

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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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
K010000	<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: 06/20/13</p> <p>Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Richmond 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 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, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000		

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>has a capacity of 122 and had a census of 92 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the two detached wooden storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/24/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 68 residents who use the main dining room, which is located adjacent to the 2 kitchen rolling fire doors.</p> <p>Findings include:</p> <p>Based on observation on 06/20/13 at 12:35 p.m. with the director of maintenance and administrator, there</p>	K010130	<p>Submission of this Plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be constructed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any conclusions set forth in this allegation by the survey agency. Accordingly the facility has prepared this Plan of correction prior to the resolution of appeal of this matter solely because of the requirements under the requirements under the state and federal law that mandate submission of a plan of correction within this time frame should in no way be considered or construed an agreement with the allegation of noncompliance or admission by the facility. This Plan of Correction is submitted as this facilities credible allegation of compliance. K 130 On 6-25-13 both metal rolling fire doors were inspected and tested to check for proper operation and full closure. All areas of the facility were inspected to ensure that there are</p>	07/01/2013			

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	were two metal rolling fire doors without inspection tags protecting the two openings from the kitchen to the main dining room. Based on interview on 06/20/13 at 1:10 p.m. with the director of maintenance, there was no additional documentation of an annual inspection or test for the two kitchen rolling fire doors to check for proper operation and full closure of the metal curtains. This was confirmed by the administrator at the exit conference on 06/20/13 at 2:00 p.m. 3.1-19(b)		not any other Horizontal or vertical sliding and rolling fire doors that are required to be inspected and tested. No other doors noted during the inspection. Annually the Maintenance supervisor will insure that the rolling fire doors are inspected and tested with proper records maintained and made available upon request. The maintenance Director will report to the quality assurance committee monthly any and all inspections.		