

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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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: 07/14/16</p> <p>Facility Number: 0000031 Provider Number: 155076 AIM Number: 100266150</p> <p>At this Life Safety Code survey, Golden Living Center-Brookview 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 facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, was determined to be of Type V (111) 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 battery</p>	K 0000	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. THE FACILITY IS KINDLY REQUESTING PAPER COMPLIANCE</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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K 0018 SS=E Bldg. 01	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 136 and had a census of 78 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 07/18/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the</p>	K 0018	What corrective actions will be	08/01/2016

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	<p>facility failed to ensure 1 of over 70 corridor doors would resist the passage of smoke. This deficient practice could affect 6 residents, staff and visitors in the vicinity of the Housekeeping and Laundry Services Room by Room 199.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:40 p.m. on 07/14/16, two separate one half inch in diameter holes above and below the door handle were noted in the corridor door to the Housekeeping and Laundry Services Room by Room 199. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned corridor door would not resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p><b>accomplished for thoseresidents found to have been affected by the deficient practice are as follows:</b></p> <p>The two ½” diameter holes in the housekeepingand laundry services door next to room 199 will be sealed using 4 hourintumescent fire caulk.</p> <p><b>How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionwill be taken is as follows:</b></p> <p>The six residents, staff and visitors in thevicinity of the housekeeping and laundry services room by room 199 will havethe potential to be affected by the same deficient practice. The two ½” diameter holes in the housekeepingand laundry services door next to room 199 will be sealed using 4 hourintumescent fire caulk. Maintenance Director/Designee would conduct facility wideinspection of corridor doors for the fire resistant passage and submit thereport to the Executive Director.</p> <p><b>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur is asfollows:</b></p> <p>Maintenancestaff will be educated on fire resist passage of smoke while maintaining door integrityand will be added to the “Daily interior rounds portion of Building Enginescheck lists program.</p>	

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K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L).	K 0069	<p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> Maintenance Director will add the doors integrity check to the "Daily interior rounds" portion of the "Building Engines" program. The results of the interior rounding will be submitted during QA for review and compliance by QA committee.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> A metal drip tray will be installed below the filter system with a capacity not to exceed 1 gal.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:</b> All kitchen staff and visitors have a potential to be affected by the same deficient practice. A metal drip tray will be installed below the filter system with a capacity not to exceed 1 gal.</p> <p><b>What measures will be put into</b></p>	08/01/2016
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K 0147 SS=E Bldg. 01	<p>This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:40 p.m. on 07/14/16, one of one designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. The designated location for the missing grease container had a one inch in diameter hole in the drip tray beneath the system filters but no container was present. Based on interview at the time of observation, the Director of Maintenance acknowledged one of one designated locations underneath the kitchen range hood system drip trays was missing an enclosed metal container for grease to drain into.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 extension</p>	K 0147	<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows:</b> A metal drip tray will be installed below the filter system with a capacity not to exceed 1 gal. All kitchen and maintenance staff will be in serviced on the purpose and use of the drip tray. Maintenance Director/Designee will add to the monthly inspection task to the kitchen exhaust hood section of the "Building Engines" system to verify the drip tray is appropriately in place.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> A monthly inspection task will be added to the kitchen exhaust hood section of the "Building Engines" system to verify the drip tray is appropriately in place. The results of the inspection will be submitted to the QA for review by QA committee for compliance by Maintenance Director/Designee.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the</b></p>	08/01/2016			

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	<p>cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft. (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft. 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p>		<p><b>deficient practice are as follows:</b>The extension cords including power strips were removed from the rooms200 and 215 immediately.</p> <p><b>How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionwill be taken is as follows:</b> The residents, staff and visitors in rooms200 and 215 have potential to be affected by this practice. MaintenanceDirector immediately removed the extensions cords and power strips.</p> <p><b>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur is asfollows:</b> Maintenance Director/Designee will conductinspection of ALL resident rooms. Maintenance Director/Designee will conductin-service with direct care, housekeeping and maintenance staff on the policyand usage of extension and power cords in resident rooms.</p> <p><b>How the corrective action will be monitored to ensure thedeficient practice will not recur i.e. what quality assurance program will beput into place and by what date the systemic changes will be completed is asfollows:</b> Maintenance Director/Designee will inspect monthlyof the resident rooms</p>	

