

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/11/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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K 000  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: 05/11/15</p> <p>Facility Number: 0000031 Provider Number: 155076 AIM Number: 100266150</p> <p>At this Life Safety Code survey, Golden Living Center-Brookview 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 facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=E Bldg. 01	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 136 and had a census of 99 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke barriers separating the first floor from the crawl space below was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be</p>	K 025	It is the practice of this facility that smoke barriers are constructed to provide a one half hour fire resistance rating in accordance with 8.3. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> A four-hour rated fire	05/29/2015

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	<p>protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect twenty residents, staff and visitors in the vicinity of the walker storage room by the Rehab Nurses Station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:05 p.m. to 3:05 p.m. on 05/11/15, the one inch annular space surrounding a four inch in diameter sprinkler pipe which penetrated the floor of the walker storage room by the Rehab Nurses Station was not filled with or protected by a material capable of maintaining the smoke resistance of the smoke barrier separating the first floor from the crawl space below. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening failed to maintain the smoke resistance of the smoke barrier separating the first floor from the crawl space below.</p> <p>3.1-19(b)</p>		<p>caulk and four-hour rated fire barrier putty stick were used to seal the space between the floor and the penetrating sprinkler pipe thus complying with smoke barrier standards. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:</b> Other residents in the vicinity of the walker storage closet could potentially be affected by the same deficient practice. Fire caulk and fire barrier putty were used to ensure proper smoke barrier is maintained. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows:</b> All contractors will be required to fire-caulk any new penetrations through existing smoke barriers. Maintenance Director will inspect such areas to confirm work performed is properly fire-caulked. <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> An annual smoke barrier inspection will be added to the Building Engines maintenance software program to</p>				

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K 062 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Service Call Report" documentation during record review with the Maintenance Director from 9:50 a.m. to 12:05 p.m. on 05/11/15, an internal pipe inspection on 05/29/14 for the facility's dry sprinkler system stated "Performed internal pipe</p>	K 062	<p>inspect the affected area and will be labeled as Therapy Walker Closet #7. This action will be completed by May 22, 2015. <b>By what date the systemic changes will be completed is as follows: 5/29/15</b></p> <p>It is the practice of this facility that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. <b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> 1. A complete flush of the automatic sprinkler piping system will be completed within the next 90 days (requesting temporary Life Safety Code waiver). 2. Data cable was separated from the sprinkler pipe to correct the deficient practice. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:</b> All residents have potential to be affected by the same deficient practice. 1. A complete flush of the automatic</p>	08/27/2015

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	<p>inspection for fire sprinkler system," "found rust and debris in cross main above Room 216 &amp; Laundry. Also in cross main above hall by Room 223. Recommend that fire sprinkler system be flushed." Based on interview at the time of record review, the Maintenance Director stated flushing of the sprinkler system on or after 05/29/14 has not been performed due to scheduling issues and acknowledged dry sprinkler system flushing has not been performed or scheduled on or after 05/29/14.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect twenty residents, staff and visitors in the vicinity of the walker storage room by the Rehab Nurses Station.</p> <p>Findings include:</p>		<p>sprinkler piping system will be completed within the next 90 days (requesting temporary Life Safety Code waiver). 2. The data cable has been detached from the 4-inch sprinkler pipe. Sprinkler piping will be maintained free of non-system components and hangers. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows:</b> 1. After completion of the flush of the automatic sprinkler piping system, an internal pipe inspection will be conducted in 2020 within 5 years of this sprinkler flush, and if needed, a sprinkler system flush will be conducted as soon as possible thereafter. All findings will be submitted to the facility Executive Director upon receiving the internal pipe inspection report. 2. All work by outside contractors will be monitored to insure no non-system components are attached or hung from the sprinkler piping or its components. <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> 1. After completion of the flush of the automatic sprinkler piping system, an</p>	

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K 211 SS=E Bldg. 01	<p>Based on observation with the Maintenance Director during a tour of the facility from 12:05 p.m. to 3:05 p.m. on 05/11/15, a data cable was attached to a four inch sprinkler pipe which penetrated the floor and the ceiling of the walker storage room by the Rehab Nurses Station. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully</li> </ul>		<p>internal pipe inspection will be conducted in 2020 within 5 years of this sprinkler flush, and if needed, a sprinkler system flush will be conducted as soon as possible thereafter. An annual inspection of the sprinkler system will be conducted to insure sprinkler system components are in place and within code.2. All work by outside contractors will be monitored to insure no non-system components are attached or hung from the sprinkler piping or its components. All internal pipe inspections will be reported to the QAPI committee and sprinkler flush progress will be reported monthly to the QAPI committee until the flush is completed. <b>By what date the systemic changes will be completed is as follows:</b> 8/27/15</p>	

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	<p>sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of 74 alcohol based hand sanitizers in resident sleeping rooms were not installed adjacent to an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 7 residents, staff and visitors in the vicinity of Room 201.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:05 p.m. to 3:05 p.m. on 05/11/15, an alcohol based hand sanitizer was installed one inch from an electrical outlet in the bathroom for resident sleeping Room 201. The aforementioned alcohol based hand sanitizer location had propylene glycol listed as an ingredient on the packaging of the sanitizer. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hand sanitizer location was alcohol based and was installed adjacent to an ignition source.</p>	K 211	<p>It is the practice of this facility that all alcohol-based hand rub (ABHR) dispensers in resident sleeping rooms are not installed adjacent to an ignition source.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</b> All ABHR dispensers will be moved away from electrical outlets to meet the standard. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken is as follows:</b> Any resident near an ABHR has potential to be affected by the deficient practice. All ABHR dispensers will be moved from areas not allowed by code.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows:</b> All rooms will be checked to ensure no ABHR is within six inches of any electrical outlet to ensure the safety of any person in the adjacent areas. A report will be made and submitted to the Executive director for review that shows each resident bathroom has been checked for ABHR and corrected if needed</p>	05/29/2015	

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	3.1-19(b)		according to code. <b>How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place and by what date the systemic changes will be completed is as follows:</b> All rooms will be checked to ensure no ABHR is within six inches of any electrical outlet to ensure the safety of any person in the adjacent areas. A report will be made and submitted to the Executive director for review that shows each resident bathroom has been checked for ABHR and corrected if needed according to code. Results will be submitted at the monthly QAPI committee meeting for review. 5-29-2015 <b>By what date the systemic changes will be completed is as follows:</b> 5/29/2015		