

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/29/12</p> <p>Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist Robert Sutton, Trainee</p> <p>At this Life Safety Code survey, Golden Living Center-Knox 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>	K0000		

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>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms were provided with battery powered smoke detectors. The facility has a capacity of 57 and had a census of 49 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services are sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K0018 SS=E	<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 a door protecting corridor openings in 1 of 4 smoke compartments would latch into the door frame. This deficient practice affects staff, visitors and 30 residents in the east wing smoke compartment.</p> <p>Findings include: Based on observation with the maintenance director on 08/29/12 at 1:35 p.m., the door to room 25 failed to latch when tested twice with the maintenance director. The maintenance director said at the time of</p>	K0018	<p>1. Room 25 door latch was readjusted and when retested closed without failure. 2. all resident and facility's door where retested and it was determined that none closed without failure.3. all resident room doors and facility's wooden fire doors will be checked each month to determine that all doors close without failure.4. Maintenance Director or designee will complete visual and manual observation of each facility and resident door to determine that each close without failure. Preventative maintenance will be completed, as necessary.5. Completed on 09/12/2012.</p>	09/12/2012			

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	<p>observation, the door needed adjustment</p> <p>3.1-19(b)</p>			

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K0021 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>Based on observation and interview, the facility failed to ensure smoke barrier doors and hazardous area doors in 1 of 5 smoke compartments were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 30 or more west wing residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 between 12:40 p.m. and 3:30 p.m.:</p> <p>a. One door in the smoke barrier between the service kitchen and</p>	K0021	<p>1. a) plate warmer was moved to allow magnet doors to close properly b) Laundry Room door and Kitchen door were adjusted and when retested closed without failure. The steam table was reconfigured to allow the plate warmer space without interfering with Magnet Closing door. 2. All Magnet Closing doors in facility were retested and closed without failure.3. Maintenance Director or designee will inservice Kitchen and Laundry employees regarding the necessity of not blocking fire doors. 4. Executive Director or designee will monitor compliance and report findings to QA&A committee.5. Completed 10/07/12</p>	09/12/2012

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	<p>main service corridor was held open by a plate warmer. At 1:15 p.m., the door was held open by staff working in the room. At 3:05 p.m., the plate warmer was again holding the door open between the unoccupied dining room and service corridor. The maintenance director acknowledged at the time of observations, the door in the smoke barrier was not allowed to close as designed. When the door was released from its impediments on 08/29/12 at 3:10 p.m., the door failed to close when it hit the door frame.</p> <p>b. One door to the laundry and one door to the kitchen each failed to self close when the fire alarm was activated and the magnets holding the doors open allowed them to close. Each of the doors hit their door frame. The maintenance director acknowledged at the time of observation, the doors need adjustments to close as they should have.</p> <p>3.1-19(b)</p>				

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K0022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure the egress path through 2 of 3 doors in the exit corridors were clearly identified. This deficient practice affects visitors, staff and 19 or more residents on the west wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 between 12:30 p.m. and 4:00 p.m., an exit sign was not posted above the smoke barrier doors in the center of the west smoke compartment. The doors were kept closed and there was nothing to identify there was exit egress behind the closed doors. This was true for the center smoke compartment as well, one door set providing exit egress through the service corridor was not visible since the doors were kept closed. The maintenance director</p>	K0022	<p>1. No immediate correction available, two lighted exit signs were ordered and installed on 9/7/2012.2. All doors in the exit corridors were observed and all doors had lighted exit signs.3. All doors in the exit corridors were clearly identified by lighted exit signs.4. Maintenance Director or designee will daily complete observation to determine that all doors in the exit corridors have lighted exit signs.5. 09/07/2012.</p>	09/07/2012			

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	<p>acknowledged a person unfamiliar with the enclosed areas might not know these were exit means of egress in the event of an emergency.</p> <p>3.1-19(b)</p>			

