

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155264	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/19/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-GOLDEN RULE	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374
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K 0000  Bldg. 01	<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: 11/19/15</p> <p>Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220</p> <p>At this Life Safety Code survey, Golden Living Center-Golden Rule 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 partial basement was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 170 and had a census of 124 at the time of</p>	K 0000	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 Federal regulatory requirements.	

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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K 0018 SS=D Bldg. 01	<p>this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three wooden detached storage sheds which were not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1 of 12 resident room corridor doors on the Alzheimer Hall would resist the passage of smoke or latch into the door frame. This deficient practice affects 1 resident who reside in resident room 69.</p> <p>Findings include:  Based on observation on 11/19/15 at</p>	K 0018	<p>K 018 12-1-15</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p>	12/01/2015

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	<p>11:40 a.m. with the maintenance supervisor, the corridor room door to resident room 69 failed to close and latch into the door frame and had a one inch gap along the latching side of the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/19/15 at 12:15 p.m.</p> <p>3.1-19(b)</p>		<p>The hinge was adjusted so that the door would latch to provide a smoke barrier.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>The surveyor and maintenance staff inspected all the doors throughout the facility. Another door was found deficient and corrective action was taken to ensure the door sealed to provide the proper smoke barrier.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>All doors will be inspected quarterly per our soft ware program to ensure</p>	

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K 0025 SS=E Bldg. 01	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,		they provide the proper smoke barriers.  Any non-compliance with the quarterly inspections are forwarded to the E.D. by the " Building Engines " soft ware program. The E.D. will ensure that the quarterly inspections are completed. Any pattern of non-compliance will be taken to the QAPI process for further action.  The deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months.  QAPI results will determine if monitoring and extended education are needed.		

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	<p>19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 3 of 7 ceiling attic access panels were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 44 residents who reside on Hall 2, Hall 3, and Hall 4 and 6 residents who use the Physical Therapy room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 11/19/15 from 8:00 a.m. to 12:15 p.m., the following locations had ceiling penetrations not firestopped, missing drywall or had ceiling plywood attic access panels;</p> <ol style="list-style-type: none"> <li>1. East Garden Hall sprinkler riser room ceiling had two, two inch gaps around a sprinkler and water pipe penetration not fire stopped.</li> <li>2. Resident room 46 closet ceiling had</li> </ol>	K 0025	<p>K 025 12-1-15</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>All of the attic access panels throughout the building are fitted with one hour fire rated cement boards .</p> <p>All penetrations cited in the CMS 2567 form have been sealed with fire rated caulk.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>An inspection was conducted by maintenance to ensure that are the</p>	12/01/2015

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	<p>three, three inch gaps around four inch water pipe penetrations not fire stopped.</p> <p>3. The Main Hall master housekeeping closet ceiling had a one inch gap around a water pipe penetration not fire stopped.</p> <p>4. The Physical Therapy room closet ceiling had a two inch by two inch area of drywall missing next to the sprinkler.</p> <p>5. The Hall 2, Hall 3, and Hall 4 two foot by four foot attic access panels were constructed of plywood. Based on an interview with the maintenance supervisor at the time of observations, the plywood attic access panels are a non rated material.</p> <p>The East Garden Hall ceiling, resident room 46 closet ceiling, Main Hall master housekeeping closet ceiling penetrations not fire stopped, the Physical Therapy room closet ceiling missing drywall, and Hall 2, Hall 3, and Hall 4 attic access panels constructed of non rated plywood was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/19/15 at 12:15 p.m.</p> <p>3.1-19(b)</p>		<p>access panels are fitted with the one hour fire rated cement boards. An inspection of the facility also was conducted for any penetrations. All deficient areas were sealed with fire rated caulk.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Maintenance and the E.D. will ensure that if any attic access doors are damaged or replaced that they will be of the fire rated material needed to meet Code standards.</p> <p>Maintenance will semi-annually and during routine repairs and rounds will inspect for penetrations and will repair to meet Code.</p> <p>Deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months.</p> <p>Any deficiency will be addressed.</p>		

