

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350
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K0000	<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: 02/22/12</p> <p>Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620</p> <p>Surveyor: Dennis Austill, Life Safety Code Survey Supervisor</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview Terrace 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The resident rooms lack smoke detector</p>	K0000	<p>This plan of correction shall serve as this facility's credible allegation of compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the 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.</p>	
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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>protection. The facility has the capacity for 176 and had a census of 143 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0014 SS=E	<p>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in the corridor had a flame spread rating of Class A or Class B in order to protect 143 of 143 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke</p>	K0014	<p>Step 1a) The paneling on the Reception Desk and Memory Lane nurse's station will be replaced with a flame retardant material.b) The faux brick was removed and the wall was painted.c) The Vinyl siding will be replaced with a flame resistant material, or removed and the wall painted.Step 2 The interior finished of the building were inspected to assure they meet fire code, and no concerns were identified.Step 3The Executive Director will review plans for all future building improvements to assure compliance with all state and federal codes.Step 4The Executive Director will present all plans for buidling improvements to the QA&A committee for seven months to assure compliance and determine the need for further monitoring.</p>	03/23/2012			

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	<p>development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., the following was noted:</p> <p>a) The Memory wing nurses station and Front Reception desk had plywood paneling used as an interior finish. Interview with the Maintenance Supervisor and Administrator after the time of observation revealed no documentation was immediately available to demonstrate the paneling exhibited a flame spread classification of Class A or B or had been treated with a flame retardant material.</p> <p>b) The Rainbow wing nurses station had a faux brick paneling on the corridor walls used as an interior finish. Interview with the Maintenance Supervisor and Administrator after the time of observation revealed no documentation was immediately available to demonstrate the paneling exhibited a flame spread classification of Class A or B or had been treated with a flame retardant material.</p>						

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	<p>c) The Gardens Porch had vinyl siding used as an interior finish. Interview with the Maintenance Supervisor and Administrator after the time of observation revealed no documentation was immediately available to demonstrate the paneling exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p>			
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K0018 SS=B	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of approximately 200 corridor doors were provided with positive latching hardware. This deficient practice could affect any resident as well as staff or visitors in the vicinity of the employee locker/vending machine room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., the employee locker/vending room corridor door lacked a positive latching mechanism. Based on interview during the time of observation, the Maintenance Supervisor and Administrator acknowledged the employee</p>	K0018	<p>Step 1The door to the locker room was fitted with a latch.Step 2All doors were inspected to assure they latch properly.Step 3Maintenance staff will audit five doors weekly for seven months to assure proper closure. Results will be reported to QA&A.</p> <p>Step 4 QA&A will review the results of the door audit for seven months to determine need for further intervention or monitoring.</p>	03/23/2012	

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	locker/vending room did not have a latch. 3.1-19(b)			
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K0050 SS=F	<p>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</p> <p>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" documentation with the Maintenance Supervisor at 10:55 a.m. on 02/22/12, a fire drill was not documented for the second shift of the fourth quarter of 2011. The Maintenance Supervisor during the time of record review, acknowledged there was no other documentation available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at</p>	K0050	<p>Step 1 An added second shift fire drill was held in the first quarter of 2012. Step 2 Quarter one fire drills were reviewed to assure that they were held as required, and at unexpected times. Step 3 A fire drill scheduling grid will be used to assure one is held on each shift in each quarter at unexpected times. The Executive Director will review the grid monthly to assure compliance. Results will be reported to QA&Q monthly for seven months. Step 4 Results of the fire drill audit will be reported to QA&A monthly for seven months and assessed to determine need for intervention or continued audit.</p>	03/23/2012			

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	<p>unexpected times under varying conditions in 2 of 3 second shift fire drills and 3 of 4 third shift fire drills. This deficient practice affects all residents in the facility including staff.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" documentation with the Maintenance Supervisor at 10:55 a.m. on 02/22/12, two second shift fire drills were conducted on 06/27/11 and 08/09/11 at 6:45 p.m. and 6:00 p.m. Two third shift fire drills were conducted on 09/29/11 and 12/30/11 at 3:30 a.m. and one third shift fire drill was conducted on 03/24/11 at 4:10 a.m. Based on interview at the time of review, the Maintenance Supervisor acknowledged fire drills were often not conducted at unexpected times.</p> <p>3.1-19(b) 3.1-51(c)</p>						

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K0051 SS=F	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00</p>	K0051	<p>Step 1 A remote annunciator will be installed at the Memory Lane nurse's station. Step 2 No other area requires a remote annunciator. Step 3 The remote annunciator will be monitored monthly for seven months with each fire drill. Step 4 Results of the annunciator monitoring will continue monthly for seven months. Results will be reported to QA&A monthly for seven months, and that committee will determine if further monitoring is required.</p>	03/23/2012			

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	<p>p.m., the fire alarm control panel (FACP) was located at the main entrance across from the receptionist's desk and remote annunciation of the fire alarm panel was not provided at any of the nurses stations. Based on interview during the time of observation, the Maintenance Supervisor indicated the receptionist's desk is not staffed from 7:00 p.m. to 8:00 a.m. and is remote from any area where continuous on site monitoring could occur, such as the nurses' station.</p> <p>3.1-19(b)</p>			
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K0056 SS=E	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers " states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect residents, staff or visitors near the Business office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., the Business office was provided with three sprinkler heads. Two of the three sprinkler heads were four feet apart.</p>	K0056	<p>Step 1 The extra spinkler head was removed from the business office.Step 2 All rooms were inspected to assure proper sprinkler coverage.Step 3 The Executive Director will review all proposed changes to the sprinkler system or spaces to assure proper sprinkler coverage.Step 4 All proposed changes to the sprinkler system or physical plant will be reviewed by QA&A monthly for seven months to assure compliance and determine need for furhter review.</p>	03/23/2012			

