

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 08/06/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| K010000 | <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: 08/06/14</p> <p>Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Petersburg 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 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 in spaces open to the corridors, plus battery operated smoke detectors in all resident</p> | K010000 | | |

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.

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 08/06/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| K010038 SS=E | <p>sleeping rooms. The facility has a capacity of 86 and had a census of 55 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except a thirty foot by eighteen foot detached garage constructed of wood framing and metal covering storing maintenance supplies and kitchen equipment, a fifteen foot by twelve foot detached portable wood shed storing paper records, and a twelve foot by nine foot detached wood shed storing the facility's water softener.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit egress for 2</p> | K010038 | What corrective action will be accomplished for those residents found to have been affected by the | 09/30/2014 |

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/06/2014 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 | | | |
| (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 | | | |
| | <p>of 9 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect up to 16 residents, as well as staff and visitors in the East Wing which also includes the Physical Therapy room.</p> <p>Findings include:</p> <p>Based on observations on 08/06/14 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with Maintenance Director, the following was noted:</p> <p>a. The concrete sidewalk/ramp outside the south exit of the east corridor had three gaps and grade changes of at least one inch which could create a tripping hazard,</p> <p>b. The concrete sidewalk/ramp outside the north exit of the east corridor had two gaps and grade changes of at least one inch which could create a tripping hazard.</p> | | <p>deficient practice:</p> <p>The concrete sidewalk/ramp outside the south exit of the east corridor and the sidewalk/ramp outside the north exit of the east corridor will be replaced.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents/visitors have the potential to be affected by the same deficient practice. The concrete sidewalk/ramp outside the south exit of the east corridor and the sidewalk/ramp outside the north exit of the east corridor will be replaced.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Maintenance Director or designee will visually inspect sidewalk/ramp outside the south exit of the east corridor and the sidewalk/ramp outside the north exit of the east corridor for any potential hazards on a monthly basis.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what</p> | | | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/06/2014 | |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 | | | |
| (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 | | | |
| K010050 SS=F | <p>Based on interview at the time of observations, the Maintenance Director acknowledged the gaps and grade changes in both sidewalks/ramps from the south and north exits of the east corridor that could be a tripping hazard.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> | K010050 | <p>quality assurance program will be put into place:</p> <p>Maintenance Director or designee will visually inspect sidewalk/ramp outside the south exit of the east corridor and the sidewalk/ramp outside the north exit of the east corridor for any potential hazards on a monthly basis x 12 months. This will be reviewed during the facility QAPI monthly meeting.</p> <p>Date the systemic changes will be completed. Due to the construction of project, facility asking for an extension till 9/30/14.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Facility found documentation of 1st quarter, night shift (11p to 7a), which is attached. Maintenance Director will perform night shift fire drills at</p> | 08/06/2014 | | | |

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/06/2014 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | | | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 | | |
| (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 | |
| | <p>Based on review of the facility's fire drills in the Life Safety Code Documentation Binder on 08/06/14 at 9:15 a.m. with the Maintenance Director present, the facility lacked written documentation a fire drill was conducted during the third shift (night) of the first quarter (January, February, and March) of 2014. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Code Documentation Binder on 08/06/14 at 9:15 a.m. with the Maintenance Director present, four of four third shift (night) fire drills were performed at 5:15 a.m., 5:15 a.m., 5:30 a.m., and 5:45 a.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the third shift fire drills were performed and agreed the times were not</p> | | <p>a more varied time.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Maintenance Director or designee will receive documentation from Vanguard Sales a copy of each testing system and the time of the drill. Maintenance Director or designee will perform third shift fire drills at a varied time.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Maintenance Director or designee will receive documentation from Vanguard Sales a copy of each testing system and the time of the drill. Maintenance Director or designee will perform third shift fire drills at a varied time.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:</p> <p>On a quarterly basis the Executive Director or designee will review the Fire Drill logs. This will be reviewed during the</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 08/06/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 |
|---|---|

| (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 |
|--------------------|--|---------------|--|----------------------|
| K010143 SS=E | <p>varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring takes place was provided with mechanical ventilation. This deficient practice could affect any number of residents, as well as staff and visitors while in the southeast corridor which included the Physical Therapy room and employee break room.</p> <p>Findings include:</p> | K010143 | <p>facilities QAPI meeting.</p> <p>Date the systemic changes will be completed.</p> <p>August 6, 2014</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The vent in the ceiling of the oxygen storage/transfer room was replaced with a mechanical vent.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> | 08/22/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 08/06/2014 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG | STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567 |
|---|---|

| (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 |
|--------------------|--|---------------|--|----------------------|
| | <p>Based on observation on 08/06/14 at 10:45 a.m. during a tour of the facility with the Maintenance Director, the oxygen storage/transfer room had three large liquid oxygen tanks. There was a vent in the ceiling of this room, however, it was not mechanically ventilated. A tissue was placed at the vent and there was no suction. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> | | <p>The vent in the ceiling of the oxygen storage/transfer room was replaced with a mechanical vent.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Maintenance Director or designee will monitor vent on a monthly basis to ensure it is working properly.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:</p> <p>Maintenance Director or designee will monitor vent on a monthly basis to ensure it is working properly. This will be reviewed during facility monthly QAPI meeting.</p> <p>Date the systemic changes will be completed. August 22, 2014</p> | |