STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-WOODLANDS	4088 FRAME RD NEWBURGH, IN 47630

(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
K 0000 Bldg. 01	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: 03/31/16 Facility Number: 000155 Provider Number: 155252 AIM Number: 100266830 At this Life Safety Code survey, Golden Living Center-Woodlands 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 sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 107 at the time of	K 0000	*Preparation and submission ofthis Plan Of Correction does not constitute any admission or agreement of anykind by the facility of the truth of any conclusion set forth in thisallegation. Accordingly, the facility has prepared and submits this Planof Correction solely as a requirement under State and Federal Law that mandatesa submission of a Plan of Correction as a condition to participate in Title 18and 19 programs, and to provide the best possible care to our residents as possible.*	

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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	this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached structures; one plastic shed, one wood framed shed, and one wood framed garage with vinyl siding used for facility storage. Quality Review completed on 04/01/16 - DA			
K 0050 SS=F Bldg. 01	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 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include:	K 0050	--F-- What corrective action will be accomplishedfor those residents found to have been affected by the deficient practice. Maintenance staff in-serviced on the Fire Drill–Shift/Time Stagger on 4/7/2016 by theExecutive Director. Reviewed importanceof shift/time stagger for each quarterly drill. --How will other residents who mayhave the	04/08/2016

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	Based on review of the facility's fire drills on 03/31/16 at 10:15 a.m. with the Maintenance Supervisor and Maintenance Assistant #1 present, the facility performed twelve fire drills during the past twelve months, however, the facility lacked fire drill documentation for the third shift (night) of the third quarter (July, August, and September), and the second shift (evening) of the fourth quarter (October, November, and December) of 2015. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)		potential to be affected be identified? All residents have the potential to be affected. --What measures will be put intoplace or what systematic changes will be made to ensure that the deficientpractice does not recur. Maintenance staff in-serviced on the Fire Drill–Shift/TimeStagger on 4/7/2016 by the Executive Director. Reviewed importance of shift/time stagger for eachquarterly drill. --How will the corrective action(s) bemonitored to ensure the deficient practice will not recur and what QA programwill be put into place? Executive director will review the fire drill report monthlyx 6 months for accuracy and report findings in QAPI monthly unless furthermonitoring is deemed necessary at that time.. --Systematic changes will be completedby: 4/8/16 **We are requesting paper compliance for K050**	