

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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<br><br>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: 08/09/16</p> <p>Facility Number: 000411<br/>Provider Number: 155384<br/>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        | Please accept this as our credible Plan of Correction for the Life Safety Survey conducted on August 9, 2016 Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility or the truth of an conclusion set forth in this allegation 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 Correction 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:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0015<br>SS=E<br>Bldg. 01 | <p>a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered except a metal shed containing facility storage and the Training Room built-in closet.</p> <p>Quality Review completed on 08/11/16 - DA</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A, Class B or Class C for a sprinklered facility. LSC 3.3.112 defines interior finish as the exposed surfaces of walls, ceilings and floors. A.3.3.112 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice</p> | K 0015        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The missing drywall and exposed studs in the Key Room will be repaired and replaced<br/>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice.</p> | 09/09/2016           |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____                |  | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0017<br>SS=E<br>Bldg. 01   | <p>could affect mostly staff, plus any resident using the Personal Care room and Physical Therapy area in the basement.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 1:45 p.m. during a tour of the facility with the Housekeeping Supervisor, there were exposed wood studs in the Key Room wall due to an eleven foot long by two foot high section that was missing drywall. This was acknowledged by the Housekeeping Supervisor at the time of observation, furthermore, the Housekeeping Supervisor acknowledged the wood studs were not concealed by drywall and said he was not aware if the wood studs had a flame spread rating.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor</p> |   | <p>Any other identified areas in the facility with missing drywall or exposed studs will be repaired and 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? The maintenance supervisor/designee will conduct audits one time per week for six months to ensure drywall is not missing or studs exposed and repairs/replacements will be made as needed</p> <p>How will the corrective action be monitored to ensure the deficient practice does not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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>under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 open use areas were separated from the corridor by walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above or met an Exception. LSC 19.3.6.1, Exception #1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient</p> | K 0017        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An automatic smoke detector will be installed in the copy room. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any areas requiring a smoke detector system will have a system installed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits one time weekly for six months to ensure all areas requiring smoke detector systems have smoke detectors installed. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> | 09/09/2016           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0018<br>SS=E<br>Bldg. 01 | <p>practice could affect staff, residents and visitors while in the area of the Copy Room which included the Business Offices, Activities, and a passing area between Stations 1 and 2.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 12:40 p.m. during a tour of the facility with the Housekeeping Supervisor, the Copy Room was open to the corridor. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The Copy Room was not protected by an electrically supervised automatic smoke detection system, or the entire space was not arranged and located to allow direct supervision by the facility staff from the nurses' station or similar staffed space. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> <p>3-1.19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch.</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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>Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure there were no impediments to closing 4 of over 200 corridor doors. This deficient practice could affect over 50 residents, as well as staff and visitors while in Station 1 and Station 4 resident sleeping room corridors, plus, residents, staff, and visitors while in the basement west corridor.</p> <p>Findings includes:</p> <p>Based on observations on 08/09/16 between 12:30 p.m. and 2:45 p.m. during a tour of the facility with the Housekeeping Supervisor, the following was noted:</p> <p>a. Resident room 14 had a small trash can placed in front of the door holding it wide open</p> <p>b. Resident room 16 had a wood wedge holding the door wide open</p> | K 0018        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The doors identified will be repaired so that they remain open without objects holding the door open. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Other doors identified will be repaired so they will stay open without objects holding the door open. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure all doors are properly installed. How will the corrective action be monitored to ensure the deficient</p> | 09/09/2016           |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____                |  | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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>c. The Station 4 Linen storage closet had a cart placed in front of the door holding it wide open</p> <p>d. The basement Employee Breakroom had a wood wedge holding the door wide open</p> <p>The placement of these items would not allow the previously mentioned corridor doors to close easily in the event of a fire emergency. This was acknowledged by the Housekeeping Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 53 resident room corridor doors would close and latched into the door frame. This deficient practice could affect up to 15 residents, as well as staff and visitors in Station 1.</p> <p>Findings includes:</p> <p>Based on observation on 08/09/16 at 12:32 p.m. during a tour of the facility with the Housekeeping Supervisor, resident room 9 door would not close and latch into the door frame. The striker plate on the door frame was bent and would not allow the door to latch. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> |   | <p>practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0021<br>SS=E<br>Bldg. 01 | <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</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 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of over 20 hazardous area room doors, such as a soiled utility room door could only be held open by something which would allow the door to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This</p> | K 0021 | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The metal kickstand will be removed. How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Other doors identified with kickstands will</p> | 09/09/2016 |
