

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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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: 06/03/13</p> <p>Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Lincoln Hills 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 lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in</p>	K010000	<p>Please accept this as our credible plan of correction for the survey event 82RX21. Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of th truth set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 Programs.</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>all resident sleeping rooms. The facility has a capacity of 86 and had a census of 80 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 two detached structures, a metal shed containing facility storage, and a cinder block building that used to house the old generator which is now empty.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 20 hazardous area room doors such as a laundry room door was only held open by a device which would allow the door to close upon activation of the fire alarm system. This deficient practice could affect up to 10 residents while in the Rehab area, which was in the same smoke compartment as the laundry room, plus staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 1:25 p.m. during a tour of the facility with the Maintenance Supervisor, the west side laundry room door was equipped with a self closer, however, when the door was tested from a wide open position the door</p>	K010021	<p>What corrective action will be accomplished for those residents affected by the deficient practice? The door identified in this citation will be replaced. A new door meeting required specifications is currently on order. How will other residents having the potential to be affected by this deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The maintenance supervisor will audit doors one monthly to ensure the doors meet required specifications. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor or designee will conduct audits once monthly to ensure doors meet</p>	07/03/2013			

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	<p>did not close, it became wedged against the floor and stayed half way open. Furthermore, the top hinge of the door was damaged and the screws would not tighten when the Maintenance Supervisor attempted to do so. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors was held open only by a device which would allow the door to close automatically upon activation of the fire alarm system. This deficient practice could affect up to 64 residents, as well as staff and visitors while in the dining room/lounge between Station 4 and Station 2.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, the south side door of the set of smoke barrier doors between Station 4 and the dining room/lounge was blocked open with a housekeeping cleaning cart which would not allow the door to close automatically when the fire alarm system was activated. This was acknowledged by the</p>		<p>required specifications. The housekeeping staff will be inserviced regarding proper storage of housekeeping carts when in use on the nursing stations. How will the corrective actions be monitored to ensure the deficient practice does not recur? The maintenance supervisor will report findings to the ED or designee during monthly QA meetings for 8 months or until corrections are no longer needed. The housekeepign supervisor will report findings to the ED or designee during monthly QA meetings for 8 months or until corrections are no longer needed. Plan of Correction Date: The facility is requesting an extention of 30 days for the replacement of the door due to contractor and material availability. The inservicing of the housekeeping staff will be completed by July 3, 2013.</p>		

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	Maintenance Supervisor at the time of observation. 3.1-19(b)				

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K010029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>1. Based on observation and interview, the facility failed to ensure 4 of 4 shower rooms which contained soiled linen and trash containers over 32 gallons were equipped with self closing devices on the doors. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/03/13 between 12:45 p.m. and 3:00 p.m. during a tour of the facility with Maintenance Supervisor, the following was observed:</p> <p>a. The Station 4 shower room had two single containers and two double containers each over thirty two gallons</p>	K010029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The doors identified in the alleged deficiency will be equipped with self closure devices. The door identified in the alleged deficiency will be replaced. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. The maintenance supervisor will conduct audits to ensure doors are in compliance with the regulation. What measures or systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor or designee will audit the doors once monthly to ensure doors meet the required</p>	08/05/2013			

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	<p>and at least half full.</p> <p>b. The Station 2 shower room had two single containers and two double containers each over thirty two gallons and at least half full.</p> <p>c. The Station 1 southeast shower room had two single containers each over thirty two gallons and at least half full.</p> <p>d. The Station 1 southwest shower room had two single containers each over thirty two gallons and at least half full.</p> <p>The four shower room doors were not equipped with self closing devices. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 20 hazardous area room doors such as a laundry room door was equipped with a self closing device on the door. This deficient practice could affect up to 10 residents while in the Rehab area which was in the same smoke compartment as the laundry room, plus staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 1:30 p.m. during a tour of the facility with Maintenance Supervisor, the south</p>		<p>specifications. How will the corrective actions be monitored to ensure the deficient practice will not recur? The maintenance supervisor will report findings during QA meetings monthly x 8 months or until corrections are no longer needed. Plan of Correction Date: The facility would like to request an extension of 30 days based on contractor and material availability.</p>		

