STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health. Survey Date: 08/10/12 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 Surveyor: Dennis Austill, Life Safety Code Supervisor At this Quality Assurance Walk-thru survey, Golden Living Center-Indianapolis was found not in compliance with 410 IAC 16.2-3.1-19(ff) This one story facility with a basement was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and battery operated smoke detectors in 56 resident rooms. The facility has a capacity of 115 and had a census of 90 at the time of this visit. The facility was found not in compliance	K0000	**Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage. All areas where residents have customary access were sprinklered. The facility did not have any detached buildings. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/20/12.		**continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler coverage throughout the facility before July 1, 2012. This deficient practice could affect any occupant in the facility.	K9999	**K9999** The facility will provide sprinkler coverage throughout the building. There were no residents affected. 1) The Maintenance Director/designee will uncap the sprinkler heads near the electrical panels on in the basement. 2) The Maintenance Director/designee will expand the sprinkler coverage to include 3 of 3 dryers. 3) The Maintenance Director/designee will install a sprinkler head inside the B wing closet across from the nurses station. The Executive Director will ensure the sprinklers have been installed. Deficient practice will be monitored monthly in QAA Committee until updated. September 9, 2012	09/06/2012

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	Findings include: Based on observation with the Maintenance Director on 08/10/12 between 8:45 a.m. and 10:30 a.m., the following was noted: 1. The basement electrical/mechanical room was partially sprinklered in that sprinkler coverage was provided over the water heaters in the room but not near the electrical panels on the opposite wall. Based on interview at the time of observation, the Maintenance Director acknowledged the sprinkler pipes near the electrical panels were plugged and had been as long as he had been employed there. 2. The dryer rear access area in the laundry located in the basement was partially sprinklered in that sprinkler coverage was provided over 1 of 3 dryers and there was duct work preventing full coverage over the 3 dryers from the one sprinkler head behind the dryers. Based on interview at the time of observation, the Maintenance Director acknowledged there was only one sprinkler head behind the dryers and had been as long as he had been employed there. 3. A closet located across from the B wing nurses' station lacked a sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged there was no sprinkler			

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	head in the closet. 3.1-19(ff)			