

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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K0000	<p>A Post Survey Revisit (PSR) to the Comparative Federal Monitoring Survey conducted on 11/05/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/07/12</p> <p>Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this PSR survey, Golden Living Center-Merrillville was found in substantial 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.</p> <p>This one story facility was determined to be to be of Type V (000) construction and was fully</p>	K0000		

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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	<p>sprinklered except areas of the exterior overhang of the roof larger than four feet for which a temporary waiver has been granted. The facility has a fire alarm system with hard wired smoke detection in corridors and spaces open to the corridors. Resident rooms are provided with battery powered smoke detectors. The facility has the capacity for 155 and had a census of 147 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, except areas of the exterior overhang of the roof larger than four feet. Areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/09/13.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=B	<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, interview and record review; the facility failed to ensure openings through ceiling smoke barriers in 5 of 12 smoke compartments were maintained to provide the 1/2 hour 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 protected so that 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 visitors, staff and 40 or more residents in smoke compartments</p>	K0025	<p>K 025 <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <p>· All penetrations noted in survey have been sealed by maintenance using the Indiana State Department of Health time-temperature requirements. <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</i></p> <p>· There are no other areas in the facility that have not been caulked with the appropriate fire/smoke caulking. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i></p> <p>· Observation of all penetration sites will be added to the weekly rounds/audit to ensure that smoke stop material is in place as per</p>	01/10/2013	

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	<p>including main lobby and dining room, outside the "Ambassador's Suite", outside the scheduler's office, at the machine room, by rooms 7, 17, 319, and 307.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/07/13 between 1:50 p.m. and 4:50 p.m., penetrations in smoke barriers above the lay in ceilings between the main lobby and dining room, outside the "Ambassador's Suite", outside the scheduler's office, at the machine room, by rooms 7, 17, 319, and 307 were sealed with caulk. A review of the manufacturer's data for the caulk used indicated it was a one component noncombustible caulk designed to resist high temperatures and smoke in nonrated construction. The maintenance director said at the time of review, he thought the high heat designation for the caulk would be sufficient for the seal.</p> <p>3.1-19(b)</p>		<p>regulations. Preventive material will be replaced as needed. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> · Review of maintenance weekly and monthly round audits will be presented at the QA&A monthly committee meeting for review. This will be an ongoing process. This will be overseen by the Maintenance Director and the Executive Director. <i>By what date the systemic changes will be completed.</i> · January 10, 2013.</p>	