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 01/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER- BROOKVIEW	7145 E 21ST ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 01/15/13 Facility Number: 000031 Provider Number: 155076 AIM Number: 100266150 Surveyor: Mark Caraher, Life Safety Code Specialist 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. 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all	K0000		

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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	areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 136 and had a census of 106 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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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 record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could	K0029	**K029** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice is as follows:** Rolling fire window was inspected by SafeCare Corporation on 1/15/13. Recommendations noted on SafeCare report were ordered to be completed by 2/8/13. Recommendations include adding a "fire fly" unit connected to the fire alarm system to drop the door automatically during any fire alarm. **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:**	02/14/2013

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	affect 50 residents, staff and visitors in the Main Dining Room. Findings include: Based on review of SafeCare "Service Call Report" documentation with the Senior Director of Maintenance during record review from 9:45 a.m. to 11:50 a.m. on 01/15/13, the most recent documented annual rolling fire door inspection was on 12/08/11. Based on observation with the Senior Director of Maintenance during a tour of the facility from 11:50 a.m. to 2:45 p.m. on 01/15/13, the rolling fire door protecting the opening from the kitchen to the Main Dining Room had an inspection tag indicating the most recent annual inspection of the rolling fire door was performed on 12/08/11. The Main Dining Room is open to the corridor, thus the rolling fire door is in a corridor wall. Based on interview at the time of record review and observation, the Senior Director of Maintenance acknowledged it has been more than one year since the most recent annual inspection of the rolling fire door was performed to check for proper operation and full closure. 3.1-19(b)		Other residents using the main dining room and adjacent areas in the same smoke compartment have the potential to be affected by this deficient practice. The rolling fire window will be inspected semi-annually by SafeCare Corporation. **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:** The rolling fire window will be inspected semi-annually by SafeCare Corporation, systematically changing the testing schedule to twice per year. Rolling fire window inspection will be scheduled to be conducted near the semi-annual fire alarm system testing to make it simpler to track. The Maintenance Director or designee will verify the testing to be complete, and alert the Executive Director as well as calling for immediate testing of rolling fire window if at any time the report is not completed on schedule. **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**	

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			as follows: Maintenance Director will monitor the corrective action by a visual check of the documentation tag attached to the roll down fire door by SafeCare Corporation semi-annually to ensure the inspection has been completed, and to ensure the deficient practice will not recur. Any information regarding roll down door testing, whether pass or fail, will be reported to the Executive Director immediately, and will be corrected immediately if a failure is noted. Testing twice a year rather than the required one test per year will ensure the requirement is met. This systematic change will be completed to ensure the deficient practice will not recur, and assure quality by adding extra testing beyond the requirements set fort by the NFPA. **By what date the systemic changes will be completed is as follows:** 2/14/13.	

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K0130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 74 of 74 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 106 residents, staff and visitors. Findings include: Based on review of "Battery Operated Smoke Detector Maintenance Log for (Year) 2012" documentation with the Senior Director of Maintenance during record review from 9:45 a.m. to 11:50 a.m. on 01/15/13, an itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. A monthly check of "all' battery operated smoke detectors was entered on the aforementioned documentation for July 2012 through October 2012. In addition, based on review of "Direct Supply: TELS documentation" monthly records of battery operated smoke detectors checks for November and December 2012 was	K0130	**K130** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice is as follows:** Corrective action was initiated the day of the Life Safety Survey by requesting an itemized room list to be added to the documentation for battery operated smoke detector testing by our Tels computerized documentation system representative. Tels representative Dave Race confirmed the change in the system via e-mail, and the change was confirmed by the Maintenance Director by accessing the Tels system to verify corrections. **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:** All residents are identified to have potential to be affected by the deficient practice as the testing occurs in each of their rooms. Although testing was completed, the documentation was made in a format that showed only one	02/14/2013

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	not available for review. Based on observations with the Senior Director of Maintenance during a tour of the facility from 11:50 a.m. to 2:45 p.m. on 01/15/13, battery operated smoke detectors were installed in all 74 resident sleeping rooms. Based on interview at the time of record review and of the observations, the Senior Director of Maintenance stated documentation of monthly battery operated smoke detector checks should have been entered in Direct Supply: TELS starting in November 2012 but acknowledged documentation of monthly testing of each battery operated smoke detector in resident sleeping rooms was not available for review. 3.1-19(a)		record for all rooms. New documentation reflects the use of a template which outlines each individual room number. **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:** Changes were put into place in our Tels computerized documentation system to document each room in the individual testing of battery operated smoke detectors on a monthly basis. This documentation structure will continue to be used indefinitely to fulfill the requirements of LSC 4.6.12.2. **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:** Maintenance Director will not change the new template for battery operated smoke detector testing, and will notify Executive Director if any changes are required. Testing of each individual unit will continue to be tested monthly and documented	

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			as such. The electronic tracking template generated by Tels will ensure the systematic change to satisfy the requirements of LSC 4.6.12.2. **By what date the systemic changes will be completed is as follows:** 2/14/13.	