|----------------------------|--|--------|---|------------|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0047<br>SS=E<br>Bldg. 01   | <p>deficient practice could affect 18 residents, as well as staff and visitors in Station 2.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 1:02 p.m. during a tour of the facility with the Housekeeping Supervisor, the Station 2 Soiled Utility Room door was equipped with a metal kickstand at the bottom of the door which would not allow the door to close if the fire alarm system was activated. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)</p> <p>Based on observation and interview, the facility failed to provide a NO EXIT sign for 1 of 1 door which appeared to be an exit, but was not. LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access, but may be mistaken for an exit shall be identified by a sign which reads NO EXIT. This deficient practice</p> | K 0047  | <p>have the kickstands removed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure doors are not equipped with kickstands<br/>How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A "No Exit" sign will be placed on the door leading from the Sun Porch to the deck. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective</p> | 09/09/2016           |   |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____         |  | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0052<br>SS=E<br>Bldg. 01   | <p>could affect 15 residents in Station 1 while using the Sun Porch.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 12:30 p.m., the door from the Sun Porch to the outside deck appeared to be an exit, but was not. The deck was elevated from ground level and was not provided with an exit stairway. The deck was also enclosed with a railing. The door from the Sun Porch to the deck was not provided with a sign saying NO EXIT. Based on interview on at the time of observation, the Housekeeping Supervisor acknowledged the door from the Sun Porch to the outside deck appeared to be an exit and was not provided with a NO EXIT sign.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 38 smoke</p> | K 0052  | <p>action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Other doors identified as needing a "No Exit" sign will have a sign placed on the door. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure doors are properly labeled with "No Exit" signs if needed. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by</p> | 09/09/2016  |  |   |  |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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>detectors were not installed where air flow would adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 18 residents, as well as staff and visitors in Station 2.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 12:57 p.m. during a tour of the facility with the Housekeeping Supervisor, there was one ceiling mounted smoke detector within one inch of an air supply vent in the Station 2 corridor between rooms 22 and 23. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure the documentation for the annual testing of 2 of 2 heat detectors connected to the fire alarm system was complete. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as heat</p> |               | <p>the deficient practice? The smoke detector placed on Station 2 between rooms 22 and 23 will be relocated. The inspection of the heat detector in Room #2 will resume upon the next inspection. Vanguard was contacted and they did acknowledge this detector was not inspected on 9/22/15. How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The company has been called and notified that all heat detectors are to be inspected and if an inspection is not completed, the Maintenance Supervisor or Executive Director is to be notified. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure all heat detectors have been properly inspected. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0056<br>SS=E<br>Bldg. 01 | <p>detectors be inspected/tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection/testing reports in the Fire Alarm Book on 08/09/16 at 11:15 a.m. with the Housekeeping Supervisor present, the quarterly fire alarm system inspection report dated 9/22/15 said the heat detector in Boiler Room #2 was not inspected/tested due to "Cannot get into. Door is blocked". There was no other information during subsequent quarterly fire alarm system inspections to show the heat detector in Boiler Room #2 has been inspected. During an interview at the time of record review, the Housekeeping Supervisor acknowledged the 9/22/15 quarterly fire alarm system inspection report did not include the inspection of the heat detector in Boiler Room #2.</p> <p>3-1.19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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>9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 10 smoke compartments. This deficient practice could affect mostly staff while in the Training Room, plus any residents, staff and visitors while in the basement west unit smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 1:58 p.m. during a tour of the facility with the Housekeeping Supervisor, there was no sprinkler head in the built-in corner closet. The closet was built from floor to ceiling and was attached to the floor and two corner walls. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> <p>3.1-19(b)</p> | K 0056        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The closet will be removed. How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any closets identified without a sprinkler will be removed or a sprinkler will be installed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure all closets are properly covered with a sprinkler. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> | 09/09/2016           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0062<br>SS=D<br>Bldg. 01 | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 1 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly staff while in the laundry area, plus residents, staff and visitors while in the Physical Therapy section which was in the same smoke compartment as the laundry area.