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	<p>laundry room door was not provided with a self closing device. Furthermore, the door and frame were damaged at the bottom edge. The metal door and frame in this area were rusted and bent and closed very tightly which made the door hard to open and close. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<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</p> <p>Based on record review and interview, the facility failed to ensure quarterly fire drills were performed on 3 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill records in the Fire Drill book on 06/03/13 at 10:45 a.m. with the Maintenance Supervisor present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <p>a. First shift (day) of the fourth quarter (October, November, and December) of 2012</p> <p>b. Second shift (evening) of the second quarter (April, May, and June), and third quarter (July, August, and September) 2012</p>	K010050	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?The maintenance supervisor will ensure quarterly fire drills are performed on 3 of 3 shifts. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?The facility recognizes that all residents have the potential to be affected by this alledged deficient practice. The Executive Director or designee will conducts audits of the fire drill records montly to ensure fire drills are being conducted on 3 of 3 shifts.What measures will be put into place or what systemic changes will be made to ensure the deficient practive does not recur?The Maintenance Supervisor will be inserviced on conducting fire drills on 3 of 3 shifts. How will the corrective actions be monitored to ensure the deficient practice will not</p>	07/03/2013	

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	c. Third shift (night) of the first quarter (January, February, and March) of 2013 The lack of fire drill records was acknowledged by the Maintenance Supervisor at the time of record review. 3.1-19(b)		recur? The ED or designee will report on findings during the monthly QA meetings for 8 months or until corrections are no longer required.		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 areas outside and attached to the building and constructed of partially combustible material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs exceeding four feet in width. This deficient practice could affect 7 residents, as well as staff and visitors in the Station 1 southeast portion of the facility.</p> <p>Findings include:</p> <p>Based on observation on 06/03/13 at 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was a nine foot by eight foot canvas canopy attached to the building outside the Station 1</p>	K010056	<p>What corrective action will be accomplished for those residents found to have been affected by this deficient practice? Sprinkler coverage will be provided to the awning attached to the building. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. The maintenance supervisor or designee will conduct audits once monthly to ensure areas requiring spinkler coverage are in compliance. What measures or systemic changes will be put into place to ensure that the deficient practice does not recur? The maintenance supervisor or designee will conduct audits once monthly to ensure areas requiring</p>	08/05/2013

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	southeast exit door. There was no sprinkler coverage provided under the canopy. Based on interview at the time of observation, the Maintenance Supervisor said there was no documentation available to show the canopy was flame retardant and also acknowledged there was no sprinkler coverage under the canopy. 3.1-19(b)		sprinkler coverage are in compliance. How will the corrective actions be monitored to ensure the deficient practice will not recur? The maintenance supervisor or designee will report findings monthly during the QA meeting for 8 months or until corrections are no longer needed.		

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered elevator equipment rooms was provided with an automatic means for disconnecting the main line power supply. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect mostly kitchen staff near the elevator equipment room, plus up to 4 residents at a time while in the elevator.</p> <p>Findings include:</p> <p>Based on observation of the elevator</p>	K010160	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?An automatic shunt system will be installed per specifications.How will other residents having the potential to be affected by this deficient practice be identified? The facility recognizes that all residents have the potential to be affected by this alledged deficient practice. The maintenance supervisor or designee will conduct audits once monthly to ensure the elevator shunt system is in place.What measures or systemic changes will be put into place to ensure the deficient practice does not recur?The maintenance supervisor or designee will conduct audits once montly to ensure the elevator shunt system is in place. How will the corrective actions be monitored to ensure the deficient practice does not recr? The maintenance supervisor will report findings in the monthly QA meetings for 8 months or until corrections are no longer needed.The facility would like to</p>	08/05/2013			

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	<p>equipment room on 06/03/13 at 1:05 p.m. during a tour of the facility with the Maintenance Supervisor, the elevator equipment room was provided with sprinkler coverage. Based on an interview at the time of observation of the elevator electrical equipment, the Maintenance Supervisor said there was no shunt trip breaker provided in the elevator equipment room to automatically disconnect the main line power supply while sprinklers were activated.</p> <p>3.1-19(b)</p>		request a 30 day extension based on contractor/material availability.		