

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 10/31/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN46219		
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K0000	<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: 10/31/11</p> <p>Facility Number: 000031 Provider Number: 155076 AIM Number: 100266150</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all</p>	K0000	<p>November 13, 2011Golden Living Center - BrookviewProvicer #155076Recertification & State Licensure Survey Plan of CorrectionSurvey Dates: October 31, 2011Preparation, submission, and implementation of this 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 continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.All corrections will be in place on November 30, 2011.</p>		

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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K0029 SS=E	<p>areas open to the corridor. The facility has a capacity of 136 and had a census of 120 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/01/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 doors in the basement serving hazardous areas such as the Mechanical Room are provided with self closing devices to latch the door into the door frame. This deficient practice could affect any staff or visitor in the vicinity of the basement Mechanical Room.</p> <p>Findings include:</p>	K0029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 of 1 door in the basement serving the mechanical room was fitted with a self closing device that causes the door to automatically close and latch into the door frame. The wall above the door frame had a 3 inch opening which was covered with sheetrock on both sides of the</p>	11/10/2011

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	<p>Based on observation with the Director of Maintenance during a tour of the facility from 10:50 a.m. to 2:30 p.m. on 10/31/11, the access door to the basement Mechanical Room is not equipped with a self closing device to latch the door into the door frame. The basement Mechanical Room houses a natural gas fired boiler and a natural gas fired water heater. Based on interview at the time of observation, the Director of Maintenance acknowledged the basement Mechanical Room door is not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas such as the basement Mechanical Room are separated from other spaces by smoke resistant partitions. This deficient practice could affect any staff or visitor in the vicinity of the basement Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 10:50 a.m. to 2:30 p.m. on 10/31/11, there was a one foot by three inch opening in the wall above the access door to the</p>		<p>upper door frame to create a smoke barrier to separate the hazardous mechanical room area from the surrounding basement area. The area was then further sealed with fire caulk. This action was completed on 11-10-11 correcting the deficiency. 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? No residents have the potential to be affected by the deficient practice because no residents have access to the basement area or the smoke compartment adjacent to the affected door. All staff or visitors in the smoke compartment adjacent to the affected door have the potential to be affected in the event of a fire or smoke in the mechanical room. The area now has an effective means to keep door closed to prevent passage of smoke. The corrective action is as stated above. 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 Director or designee will assess the door function on all smoke barrier doors during all inspections which occur quarterly to ensure they remain in working order providing a means suitable for keeping the doors closed. How will the corrective</p>		

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K0048 SS=E	<p>basement Mechanical Room. The basement Mechanical Room houses a natural gas fired boiler and a natural gas fired water heater. Based on interview at the time of observation, the Director of Maintenance acknowledged there was a one foot by three inch opening in the wall above the access door to the basement Mechanical Room.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility to protect 120 of 120 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for</p>	K0048	<p>action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Director or designee will assess the door function on all smoke barrier doors during all office, closet, bathroom, mechanical room, and room inspections which occur quarterly to ensure they remain in working order and provide a means suitable for keeping the doors closed. Results will be recorded in the building engines system. Any deficiency found will be reported to the Executive Director for immediate repair.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Information regarding the full "Fire Emergency Action Plan" will be placed in the Life Safety Documentation Binder detailing the types of different fire extinguishers and their uses. This information was found in the Safety and Loss Control Online Manual, printed out, and added to the "Fire Emergency Action Plan". This action took place on 11-10-11 correcting the deficient practice affecting any resident, staff or visitor in the vicinity of the kitchen. How other residents</p>	11/10/2011			

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	<p>evacuation</p> <p>(8) Extinguishment of fire This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Emergency Action Plan" for Golden Living Center-Brookview during record review with the Director of Maintenance from 9:20 a.m. to 10:50 a.m. on 10/31/11, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Director of Maintenance acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents, staff or visitors in the area adjacent to the kitchen have the potential to be affected in the event of a grease fire in the kitchen. Information regarding the full "Fire Emergency Action Plan" was placed in the Life Safety Documentation Binder detailing the difference between ABC type, and Type K fire extinguishers and their uses on 11-10-11. The corrective action is as stated above. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Maintenance will ensure the proper paperwork is maintained in the Life Safety Documentation Binder at all times. Binder will be available for review by the Executive Director at all times. No information contained in the "Fire Emergency Action Plan" will be removed without prior approval of the Executive Director. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The "Fire Emergency Action Plan" will be reviewed annually by the Executive Director to ensure</p>		

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K0051 SS=F	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure the Digital Alarm Communicator Transmitter (DACT) telephone dialer(s) for the facility's fire alarm system would send a trouble signal within 4 minutes to a supervisory station to protect 120 of 120 residents. LSC Section 9.6.4 requires supervisor station notification to be in accordance with</p>	K0051	<p>the documentation is in place regarding the use of ABC extinguishers and type K extinguishers. Any information that is found to be out of place will be replaced immediately. All information will also be available online under the Golden Living "Safety and Loss Control Manual".</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 10-31-11 as the fire alarm system failed to send a trouble signal to the Safe Care Monitoring company, Safe Care was contacted immediately, and came in while survey was still in progress. The technician diagnosed the problem as a</p>	10/31/2011

