

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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. 01	<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: 01/12/16</p> <p>Facility Number: 000062 Provider Number: 155137 AIM Number: 100271400</p> <p>At this life Safety Code Survey, Golden Living Center-Valparaiso 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 with a partial basement was determined to be of Type IV (2HH) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 85 and had a census of</p>	K 0000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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 0025 SS=D Bldg. 01	<p>77 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 01/14/16 - DA</p> <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 1 of 1 ceiling smoke barriers was maintained to provide a one half 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 staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 01/12/16 at</p>	K 0025	<p>1. No residents were effected by the deficient practice. Pipes were sealed with fire barrier. 2. All residents have the potential to be effected by this deficient practice. 3. An audit tool will be completed by the maintenance director to monitor all modifications to the facility's structure to ensure any smoke barrier penetrations are properly sealed. This audit tool will be completed when modifications are being made. 4. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5. 2/3/2016</p>	02/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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 0048 SS=E Bldg. 01	<p>11:42 a.m., the ACU Electrical Room had one 5 inch and seven 1/2 inch conduit tubes running from the floor to the basement ceiling. Based on interview at the time of observation, the Maintenance Director confirmed the conduit tubes were not sealed inside and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>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. 19.7.1.1 Based on record review, observation, 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:</p> <p>(1) Use of alarms (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</p>	K 0048	<p>1. No residents were effected by the deficient practice. 2. All residents have the potential to be effected by thisdeficient practice. 3. Maintenance Director will in-service the staff on the location of the smoke barrier doors within the building, and where to re-locate residents in the event of a fire. An audit tool will be completed 5 x per week for 4 weeks, and then once per week for 8 weeks. 4. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5. 2/3/2016</p>	02/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>evacuation (8) Extinguishment of fire This deficient practice could affect 28 residents in the ACU unit.</p> <p>Findings include:</p> <p>Based on a record review on 01/12/16 between 10:02 a.m. and 11:20 a.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. Based on observation at 11:33 a.m., there was a set of doors in the ACU unit that was not part of a complete smoke barrier which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview at the time of observation, a Licensed Practical Nurse was asked where she would evacuate residents in the event of a hallway fire. The Licensed Practical Nurse indicated she would horizontally evacuate beyond the closest door which was part of the non-compliant door. Based on interview, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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 0072 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 2 of 7 exits. This deficient practice could affect at least 28 residents.</p> <p>Findings include:</p> <p>Based on observation with the the Maintenance Director on 01/12/16 at 11:20 a.m. then again at 11:45 a.m., the exit discharge for the Dining room was obstructed by a two inch accumulation of snow. Additionally, a coaxial wire was hanging down in the path of egress to five feet off the ground. Then again the exit discharge for the north east exit in the ACU Unit was obstructed by a two inch accumulation of snow. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0072	<p>1. No residents were effected by the deficient practice. Snow was removed by the maintenance department, and the coaxial cable (no longer in operation) was completely removed. 2. Snow-covered outdoor pathways leading from exit doors and cables hanging too low over an egress pathway have the potential to effect all residents. 3. When snow occurs and the snow removal service is unable to respond in a timely basis, the Maintenance Director or his designee will remove the snow themselves. During maintenance's daily outside rounding, they will look to correct any cables that are hanging down. 4. An audit tool will be completed (only when it snows or if snow is present) by the Executive Director/designee, 3x daily until the snow is no longer an issue. An audit tool will be completed by the Executive Director/designee one time per week, verifying that the outside pathways are absent of low hanging cables. Audit tools will be completed for 12 weeks. Audit tool will be reviewed monthly for 6</p>	02/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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 0076 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the oxygen storage room on the second floor was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/12/16 at</p>	K 0076	<p>months in facility QAPI meeting. 5. 2/3/2016</p> <p>1. No residents were effected by the deficient practice. (a)Outlet/switch was removed. (b) Oxygen cylinder was removed from Central Supply and moved to a secured location. 2. All residents have the potential to be effected by this deficient practice. 3. Maintenance director will complete an audit tool 5x per week for 4 weeks, and then 1x per week for 8 weeks, to verify that oxygen tanks are secured in the oxygen room. 4. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting. 5. 2/3/2016 We respectfully request that we are granted papercompliance. Thank you.</p>	02/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
---	--

(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>10:47 a.m., there is one electrical outlet on the wall in the oxygen transfilling room fifty four inches off the ground. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in Central Supply of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/12/16 at 12:07 p.m., Central Supply room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/12/2016
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383		
(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)				