

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN47401
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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: 10/20/11</p> <p>Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Bloomington 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 V (000) construction and was fully sprinklered except for the basement electric room and auxiliary room. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors.</p>	K0000	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that the Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employee, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</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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K0017 SS=E	<p>The facility has a capacity of 153 and had a census of 134 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/25/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 metal rolling doors separating the kitchen, a hazardous area, from the corridor would close automatically with the fire alarm system to maintain a smoke resistant barrier. This deficient practice could affect 6 residents observed in the main dining room as well as visitors and staff.</p>	K0017	K 17 1. No residents were affected by this finding. 2. Living Center had identified in August 2011 the metal door did not release upon activation of the fire alarm system that would protect the safety of all residents. The had documentation available at the time of survey that a new door was ordered and awaiting delivery and installation. 3. The door that automatically closes upon activation of the fire alarm system	11/08/2011	

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	<p>Findings include:</p> <p>Based on observation on 10/20/11 at 11:40 a.m. with the Maintenance Supervisor, the metal rolling door in the south kitchen wall was open to the Main dining room which was open to the corridor, it was inspected annually, but it did not release upon activation of the fire alarm system leaving a hazardous area open to the escape route corridor. Based on interview on 10/20/11 at 11:45 a.m. with the Maintenance Supervisor, it was acknowledged by the Maintenance Supervisor the rolling metal door does not close automatically upon activation of the fire alarm system and would leave the dining area unprotected as well as the corridor.</p> <p>3.1-19(b)</p>		<p>is being installed 11/8/11. All fire door have been audited for automated devices. 4. Maintenance Supervisor/designee will monitor closing of door daily and during monthly fire safety drills to assure proper closing. Maintenance Supervisor will immediately report any issues on daily audits to the Executive Director. Maintenance Supervisor will report to Executive Director summary of drills to assure safety and protection of the residents. Maintenance Supervisor will present any changes and outcomes to the monthly QA Committee.</p>		

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K0018 SS=E	<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. Based on observation and interview, the facility failed to ensure 2 of 2 sets of corridor doors provided for the auxiliary dining room north would latch into their frame. This deficient practice could affect 6 residents observed in the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/20/11 at 12:35 p.m. with the Maintenance Supervisor, the west and south set of corridor doors leading into the auxiliary dining room did not latch into their frames. Based on interview on 10/04/11 at 12:37 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned doors would not latch into their frame.</p>	K0018	<p>K 18 1. No residents were affected by this finding. 2. The Living Center is removing the doors from this area. No residents or visitors are affected. 3. The doors are not required and will be removed from this room. All doors in Living Center have been checked to assure proper closing devices to prevent smoke barriers. 4. Maintenance Supervisor/designee checks fire doors daily for proper latching. Maintenance Supervisor/designee will also monitor closing of door during monthly fire safety drills to assure proper closing. Maintenance Supervisor will immediately report any issues on daily audits to the Executive Director. Maintenance Supervisor will report to Executive Director summary of drills to assure safety and protection of the residents. Maintenance Supervisor will present any</p>	11/19/2011			

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K0029 SS=D	<p>3.1-19(b)</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 4 of 7 doors leading to hazardous areas in the basement such as rooms with combustible items were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects mainly staff in the basement.</p> <p>Findings include:</p> <p>Based on observation on 10/20/11 at 2:00 p.m. with the Maintenance Supervisor, the following rooms in the basement which were greater than fifty square feet in size and stored combustible cardboard boxes were not equipped with a self closing</p>	K0029	<p>changes and outcomes to the monthly QA Committee.</p> <p>K 29 1. No residents were affected by this finding. 2. This area is located in the basement and is limited to authorized employees only. Residents are not allowed in this area. 3. Door closures will be installed on the central supply storage room, housekeeping office, central supply office, and storage rooms. All other doors in this area have been audited for proper closing devices. 4. Maintenance Supervisor/designee will monitor closing of door during monthly fire safety drills to assure proper closing. Maintenance Supervisor will immediately report any issues on daily audits to the Executive Director. Maintenance Supervisor will report to Executive Director summary of drills to assure safety and protection of the residents.</p>	11/19/2011	

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K0056 SS=D	<p>device on the corridor door:</p> <p>a. Central supply storage had fifty cardboard boxes,</p> <p>b. Housekeeping office had thirty four cardboard boxes,</p> <p>c. Central supply office had 47 cardboard boxes,</p> <p>d. Storage room on the southwest end of basement had 70 cardboard boxes.</p> <p>Based on interview on 10/20/11 at 2:20 p.m. with the Maintenance Supervisor, it was confirmed the aforementioned doors leading into basement storage rooms were not equipped with a self closing device on the corridor doors.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the</p>	K0056	Maintenance Supervisor will present any changes and outcomes to the monthly QA Committee.	11/19/2011	

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	<p>facility failed to ensure 2 of 3 rooms behind the dryers in the basement were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. NFPA 13, 5-13.11 states, sprinkler protection shall be required in electrical equipment rooms. Exception: Sprinklers shall not be required where all of the following conditions are met: a) The room is dedicated to electrical equipment only. b) Only dry type electrical equipment is used. c) Equipment is installed in a 2 hour fire rated enclosure including protection for penetrations. d) No combustible storage is permitted to be stored in the room. This deficient practice could affect mainly staff in the basement.</p> <p>Findings include:</p> <p>Based on observation on 10/20/11 at 03:17 p.m. with the Maintenance Supervisor, the electric room behind the dryers in the basement which measured ten feet by eight feet was not provided with a sprinkler head. Furthermore, the auxiliary space behind the dryers which measured four feet by four feet lacked sprinkler coverage. Based on interview on 10/20/11 at 03:20 p.m. with the Maintenance Supervisor, it was acknowledged when the basement had been subdivided two years ago these two</p>		<p>area is located in the basement and is limited to authorized employees only. Residents are not allowed in this area. 3. 5 Sprinkler heads will be added to this area. Laundry area was inspected to determine adequate fire protection. 4. Maintenance supervisor/designee will monitor sprinkler head system for function on a monthly. Maintenance will immediately notify Executive Director of any changes, issues or concerns. Maintenance Supervisor will report concerns or trends to the monthly QA Committee.</p>		

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K0143 SS=E	<p>areas were left unsprinklered.</p> <p>3.1-19(b)</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen transfer areas had working continuous electrically powered mechanical ventilation. This deficient practice could affect 16 residents on 100 Hall east as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 10/20/11 at 1:46 p.m. with the Maintenance Supervisor, the oxygen storage room on 100 hall east used to store and transfer oxygen was</p>	K0143	<p>K 143 1. No residents were affected by this finding 2. All oxygen storage areas have been audited for proper continuous working vents to assure the safety of all residents and visitors. 3. The ventilation unit was replaced on 10/21/11. All oxygen storage room have been audited and have working ventilation units. 4. Maintenance Supervisor/designee will daily check the oxygen storage vents to assure the units are working properly. Maintenance Supervisor will immediately report to Executive Director any issues.</p>	10/21/2011	

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	<p>provided with an electrically powered mechanical ventilation, but it did not work. Based on interview on 10/20/11 at 1:50 p.m., it was acknowledged by the the Maintenance Supervisor and unit nurse # 1, this room was used to transfer oxygen and though it had an electrically powered mechanical vent, it was not working.</p> <p>3.1-19(b)</p>		<p>Maintenance Supervisor will present any changes and outcomes to the monthly QA Committee.</p>		