STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-PETERSBURG	309 W PIKE AVE PETERSBURG, IN 47567

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K0000	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). Survey Date: 03/27/12 Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Petersburg 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. This one story facility was determined to be of Type V (000) construction and was fully	K0000	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 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 federa regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms were not provided with smoke detection. The facility has a capacity of 86 and had a census of 52 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/29/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	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			
	Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect any of the 38 residents, as well as staff and visitors in the west unit. Findings include: Based on observation on 03/27/12 at 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall in the attic above the smoke barrier doors between resident rooms 122 and 123 had a one and a half foot by one and a half foot section of drywall missing. This was acknowledged by the Maintenance	K0025	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Smoke barriers between resident room 122 and 123 will be repaired by 5/8 fire code drywall. **How others residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Director of Maintenance will inspect all smoke bearing walls in attic and repair as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director will inspect	04/26/2012

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	Supervisor at the time of observation. 3.1-19(b)		all smoke bearing walls every 6 months or if any work related repairs are completed in the attic region. **How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place:** Maintenance Director will inspect all smoke bearing walls every 6 months or if any work related repairs are completed in the attic region. This will be monitored through our QA&A meeting monthly times 3 then quarterly or as needed.	

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K0029 SS=E	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 Based on observation and interview, the facility failed to ensure 2 of 10 hazardous area room doors, such as rooms over 50 square feet in size containing a large amount of combustible material or soiled linens, were equipped with self closing devices on the doors. This deficient practice could affect 14 residents, as well as staff and visitors in the east unit. Findings include: Based on observation on 03/27/12 between 11:30 a.m. and 1:30 p.m. during a tour of the facility with Maintenance Supervisor, the sprinkler riser room/soiled utility room was over fifty square feet in size and had	K0029	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Self closing devices have been installed on the East End Soiled Utility Room and room 144. **How others residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** Any room over 50 square feet in size containing a large amount of combustible material or soiled linens, will be equipped with self closing devices on the doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	04/26/2012

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	two soiled linen barrels with over 32 gallons capacity each and one large hazardous waste box, furthermore, the maintenance storage room was over fifty square feet and full of cardboard boxes, wood furniture, and cleaning supplies. The doors to these rooms were not provided with self closing devices. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)		Maintenance director audited all storage rooms to ensure that they are equipped with self closing devices. New storage areas will be equipped with the self closing devices. **How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place:** Maintenance director audited all storage rooms to ensure that they are equipped with self closing devices. New storage areas will be equipped with the self closing devices. This will be monitored through QA&A monthly for 3 months then quarterly as needed.	

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K0048 SS=B	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 and interview, the facility failed to provide 1 of 1 written fire safety plans addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2 in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (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 evacuation (8) Extinguishment of fire This deficient practice could affect any staff in the kitchen and any residents in the vicinity of the kitchen in the event of an emergency. Findings include:	K0048	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Inservice will be conducted with dietary staff to ensure knowledge and use of K-Class fire extinguisher. A sign above fire extinguisher will state: K-Class fire extinguisher use on stove only. An addendum will be added to our Fire and Evacuation plan to address the K class fire extinguisher in relationship with the use of the kitchen overhead extinguishing system. **How others residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. A sign above fire extinguisher will state: K-Class fire extinguisher use on stove only. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A sign above fire extinguisher will state:	04/26/2012

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	Based on a review of the facility's Fire and Evacuation Plan on 03/27/12 at 11:00 a.m. with the Maintenance Supervisor present, the fire safety plan did not address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan did not mention the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. 3.1-19(b)		K-Class fire extinguisher use on stove only. An addendum will be added to our Fire and Evacuation plan to address the K class fire extinguisher in relationship with the use of the kitchen overhead extinguishing system. **How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place:** Maintenance Director will monitor monthly during fire extinguisher checks to ensure sign in place. This will be monitored through QA&A monthly times 3 then quarterly as needed.	

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K0050 SS=F	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 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire Drill Records on 03/27/12 at 10:15 a.m. with the Maintenance Supervisor present, the facility lacked written documentation a fire drill was conducted during the second (evening) shift of the fourth quarter (October, November, and December) of 2011. This was acknowledged by the Maintenance Supervisor at the time of record review.	K0050	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Maintenance Director will ensure he receives receipt on each fire drill from Vanguard Services showing times of testing of fire drills. It will then correspond with the in-service sheet signed with the associates in attendance. The fire drills will be varied in times and at least one drill per month. **How others residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. Maintenance Director will ensure he receives receipt on each fire drill from Vanguard Services showing times of testing of fire drills. It will then correspond with the in-service	04/26/2012

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	3.1-19(b) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire Drill Records on 03/27/12 at 10:15 a.m. with the Maintenance Supervisor present, two of three second shift (evening) fire drills since January of 2011 were both performed at 3:45 p.m., furthermore, the third fire drill performed on the second shift did not have a time included. Also, on two occasions fire drills were performed on the same day; on 06/30/11, a second shift fire drill was performed at 3:45 p.m. and a third shift fire drill was performed at 5:30 a.m., and on 09/22/11, a first shift fire drill was performed at 2:40 p.m. and a second shift fire drill was performed at 3:45 p.m. This was acknowledged by the Maintenance Supervisor at the		sheet signed with the associates in attendance. The fire drills will be varied in times and at least one drill per month. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director will ensure he receives receipt on each fire drill from Vanguard Services showing times of testing of fire drills. It will then correspond with the in-service sheet signed with the associates in attendance. The fire drills will be varied in times and at least one drill per month. **How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place:** Maintenance Director will present monthly reports to Executive Director or designee from Vanguard Services and facility in-service for accurate documentation of fire drills. This will be monitored through QA&A monthly times 3 then quarterly as needed.	

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	time of record review. 3-1.19(b)			