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	<p>NFPA 72 National Fire Alarm Code. NFPA Section 5-5.3.2.1.6.1 states: A DACT shall employ one of the following combinations of transmission channels:</p> <p>(1) Two telephone lines (numbers) (2) One telephone line (number) and one cellular telephone connection (3) One telephone line (number) and a one-way radio system (4) One telephone line (number) equipped with a derived local channel (5) One telephone line (number) and a one-way private radio alarm system (6) One telephone line (number) and a private microwave radio system (7) One telephone line (number) and a two-way RF multiplex system (8) A single integrated services digital network (ISDN) telephone line using a terminal adapter specifically listed for supervising station fire alarm service, where the path between the transmitter and the switched telephone network serving central office is monitored for integrity so that the occurrence of an adverse condition in the path shall be annunciated at the supervising station within 200 seconds.</p> <p>NFPA 72 at 5-5.3.2.1.6.2 states the following requirements shall apply to all combinations in 5-5.3.2.1.6.1:</p> <p>(1) Both channels shall be supervised in a manner approved for the means of</p>		<p>programming error, and reprogrammed the system immediately, and successfully tested the system. The system sent a trouble signal to the monitoring company in under 200 seconds as each of two phone lines were disconnected one at a time. Corrective action took place immediately for those residents found to have been affected by the deficient practice. 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? All residents have been identified to have the potential to be affected by the deficient practice. Corrective action is as stated above. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Communication with the Digital Alarm communicator Transmitter is tested automatically on a daily basis by Safe Care Monitoring to ensure signal is maintained. Inspection of the D.A.C.T. programming will be included in the fire alarm system inspections conducted by Safe Care conducted on an annual basis. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>		

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	<p>transmission employed.</p> <p>(2) Both channels shall be tested at intervals not exceeding 24 hours. Exception No. 1: For public cellular telephone service, a verification (test) signal shall be transmitted at least monthly. Exception No. 2: Where two telephone lines (numbers) are used, it shall be permitted to test each telephone line (number) at alternating 24-hour intervals.</p> <p>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.</p> <p>(4) When one transmission channel has failed, all status change signals shall be sent over the other channel. Exception: Where used in combination with a DACT, a derived local channel shall not be required to send status change signals other than those indicating that adverse conditions exist on the telephone line (number).</p> <p>(5) The primary channel shall be capable of delivering an indication to the DACT that the message has been received by the supervising station.</p> <p>(6) The first attempt to send a status change signal shall use the primary channel. Exception: Where the primary channel is known to have failed.</p> <p>(7) Simultaneous transmission over both channels shall be permitted.</p>		<p>into place? Communication with the Digital Alarm communicator Transmitter is tested automatically on a daily basis by Safe Care Monitoring to ensure signal is maintained. Inspection of the D.A.C.T. programming will be included in the fire alarm system inspections conducted by Safe Care conducted on an annual basis. Documentation will be maintained in the Life Safety Documentation Binder, and reviewed by Maintenance Director and Executive Director to ensure D.A.C.T. programming has been tested. Initial testing documentation is currently in the Life Safety Documentation Binder, and was completed on 10-31-11.</p>		

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	<p>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 1:18 p.m. to 1:34 p.m. on 10/31/11, when the DACT primary telephone line was disconnected from 1:18 p.m. to 1:24 p.m. and from 1:27 p.m. to 1:34 p.m. the facility's fire alarm system failed to send a trouble signal to a supervisory station. Based on interview at the time of observation, the Director of Maintenance stated the facility's fire alarm system monitoring company did not receive a trouble signal when the DACT primary telephone line was disconnected twice and acknowledged the facility's fire alarm system failed to send a trouble signal to a supervisory station each time the DACT primary telephone line was disconnected.</p> <p>3.1-19(b)</p>				

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K0144 SS=C	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators was signed by a person with the technical expertise to make the reliable source claim. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient</p>	K0144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Documentation for the off-site fuel source for 1 Of 1 emergency generators was formerly signed by a "Commercial Sales Consultant". A new letter was requested from Citizens Gas signed by a person of technical background qualified to make a claim of reliability of our natural gas fuel source. A letter was promptly sent by Citizens Gas making the necessary correction. The letter was received on 11-2-11 and placed in the Life Safety Documentation Binder. 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? All residents have the potential to be affected by this deficient practice. A new letter was requested from Citizens Gas signed by a person of technical background qualified to make a claim of reliability of our natural gas fuel source. A letter was promptly sent by Citizens Gas making the necessary correction. The letter was received on 11-2-11 and placed in the Life Safety Documentation Binder.</p>	11/02/2011			

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	<p>practice could affect all clients, staff and visitors.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Citizens Gas natural gas supplier letter faxed to the facility on 08/27/08 with the Director of Maintenance during record review from 9:20 a.m. to 10:50 a.m. on 10/31/11, the natural gas provider letter was signed by the "Commercial Sales Consultant."</p> <p>Based on interview at the time of record review, the Director of Maintenance stated the fuel source for the emergency</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 letter of reliability by Citizens Gas will be maintained in the Life Safety Documentation Binder, and will be available for review by the Executive Director at all times. The letter will remain in the binder at all times, and will be maintained by the Director of Maintenance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The letter of reliability by Citizens Gas will be maintained in the Life Safety Documentation Binder, and will be available for review by the Executive Director at all times. The letter will remain in the binder at all times, and will be maintained by the Director of Maintenance. The letter will be verified annually by the Executive director.</p>		

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	generator was natural gas and acknowledged the natural gas provider letter was not signed by a person with the technical expertise to make the reliable source claim. 3.1-19(b)				