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 2:15 p.m. during a tour of the facility with Housekeeping Supervisor, the sprinkler head in the enclosed dryer room within the laundry area was covered with green corrosion. This was acknowledged by Housekeeping Supervisor at the time of observation.</p> | K 0062        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler head in the laundry room will be free of corrosive material</p> <p>How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any sprinklers identified with corrosive material will be cleaned or replaced What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure all sprinklers are in proper operating condition. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> | 09/09/2016           |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>01</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0072<br>SS=E<br>Bldg. 01 | <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 10 corridor means of egress was continuously maintained free of obstructions. This deficient practice affects 41 residents who reside on Station 4, and residents, as well as staff and visitors while in the basement west corridor which includes the Personal Care room.</p> <p>Findings include:</p> <p>Based on an observations on 08/09/16 between 12:30 p.m. and 2:45 p.m. during a tour of the facility with the Housekeeping Supervisor, the basement west corridor had eight lift chairs, two bed frames, two wheel chairs, and two boxes of books stored in the corridor, furthermore, the Station 4 north corridor had a sitting chair and a wheel chair stored in the corridor. All of these items were observed stored in the same</p> | K 0072 | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All items listed sitting in the hallway were removed. The refrigerator blocking the sidewalk to the parking lot was disposed of. How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any items blocking hallways or sidewalks will be removed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure there are no items blocking hallways and sidewalks. How will the corrective action be</p> | 09/09/2016 |
|----------------------------|---|--------|--|------------|

|  |  |   |  |                      |   |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 0144<br>SS=C   | <p>corridors during the initial entrance walk through at 9:30 a.m. This was acknowledged by the Housekeeping Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 12 exits was maintained to provide clear access to the public way. This deficient practice could residents, as well as staff and visitors while in the basement west corridor in the event of an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 2:02 p.m. during a tour of the facility with the Housekeeping Supervisor, the sidewalk outside the basement west corridor north exit had a refrigerator blocking part of the sidewalk to the parking lot (public way). This would also make it difficult to traverse with a wheelchair in the event of an evacuation to get to the public way. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD</p> |   | monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed. |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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 |
|--------------------|--|---------------|---|----------------------|
| Bldg. 01           | <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.<br/>3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to provide documentation that the transfer time for the generator was being recorded after each load test for 1 of 1 emergency generator. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's monthly Generator Log on 08/09/16 at 10:42 a.m. with the Housekeeping Supervisor present, the generator log form documented the generator was tested monthly for 40 minutes under load, however, there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Housekeeping Supervisor acknowledged the monthly generator log</p> | K 0144        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The generator log will have documentation of generator transfer time being recorded. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The documentation of generator transfer times will be recorded following load tests. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure the documentation of the load tests are recorded. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further corrective action is needed.</p> | 09/09/2016           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>08/09/2016 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>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<br>SS=D<br>Bldg. 01 | <p>did not include documentation of a generator transfer time being recorded.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1<br/>Based on observation and interview, the facility failed to ensure extension cords were not used as a substitute for fixed wiring in 1 of 53 resident sleeping rooms. 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 2 resident in resident room 35.</p> <p>Findings include:</p> <p>Based on observation on 08/09/16 at 1:07 p.m. during a tour of the facility with the Housekeeping Supervisor, resident room 35 had a television plugged into an extension cord. This was acknowledged by the Housekeeping Supervisor at the time of observation.</p> | K 0147        | <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The extension cord in Room #35 will be removed<br/>How will other residents having the potential to affected by the same deficient practice be identified and what corrective action(s) will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any extension cords being used as a substitute for fixed wiring will be removed<br/>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance supervisor/designee will conduct an audit one time weekly for six months to ensure there are no extension cords being used for fixed wiring. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly</p> | 09/09/2016           |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155384 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____   |                            | X3) DATE SURVEY<br>COMPLETED<br>08/09/2016 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GOLDEN LIVING CENTER-LINCOLN HILLS |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>402 19TH ST<br>TELL CITY, IN 47586  |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
|  | 3.1-19(b)  |  | QAPI committee meeting for six<br>months or until no further<br>corrective action is needed.                             |                            |  |