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K0025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure an opening through 1 of 3 smoke barriers was sealed with a material to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or 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 could affect visitors, staff and 30 residents in the east wing.</p> <p>Findings include:</p>	K0025	<p>1. Foam in the east smoke barrier was removed and repalced with fire stop chaulking. 2. Maintenace Director observed all smoke barriers in the facility to determine that fire stop chaulking was used and foam was not used.3. Maintenance Director or designee will instruct all outside contractors to use fire stop chaulking when repairing or repacing cables throughout the facility.4. Maintenance Director will inspect the repair work prior to outside contractors completing work assignment. 5. Completed on 09/10/12</p>	09/10/2012	

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	<p>Based on observation with the maintenance director on 08/29/12 at 2:30 p.m., there was a gap between cables and the east smoke barrier wall filled with foam. The maintenance director agreed at the time of observation, the penetration had not been properly sealed.</p> <p>3.1-19(b)</p>				

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to maintain the smoke resistance of 1 of 5 smoke barrier door sets. This deficient practice could affect staff, visitors and 30 or more residents in the east smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 at 2:15 p.m., the smoke barrier door set located near the kitchen had four half inch holes where equipment had been removed. The maintenance director said at the time of observation, a locking mechanism had been removed and the holes were not sealed.</p>	K0027	<p>1. The four 1/2 inch holes where equipment had been removed were chaulked and sealed with fire stop chaulking.2. Maintenance Director observed all the wooden fire doors within the facility to determine that there were no additional holes.3. Maintenance Director or designee will observe, 5 times per week, all doors to determine that there are no holes in wooden fire doors and repair, as needed.4. Executive Director or designee will observe all wooden fire doors,at least monthly, during enviornmental inspection.5. Completed 09/05/2012</p>	09/05/2012			

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K0039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure the clear and unobstructed minimum width was maintained for 1 of 2 west wing exits. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires that an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 at 1:15 p.m., the egress path for the southwest exit from the west wing was cluttered with 30 cardboard cartons stacked on the floor, an upholstered club chair, wheel chair scale, table top</p>	K0039	<p>1. Cardboard cartons and other items were immediately removed from the west wing hallway. 2. Maintenance Director completed a observation of all hallways in the facility to determine that egress path is unobstructed. 3. Maintenance Director or designee will observe all hallways, 5 times per week, to ensure that the hallways are free of obstruction and impediments. 4. Maintenance Director or designee will maintain results of observations and the results will be reviewed in QA&A for 6 months. 5. Completed 9/5/2012.</p>	09/05/2012

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	<p>and other equipment stored on both sides of the exit corridor which diminished the egress to three and one half feet in one area. The maintenance director said at the time of observation, the items were "not usually kept there."</p> <p>3.1-(19)</p>			

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K0048 SS=F	<p>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 observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 49 of 49 residents. This deficient practice could affect occupants in all areas.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 between 12:45 a.m. and 3:30 p.m., battery powered smoke detectors were installed in all resident rooms. All resident room smoke detectors activated only a local alarm which could be heard inside each resident room and the adjoining corridor if the door were open. Based on review of the facility's Fire Plan with the maintenance director on 08/29/12 at 4:10 p.m., there was no procedure specific for response to the battery powered smoke detector alarms. The maintenance</p>	K0048	<p>1. Immediate corrective action not available. 2. N/A3. Director of Clinical Education and Maintenance Director will inservice all employees on Battery Powered Smoke Detectors including procedures and the sound of the alarm.4. Director of Clinical Education and Maintenance Director will ensure all new employees will be inserviced during orientation and all employees will complete inservice during Annual Inservice Training.5. Completion 10/05/2012.</p>	10/05/2012

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	<p>director confirmed at the time of observation, no training specific to response to the battery powered smoke had been done to familiarize staff to the necessary procedures and the sound of the alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p>			