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K 0029 SS=B Bldg. 01	<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>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 18 hazardous areas, such as combustibile storage rooms over 50 square feet, was provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect staff only and no residents in the Service Hall housekeeping supply room.</p> <p>Findings include:</p> <p>Based on observations on 11/19/15 at 9:20 a.m. with the maintenance supervisor, the Service Hall housekeeping supply room, which measured one hundred ten square feet and had fifteen shelves filled with nineteen cardboard boxes filled with cloth towels, lacked a self closing device</p>			K 0029	<p>K 029 12-1-15</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>A self closing door mechanism was installed on the housekeeping supply room door.</p> <p>Other residents having the potential to be affected by the same deficient</p>		12/01/2015

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	<p>on the door. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/19/15 at 12:15 p.m.</p> <p>3.1-19(b)</p>		<p>practice will be identified and the corrective actions taken are as follows:</p> <p>An inspection to identify any other deficient did not find any other areas on non-compliance.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>During routine rounds and repairs maintenance will identify any non-compliant areas and make correction to ensure that all areas within the facility are Code compliant. Any areas that need corrective actions will be reported to the E.D. or designee. If there is any trend in non-compliance the trend will be reported to the QAPI committee and an action plan will be made.</p> <p>The deficient practice was addressed</p>	

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K 0062 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 replace 1 of over 300 sprinklers in the facility covered in white paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice affects 2 residents who reside in resident room 3.</p> <p>Findings include:</p> <p>Based on observation on 11/19/15 at</p>	K 0062	<p>during monthly QAPI meeting and will be monitored monthly x 6 months.</p> <p>QAPI results will determine if monitoring and extended education are needed.</p> <p>K 062 12-1-15</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Corrective action was performed per NFPA 25 that requires all sprinkler which are painted, corroded or damaged to be replaced. Room 3 sprinkler was replaced.</p> <p>Other residents having the potential to be affected by the same deficient</p>	12/01/2015

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	<p>10:10 a.m. with the maintenance supervisor, resident room 3, bed 1 sprinkler was completely covered in white paint. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/19/15 at 12:15 p.m.</p> <p>3.1-19(b)</p>		<p>practice will be identified and the corrective actions taken are as follows:</p> <p>Our contractor for sprinkler inspection, VFP, will inspect the building for any other sprinklers that need replaced and those identified have been replaced.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>During quarterly sprinkler inspections sprinklers will be identified and replaced as needed to meet LSC 9.7.5. Any trend in finding and replacing sprinklers that do not meet LSC 9.7.5 will be reported to the E.D. by Maintenance. The E. D. will report to the QAPI Committee if needed to recommend and implement a plan of action.</p>		

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K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 122 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. 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 ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact</p>	K 0147	<p>Deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months.</p> <p>Any deficiency will be addressed.</p> <p>K 147 12-1-15</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>A GFCI receptacle was installed in the main hall men's and women's hand sink identified in the 2567. The main hall physical therapy sink had a GFCI breaker that was not labeled/identified during survey but upon further inspection the GFCI</p>	12/01/2015

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	<p>resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 58 residents who use the Main Hall restrooms and 6 residents who use the therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/19/15 at 9:50 a.m., the Main Hall men's and women's restrooms each had a shared hand wash sink with an electric receptacle on the wall within one foot of the handwash sink with no ground fault circuit interrupter on the electric outlet. Furthermore, the Main Hall Physical Therapy room handwash sink had an electric receptacle on the wall within two feet of the handwash sink with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breakers for the Main Hall men's and women's restroom handwash sink electric outlet and Therapy room electric outlet were not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/19/15 at 12:15 p.m.</p>		<p>breaker was identified and labeled.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>No other areas requiring GFCI protection were found during rounds.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>During Maintenance rounds, repairs, and inspections areas will be examined for any needs for GFCI protection. If there is any trend of discovery of areas that lack proper GFCI protection, it will be reported by maintenance to the E.D. , who will report the trend to the QAPI</p>	

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	3.1-19(b)		<p>committee.</p> <p>The deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months.</p> <p>QAPI results will determine if monitoring and extended education are needed.</p>		