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K 0154 SS=C Bldg. 01	<p>Based on observations with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:40 p.m. on 07/14/16, the following was noted:</p> <p>a. a wheelchair charger was plugged into a power strip on the floor four feet from the resident bed nearest the window in Room 200.</p> <p>b. the resident bed nearest the corridor door, an oxygen concentrator and a Precision Medical Easy Air Compressor were each plugged into a power strip on the floor underneath the bed in Room 215.</p> <p>Based on interview at the time of the observations, the Director of Maintenance acknowledged a power strip was being used as a substitute for fixed wiring in the patient care vicinity in Room 200 and in Room 215.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete</p>	K 0154	<p>for compliance and submit the results to QA committee for review and compliance.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the</b></p>	08/01/2016			

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	<p>written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period for 1 of 2 written plans in order to protect 78 of 78 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Action Plan: Fire Alarm System Impairments" documentation with the Director of Maintenance during record review from 9:10 a.m. to 11:30 a.m. on 07/14/16, the written fire watch policy for the facility did not include procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period and did not include notification of the Indiana State Department of Health (ISDH) which is an authority having jurisdiction. The aforementioned written</p>		<p><b>deficient practice are as follows:</b>The "Emergency Action Plan: Fire Alarm System Impairments" documentation will be update with inclusion of the language of notification to the ISDH in case the service is out of place for four hours more within a 24 hours period.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:</b> All residents and staff have potential to be affected by the same deficient practice. The "Emergency Action Plan: Fire Alarm System Impairments" documentation will be update with inclusion of the language of notification to the ISDH in case the service is out of place for four hours more within a 24 hours period. Maintenance Director/Designee will update all the Emergency Action Plan manuals.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows:</b></p> <p>The "Emergency Action Plan: Fire Alarm System Impairments" documentation will be update with inclusion of the language of notification to the ISDH in case the service is out of place for four hours more within a 24 hours period. Maintenance Director/Designee will</p>	

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K 0155 SS=C Bldg. 01	<p>fire watch policy for automatic sprinkler system impairment is the plan made available for administrative staff and did not include all provisions of the Director of Maintenance's written fire watch policy version for automatic sprinkler system impairment titled "Fire Protection/Fire Alarm System Impairment." Based on interview at the time of record review, the Director of Maintenance acknowledged the written fire watch policy made available to administrative staff did not include procedures to be followed for the facility in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period and did not include notification of ISDH.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the facility containing procedures to be followed in the event the fire alarm system has to be placed out</p>	K 0155	<p>update all the Emergency Action Plan manuals. The Emergency Action Plan will be reviewed annually by Maintenance Director/Designee.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> Maintenance Director/Designee will audit ALL Emergency Action Plan annually and submit the finding to QA committee for compliance.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> Fire watch policy for Fire Alarm System Impairment procedure</p>	08/02/2016

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	<p>of service for four hours or more in a 24 hour period for 1 of 2 written plans in accordance with LSC, Section 9.6.1.8 in order to protect 78 of 78 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Action Plan: Fire Alarm System Impairments" documentation with the Director of Maintenance during record review from 9:10 a.m. to 11:30 a.m. on 07/14/16, the written fire watch policy for the facility in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period and which is made available to administrative staff did not include notification of the Indiana State Department of Health (ISDH) which is an authority having jurisdiction. The aforementioned written fire watch policy for fire alarm system impairment is the plan made available for administrative staff and did not include all provisions of the Director of Maintenance's written fire watch policy version for fire alarm system impairment titled "Fire Protection/Fire Alarm System Impairment." Based on interview at the time of record review, the Director of Maintenance acknowledged the written fire watch policy for the facility in the</p>		<p>will be added to all EmergencyAction Guides that outline the procedure if the fire alarm system is impaired,and will include language to report to ISDH if system is impaired for fourhours in a 24 hour period as well as the complete fire watch procedure for firealarm system impairments.</p> <p><b>How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective actionwill be taken is as follows:</b> All residents and staff have potential to be affected by the samedeficient practice. : Fire watch policy for Fire Alarm System Impairment procedure will beadded to all Emergency Action Guides that outline the procedure if the firealarm system is impaired, and will include language to report to ISDH if thefire alarm system is impaired for four hours in a 24 hour period as well as thecomplete fire watch procedure for fire alarm system impairments.</p> <p><b>What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur is asfollows:</b> The "Emergency Action Guide will be update with theinclusion of language of reporting to the ISDH if the Fire Alarm Systemimpaired for four hours or more within 24 hr. period. The maintenance director/Designee will updateALL the Emergency Action</p>	

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	event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period and which is made available to administrative staff did not include notification of ISDH.  3.1-19(b)		Guides ensuring the inclusion of the reporting language.  <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> Maintenance Director/Designee will audit ALL Emergency Action Plan annually and submit the finding to QA committee for compliance		