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	Based on interview at the time of observation, the Maintenance Supervisor acknowledged two of the three sprinkler heads were less than 6 feet apart. 3.1-19(b)			
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K0062 SS=E	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect any resident, staff or visitor outside the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., at least 10 of the 100 exterior sprinkler heads located underneath the canopies at each of the facility's exits had paint on the fusible link. Based on interview during the time of observation, the Maintenance Supervisor acknowledged the sprinkler heads links had paint on them.</p> <p>3.1-19(b)</p>	K0062	<p>Step 1The identified sprinkler head will be replaced. The new sprinkler heads will be ordered by 3/9/12, and installed by 4/20/12. Step 2All sprinkler heads were inspected Those that required replacement will be ordered by 3/9/12, and installed by 4/20/12. Step 3All Maintenance staff were re-educated to assure that sprinkler heads are not painted when an area is being painted. The Executive Director or designee will inspect five sprinkler heads weekly for one month, then five monthly for six months to assure compliance. Step 4Results of the sprinkler head audit will be reported to QA&A monthly for seven months to determine the need for a change or continuation of monitoring.</p>	03/23/2012			

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K0074 SS=F	<p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 81 of 81 rooms were flame retardant. This deficient practice could affect any resident, staff and visitor within the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., window curtains in the resident rooms lacked attached documentation that they were inherently flame retardant. Interview with the Maintenance Supervisor and Administrator after the time of observation revealed no documentation was immediately available</p>	K0074	<p>Step 1The identified curtains will be sprayed with flame resistant solution.Step 2All curtains that could not have flame resistance verified will be sprayed with a flame resistant solution. Step 3. Maintenance will maintain a record to assure that all new fabrics purchased are flame retardant, and that all treated fabrics are resprayed after laundering. The Executive Director will review this log monthly for seven months and report results to QA&A monthly for seven months.Step 4 Results of the audit will be reported to QA&A montly for seven months to determine need for continued monitoring.</p>	03/23/2012			

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	regarding flame retardancy for these window curtains. 3.1-19(b)			

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K0076 SS=D	<p>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>Based on observation and interview, the facility failed to administer oxygen in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities Section 8-6.2.1.4 which states nonmedical appliances that have hot surfaces or sparking mechanisms shall not be permitted within oxygen delivery equipment or within the sight of intentional expulsion. This deficient practice could affect 1 of the 143 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator on 02/22/12 at 1:45 p.m., resident # 1 was being administered oxygen via a nasal cannula from a portable liquid oxygen container while under a hair dryer with the hair dryer on and producing heat in the beauty shop. Based on interview at the time of</p>	K0076	<p>Step 1 The hair dryer was turned off, and the resident removed from the salon. Step 2 No other residents were affected by this observation. Step 3 The beautician was re-educated to the following guidelines as published in the November 2010 ISDH Newsletter. a. The living center already has a system of routine maintenance of dryers to insure that machines, electric cords, and etc are in operating condition. b. A fire extinguisher was placed in the salon. c. The beautician was training in follwing emergency fire procedures, including location and use of a fire extinguisher. d. The beautician was trained keeping the hair dryer setting on low heat and continueing to monitor the air to prevent it from being too warm. e. The beautician was trained to keep the oxygen concentrator or portable tank as far away as possible from the hair dryer as the oxygen tubing will allow without creating a hazard for other residents. f. The</p>	03/23/2012			

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	<p>observation, this deficient practice was acknowledged by the Maintenance Supervisor and Administrator.</p> <p>3.1-19(b)</p>		<p>beautician was trained to never leave a resident on oxygen unsupervised when in the area of the salon. Step 4. The Executive Director will monitor the use of the salon three times weekly for seven months. Results will be reported to QA&A monthly for seven months to determine need for further monitoring.</p>	

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K0147 SS=E	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, 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 any resident, staff of visitor throughout the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00 p.m., extension cords were noted in the following locations:</p> <p>a. In resident room 215, two separate powerstrips were plugged into and providing power for two refrigerators.</p> <p>b. In resident room 216, a powerstrip was plugged into and providing power for a nebulizer and oxygen concentrator.</p> <p>c. In resident room 219, a powerstrip was plugged into and providing power to a refrigerator.</p>	K0147	<p>Step 1 All appliances/equipment were removed from the extension cord and plugged into a wall outlet. The identified outlet was changed to GFI outlet. Step 2 All Resident rooms were inspected to identify improper use of an extension cord. Any noncompliance was corrected immediately. All outlets near a water source were checked to assure compliance. Step 3 All staff were re-educated regarding use of extension cords. The Executive Director or Designee will Audit five rooms weekly for one month, and five monthly for the next six months to assure compliance. Step 4 Results of the audit will be reported to QA&A monthly for seven months to determine need for ongoing monitoring.</p>	03/23/2012			

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	<p>d. In the Employee lounge, a powerstrip was plugged into and providing power to a toaster and microwave oven. These were acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Alzheimer Care Unit wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as areas subjected to wet conditions. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff using the Alzheimer Care Unit sink in the event of an electrical short.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/22/12 during the tour from 12:45 p.m. to 3:00</p>			
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	p.m., the Alzheimer Care Unit had an electrical receptacle on the wall within three feet of the sink which was not provided with GFCI protection to prevent electric shock. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
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