

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155138	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/06/2011
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN46203
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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: 12/06/11</p> <p>Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Indianapolis 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 basement was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 101 and had a census of</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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K0029 SS=E	<p>87 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/08/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are provided with self closing devices to close and latch the door into the door frame to maintain the smoke resistant partition. This deficient practice could affect any resident, staff or visitor in the vicinity of the storage room by Room 7.</p> <p>Findings include:</p>	K0029	<p>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> <p>K 029 Corrective action: An automatic door closer and new door handle has been installed on the door located by room #7.</p>	12/07/2011

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K0038 SS=F	<p>Based on observation with the Maintenance Director during a tour of the facility from 11:05 a.m. to 1:55 p.m. on 12/06/11, the access door to the storage room by Room 7;</p> <p>a) is not equipped with a self closing device to latch the door into the door frame, and</p> <p>b) had a one inch gap in the door around the annular space where the door handle is located which resulted in the door not being smoke resistant.</p> <p>The storage room by Room 7 is a former shower room and measures 150 square feet and is used to store combustible boxes and diapers. Based on interview at the time of observation, the Maintenance Director acknowledged the storage room by Room 7 measures greater than fifty square feet, is used to store combustible supplies, the access door is not equipped with a self closing device and the access door is not smoke resistant.</p> <p>3.1-19(b)</p> <p>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 the means of egress through 4 of 4 exits were readily</p>	K0038	<p>Other residents affected: Any resident located in the vicinity of the storage room located by room 7 has the potential to be affected by this deficient practice.</p> <p>Systemic changes: The Maintenance Director has conducted a walk through of all other storage room doors to ensure proper self closers and door knobs are in place.</p> <p>Monitoring: Maintenance Director or designee will ensure that all storage rooms have their self-closing devices and doorknobs in place. The Maintenance Director or designee will report any deficiencies to the Executive Director for immediate repair.</p> <p>Date of completion: December 7, 2011</p> <p>K 038 Corrective action: A sign posting has been placed at each mentioned entrance with the code</p>	12/23/2011	

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	<p>accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects approximately 81 of 87 residents and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:05 a.m. to 1:55 a.m. on 12/06/11, the main lobby exit door, the exit door by Room 11, the exit door by Room 31 and the exit door by Room 51 were each magnetically locked and could be opened by entering a four digit code but the code was not posted at each exit door. Based on interview with the Director of Nursing at 1:00 p.m., 81 of the 87 the residents do not have a clinical diagnosis to be in a secure building. The Director of Nursing stated 6 residents</p>		<p>placed within a sentence allowing for those residents and visitors without a clinical diagnosis to freely use the egresses.</p> <p>Other residents affected: All residents without a clinical diagnosis and visitors have the potential to be affected by the deficient practice.</p> <p>Systemic changes: The Maintenance Director has conducted a walk through to ensure public egress doors have proper notification of how to release the magnetic locking device.</p> <p>Monitoring: Maintenance Director or designee will ensure that all door egresses have proper notification during each fire drill session as required. The Maintenance Director or designee will report any deficiencies to the Executive Director for immediate repair.</p> <p>Date of completion: December 23, 2011</p>		

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K0048 SS=E	<p>have a clinical need to be in a secured building but each of the six residents is not housed in a secured wing of the facility. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any</p>	K0048	<p>K 048</p> <p>Corrective action: The kitchen staff was educated on proper use of the overhead extinguisher system before use of the ABC or K class fire extinguishers.</p> <p>Other residents affected: The deficient practice may affect any resident, staff, or visitors in the vicinity of the kitchen.</p> <p>Systemic changes: The facility's written fire safety plan was updated to include necessary language and training requirements for dietary personnel on the proper use and function of the overhead fire suppression system in conjunction with the use of ABC and K class fire extinguishers.</p>	12/23/2011

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	<p>resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Emergency Action Guide: Fire" for Golden Living Center-Indianapolis during record review with the Maintenance Director from 9:00 a.m. to 11:05 a.m. on 12/06/11, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>Monitoring: Maintenance Director of designee will ensure that the updated "Emergency Action Guide: Fire" contains needed language and training on a quarterly basis as part of the normal needed documentation audits performed.</p> <p>Date of completion: December 23, 2011</p>		