

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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	<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: 07/01/15</p> <p>Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100</p> <p>At this Life Safety Code survey, Golden Living Center-Lincoln Hills 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 with a lower level 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 86 and had</p>	K 0000	Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility set forth. Accordingly, the facility has prepared and submits this Plan of correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correcton as a condition to participate in Title 18 and Title 19 Programs.	
------------------------	---	--------	--	--

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: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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 0029 SS=E Bldg. 01	<p>a census of 80 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 metal shed containing facility storage.</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 shower rooms which contained soiled linen and trash containers with a capacity over 32 gallons, were equipped with positive latching doors. This deficient practice could affect any number of residents, as well as staff while in the four shower rooms.</p> <p>Findings include:</p>	K 0029	<p>What corrective actions will be accomplished for those residents found to have been affected by this deficient practice? The 4 shower room doors will have positive latching installed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The latches on the doors will be replaced. After</p>	08/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586			
(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 0050 SS=F Bldg. 01	<p>Based on observations on 07/01/15 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:</p> <p>a. The Station 4 Bathroom had a total of six soiled linen and trash carts. The door to the corridor was not provided with positive latching.</p> <p>b. The Station 2 Men's Bathroom had a total of three soiled linen and trash carts. The door to the corridor was not provided with positive latching.</p> <p>c. The Station 2 Women's Bathroom had a total of three soiled linen and trash carts. The door to the corridor was not provided with positive latching.</p> <p>d. The Station 1 Bathroom had a total of three soiled linen and trash carts. The door to the corridor was not provided with positive latching.</p> <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</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</p>		<p>the correct latches are installed, latches will not be changed without Executive Director approval. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be put into place for monitoring the reporting procedure. Audits will be conducted once weekly by the Maintenance Supervisor or designee for six months or until audits are no longer required. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until corrective action is no longer required.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586		
(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>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 2 of 3 shifts during 2 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 Fire Drill book on 07/01/15 at 9:45 a.m. with the Maintenance Supervisor present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters:</p> <p>a. Third shift (night) of the fourth quarter (October, November, and December) 2014</p> <p>b. First shift (day) of the first quarter (January, February, and March) 2015</p> <p>This was acknowledged by the Maintenance Supervisor 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 2 of 3 employee shifts during 4 of 4 quarters.</p>	K 0050	<p>What corrective action will be accomplished for those residents found to have been affected by this deficient practice? Quarterly fire drills will be conducted at various times on each shift. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents will have the potential to be affected by this deficient practice. Quarterly fire drills will be staggered on shifts. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted once weekly for six months by the Maintenance Supervisor/designee or until no further audits are needed. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until no more corrective actions are required. An</p>	08/01/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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 0051 SS=F Bldg. 01	<p>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 Fire Drill book on 07/01/15 at 9:45 a.m. with the Maintenance Supervisor present, three of three first shift (day) fire drills were performed between 9:15 a.m. and 10:10 a.m., furthermore, six of six second shift (evening) fire drills were performed between 2:05 p.m. and 3:20 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the first and second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586			
(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 egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/01/15 at 1:20 p.m. during a tour of the facility with Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) was located in a lower level empty office off of the dietary corridor. When the DACT was placed in trouble from phone line failure it did actuate a local audio trouble signal, however, the local trouble signal at the DACT did not activate a trouble signal at the Station 3 nurses' stations where the main fire alarm panel was located. The lower level</p>	K 0051	<p>What corrective action will be accomplished for those residents found to have been affected by this deficient practice? A fire alarm system in accordance with NFPA 72. NFPA 72, 1-5.4.6 which requires a trouble signal to be located in an area where it is likely to be heard will be installed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. A fire alarm system in accordance with NFPA 72. NFPA 72, 1-5.4.6 which requires a trouble signal to be located in an area where it is likely to be heard will be installed. What measures or systemic changes will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be put into place for monitoring the the fire alarm system. Audits will be conducted one time per week by the Maintenance Supervisor/Designee for six months or until no further audits</p>	08/01/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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 0147 SS=E Bldg. 01	<p>empty office was located in an area that was not occupied by staff at all times of the day, and the local audio trouble signal at the DACT could not be heard at any of the facility's three nurses' stations. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the phone line failure did not send a trouble signal to the main fire alarm panel or could be heard at any of the three nurses' stations.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 4 of 54 resident rooms, plus the Station 2 Kitchenette and the Social Services office. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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. This deficient practice could affect 7 residents in rooms 29, 33, 35, and 64, plus staff while in the</p>	K 0147	<p>are needed. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time per month in the QAPI meeting for six months or until no further corrective actions are required.</p> <p>ADDENDUM - The facility had requested an extension until 10/1/15. The corrected corrective action date will be 8/1/15. What corrective action will be accomplished for those residents to have been affected by this deficient practice? Rooms 64, 29, 33, and 35 will have electrical outlets installed. The station 2 kitchenette and Social Services office will have electrical outlets installed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Resident</p>	08/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
--	---

(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>Station 2 Kitchenette and the Social Services office.</p> <p>Findings include:</p> <p>Based on observation on 07/01/15 between 11:45 a.m. and 1:30 p.m. during a tour of the facility the Maintenance Supervisor, the following was noted:</p> <ul style="list-style-type: none"> a. Resident room 64 had a small refrigerator plugged into a power strip b. Resident room 29 had a lift chair plugged into a power strip c. Resident room 33 had a small refrigerator plugged into a power strip d. Resident room 35 had a small refrigerator plugged into a power strip e. The Station 2 Kitchenette had a microwave oven and small refrigerator plugged into a power strip f. The Social Services office had a portable AC unit plugged into a power strip <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>rooms, offices and kitchenettes will be monitored for incorrect use of power strips. Any identified areas will have electrical outlets installed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted one time per week for six weeks by the Maintenance Supervisor/Designee or until no further corrective action is needed. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until no more corrective actions are required.</p>	