted building rounds on 9/16/14 and no other areas were identified as deficient. The Maintenance Director and his	10/04/2014			

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K010050 SS=F	<p>Based on observation on 09/16/14 at 2:10 p.m. with the Maintenance Supervisor, the two public restrooms on Main hall had slide bolts on the inside of each door when in the locked position could not be opened by staff to evacuate the occupants in an emergency. Based on interview on 09/16/14 at 2:12 p.m. it was acknowledged by the Maintenance Supervisor when the slide bolt locks were engaged inside the two public restrooms the occupants could be trapped inside if they required assistance from staff during an emergency and it was further stated they should be removed.</p> <p>3/1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between</p>	K010050	<p>assistant were in-serviced by the Executive Director on 10/03/14 regarding this regulation. The Maintenance Director and/or his assistant will conduct walking rounds at least weekly as part of the preventative maintenance program to ensure that all doors are in compliance. All noncompliance issues will be addressed immediately. The Maintenance Director is responsible for monitoring and ensuring compliance. The Executive Director or designee will do weekly facility walk through rounds to ensure compliance is maintained. The Maintenance Director or designee will review all noncompliance issues with the Executive Director weekly and to the QA Committee quarterly.</p> <p>No residents were identified to have been affected by the alleged deficient practice. The Maintenance Director and his assistant were in-serviced by the Executive Director on 10/03/14</p>	10/04/2014			

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K010144 SS=F	<p>6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 09/16/14 at 2:04 p.m. with the Maintenance Supervisor, the documentation for the fire drills performed between 6:00 a.m. and 9:00 p.m. for the past twelve months, from 08/2013 to 08/2014, indicated the fire alarm system had been activated, but the verification of the transmission of the signal was not documented. Based on interview on 09/16/14 at 2:05 p.m., it was acknowledged by Maintenance Supervisor none of the fire drill reports documented the transmission of the signal was received by the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per</p>		<p>regarding this requirement. The Maintenance Director or designee will record on the Report of Monthly Fire Drill the time and date the transmission of the signal was received by the monitoring station. In addition, the Maintenance Director or designee will receive from monitoring station a monthly Activity Report verifying the transmission of the signal. The Maintenance Director is responsible for conducting fire drills and ensuring proper documentation is recorded and logged. The Maintenance Director will review fire drill documentation with the Executive Director monthly and to the QA Committee quarterly.</p>				

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	<p>month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p>	K010144	<p>No residents were identified to have been affected by the alleged deficient practice. The Maintenance Director was in-serviced by the Area Maintenance Supervisor on 10/02/14 regarding documentation requirements when conducting Generator System Testing. The Maintenance Director conducted a monthly Generator Load Test on 10/03/14 and recorded all required generator readings. The Maintenance Director is responsible for ensuring monthly Generator System Testing is completed and all applicable generator readings are recorded. The Maintenance Director or designee will review all noncompliance issues with the Executive Director weekly and to the QA Committee quarterly.</p>	10/04/2014	

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K010147 SS=E	<p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 09/16/14 at 2:38 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating and no other method was used to document monthly load for the past twelve months. Based on interview on 09/16/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly, but was unaware it had to be documented at 30 percent and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <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 2 of 14 surge protectors observed including extension cords, non-fused extension cords and/or multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that,</p>	K010147	The surge protectors that were located in room #228 and #229 were removed and the medical devices were plugged directly into a wall outlet. The Maintenance Director and his assistant conducted building rounds on 09/16/14 and no other areas were identified as deficient. The Maintenance Director and his	10/04/2014	

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	<p>unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in room #228 and 2 residents in room #229 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 09/16/14 during the tour between 1:26 p.m. to 1:40 p.m., a surge protector was used to provide power to a resident bed which is medical equipment in room #228, and an oxygen concentrator in room #229 was plugged into a surge protector instead of directly plugging the medical equipment into a wall outlet. Based on interview on 09/16/14 concurrent with the observations it was acknowledged by the Maintenance Supervisor, surge protectors were used to power the aforementioned medical devices.</p> <p>3.1-19(b)</p>		<p>assistant were in-serviced by the Executive Director regarding this requirement on 10/03/14. The Maintenance Director and/or his assistant will conduct walking rounds at least weekly as part of the preventative maintenance program to ensure that all medical devices are plugged directly into a wall outlet. All noncompliance issues will be addressed immediately. The Maintenance Director is responsible for monitoring and ensuring compliance. The Executive Director or designee will do weekly facility walk through rounds to ensure compliance is maintained. The Maintenance Director or designee will review all noncompliance issues with the Executive Director weekly and to the QA Committee quarterly.</p>				