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K0062 SS=E	<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 ensure a shower room sprinkler head in 1 of 5 smoke compartments was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and obstructions should be 18 inches or more. This deficient practice affects visitors, staff and 30 residents in the west smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/29/12 at 1:00 p.m., the shower curtain in the west shower room hung three inches from the ceiling. The single sprinkler head could not penetrate the solid</p>	K0062	<p>1. The shower curtains in the unused shower were removed from the shower room and destroyed. 2. The other shower room was checked to ensure that acceptable shower and privacy curtains were being used. 3. The identified shower curtains were removed from the building and destroyed. 4. Maintenance Director or designee will observe monthly to ensure only shower curtains that are acceptable are used in the shower room. 5. Completed 09/05/2012.</p>	09/05/2012			

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	<p>material which extended above the 18 inch minimum clearance required for sprinkler protection to the area behind the curtain. The maintenance director agreed the shower curtain did not provide the clearance needed to prevent obstructing spray from the single sprinkler head protecting the room.</p> <p>3.1-19(b)</p>			

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K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff and 19 or more residents in the adjacent dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 08/29/12 at 2:50 p.m. with the maintenance director, the laundry room had two, gas fueled dryers and a fresh air intake was not observed. The maintenance director acknowledged at the time of observation, the dryers did not</p>	K0068	<p>1. Immediate corrective action not available. Bid request extended to outside contractors to install suitable outside fresh air intake equipment.2. N/A3. Planned installation of equipment should ensure no reoccurrence of deficiency.4. Maintenance Director or designee will observe, 5 times per week, that equipment is operating and fresh air is being received in the laundry room.5. 10/05/12</p>	10/05/2012			

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	have any fresh air intake. 3.1-19(b)				

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient</p>	K0144	<p>1. Immediate corrective action not available. Bid request extended to outside contractors to install external stop emergency generator switch.2. N/A3. Planned installation of a stop emergency generator switch should ensure no reoccurrence of deficiency. 4. Annual Inspection of emergency generator and stop emergency generator switch will be completed. All employees will be inserviced at the time of hire and annual on location and operation of the stop emergency generator switch. 5. Completed on 10/05/2012.</p>	10/05/2012

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	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the emergency generator and adjunct equipment on 08/29/12 at 3:20 p.m., an emergency generator stop was not observed. The maintenance director said during an interview on 8/29/12 at 4:25 p.m., there was no remote emergency shut off for the generator.</p> <p>3.1-19(b)</p>				

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K0147 SS=E	<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>1. Based on observation and interview, the facility failed to ensure 2 of 2 wet locations for medicine rooms were provided with GFCI (ground-fault circuit-interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas 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 GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 10 or more nursing staff providing resident services.</p> <p>Findings include:</p>	K0147	<p>1. 1) Next day, Maintenance Director replaced electrical outlets in East and West Nurse's Medicine Rooms with GFCI protection outlets, 2) removed power strips from Room 28 and Family Room. Bid request extended to outside contractors to determine feasibility of rewiring wall electrical outlets to accomodate 4 plugs. 2. 1) All potential electrical outlets within 18 inches of the sink were inspected and determined to be in compliance and 2) all rooms were inspected for power strip usage and it was determined all rooms were in compliance.3. 1) All outlets within 18 inches of a sink are GFCI approved and 2) accepting bids to rewire electrical outlet to accept 4 plugs and eliminate use of all power strips. 4. Maintenance Director or designee will all resident and work areas for appropriate use of power strips. 5. Completed on 10/05/2012.</p>	10/05/2012

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	<p>Based on observation with the maintenance director on 08/29/12 between 12:30 p.m. and 4:30 p.m., electrical outlets in the east and west nurses' medicine rooms were located 18 inches from sinks. The outlets were not provided with GFCI protection to prevent electric shock. The maintenance director acknowledged, the outlets were not GFCI protected.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 37 residents in the south east and west smoke compartments</p> <p>Findings include:</p> <p>Based on observation with the</p>				

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	<p>maintenance director on 08/29/12 at 1:40 p.m., a power strip extension cord was used to supply power to a medical mattress and oxygen concentrator in room 28 and a power strip powered a coffee pot, microwave and refrigerator in the west wing family room. The maintenance director acknowledged the power strips were providing power because there were not enough electrical outlets for the equipment.</p> <p>3.1-19(b)</p>				