

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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(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 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: 02/24/15</p> <p>Facility Number: 000062 Provider Number: 155137 AIM Number: 100271400</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this life Safety Code Survey, Golden Living Center-Valparaiso 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 partial basement was determined to be of Type IV (2HH) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors,</p>	K 000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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 029 SS=E Bldg. 01	<p>and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 85 and had a census of 55 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/27/15.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</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>			

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	<p>Based on observation and interview, the facility failed to ensure 2 of 2 south wing shower rooms used to store soiled linen and trash receptacles with a total capacity exceeding 32 gallons in a 64 square foot area, were protected as hazardous areas. This deficient practice affects visitors, staff and 10 or more residents on the south wing.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director on 02/24/15 at 2:45 p.m., multi bin soiled linen and trash receptacles were stored in the east and west shower rooms on the south wing. The multi bin receptacles were full and each had the capacity for 28 to 32 gallons. Doors had no latches and were each equipped with a six by eight inch fixed louvered vent. The Executive Director acknowledged at the time of observation, the doors did not latch and could not prevent the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 8 exit</p>	K 029	<p>1. No residents were effected by the deficient practice.2. Linen/trash carts stored in the shower room have the potential to affect all residents.3. In-services of staff as to the policy of the facility were conducted. Staff were instructed to not store linen/trash carts in the shower rooms.4. An audit tool will be completed by the Maintenance Director or his designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. Audit tool will be reviewed monthly for 6 months in facility QAPI meeting.5. March 14, 2015</p>	03/14/2015			
K 038 SS=E Bldg. 01	<p>Based on observation and interview, the facility failed to ensure 3 of 8 exit</p>	K 038	<p>1. No residents were effected by the deficient practice. Snow removal service was contacted on</p>	03/14/2015			

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K 062 SS=E Bldg. 01	<p>discharges were arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects visitors, staff and 10 or more residents on the north wing and dining room.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director on 02/24/15 between 12:45 p.m. and 3:45 p.m., the exit discharges for the east exit from the north wing and two exits from the main dining room were each covered with four inches of snow. The Executive Director acknowledged at the time of observations, these were not available for immediate use.</p> <p>3.1-(19)</p> <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>Based on observation and interview, the facility failed to ensure sprinklers</p>	K 062	<p>the day of the survey, and they came out and completely cleared the snow off of the pathways.2. Snow-covered outdoor pathways leading from exit doors have the potential to effect all residents.3. When snow occurs and the snow removal service is unable to respond in a timely basis, the Maintenance Director or his designee will remove the snow themselves.4. An audit tool will be completed (only when it snows or if snow is present) by the Executive Director, or his designee, 3x daily until the snow is no longer an issue.5. March 14, 2015</p> <p>1. No residents were effected by the deficient practice.2. All residents have the potential to be</p>	03/14/2015

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	<p>protecting 1 of 2 soiled utility rooms were protected by sprinklers with the same temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, Table 3-2.5.1 rates sprinklers with temperature ratings between 135 and 170 degrees Fahrenheit (F) as Ordinary and sprinklers with temperature ratings between 175 and 225 degrees F as Intermediate. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 requires spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. This deficient practice could affect visitors, staff and 10 or more residents on the south hall.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director on 02/24/15 at 2:45 p.m., the south wing soiled utility room had two different sprinklers protecting the room. One was the glass red liquid filled Ordinary rated sprinklers (160 degrees F) and the other was an Intermediate rated sprinkler with a fusible link (212 degree F). The sprinkler temperature ratings were verified by the on call maintenance supervisor at the time of observations by</p>		<p>affected by this deficient practice. After a facility-wide audit was conducted by the Maintenance Director and the facility's contractor, it came to our attention that the sprinkler heads in question (per the tag) are within the same range, although they looked physically different. However, the sprinkler heads in the soiled utility room, along with one other, were replaced so there would be no further confusion that incompatibility might exist base on their physical appearance.3. Our vendor will continue their quarterly inspections of the sprinkler system.4. Maintenance Director will continue to tour quarterly with vendor to ensure that there are no issues.5. March 14, 2015 We respectfully request that we are granted paper compliance. Thank you.</p>	

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	observing the spare sprinklers in the spare sprinkler cabinet. The Executive Director acknowledged at the time of observations, the room was protected by sprinklers with two different ratings. 3.1-19(b)				