STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/22/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374	

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K010000	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). Survey Date: 10/22/14 Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Golden Rule 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. This one story facility with a partial basement was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping	K010000	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 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.	

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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	155264		10/22/2014

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GOLDEN LIVING CENTER-GOLDEN RULE	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

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	rooms. The facility has a capacity of 170 and had a census of 124 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three wooden detached storage sheds which were not sprinkled. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20	K010027	K 027 The Hall 5 set of smoke barrier doors were repaired so that they provide a smoke barrier in compliance with NFPA 101 Life Safety Code standard K 027 on	10/23/2014

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	minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 26 residents who reside on the 5 Hall. Findings include: Based on observation on 10/22/14 at 12:45 p.m. with the regional maintenance director, the 5 Hall set of smoke barrier doors had a two inch gap along the latching side of the door with the door in the closed position. This was verified by the regional maintenance director at the time of observation and acknowledged at the exit conference on 10/22/14 at 2:25 p.m. 3.1-19(b)		10-23-14. All other fire/smoke barrier doors were assessed on 10-22-14 by the Life Safety Surveyor and the Regional Maintenance Supervisor and found to be in compliance. All sets of fire/smoke barrier doors will be assessed monthly during required fire drills. Any sets of doors identified not to be compliance with Life Safety Code standards will be put into compliance. The Maintenance Supervisor will inform the Executive Director of any sets of doors found not to be in compliance. The E. D. will inform the QAPI Committee of any trend or pattern of barrier door failures and the Committee will develop and execute a plan to ensure correction and compliance.	
K010062 SS=E	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 Based on observation and interview, the facility failed to ensure 7 of over 300	K010062	K 062	11/04/2014

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	sprinkler heads in the facility were maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect 26 residents who reside on the 5 Hall, any residents who use the center lounge, any resident who uses the rehabilitation room bathroom, 2 residents who reside in room 74 and 2 residents who reside in room 66. Findings include: Based on observations on 10/22/14 during a tour of the facility with the regional maintenance director from 9:00 a.m. to 2:15 p.m., the Maintenance Hall sprinkler near the sprinkler riser room, the center lounge sprinkler by the fish tank, the rehabilitation bathroom sprinkler, resident room 66 sprinkler, resident room 74 sprinkler, and the south medical supply room sprinkler each had between one half inch and one inch gaps around the sprinkler escutcheon where the sprinkler escutcheons were not tight fitting to the ceiling. This was verified by the regional maintenance director at the time of observations and acknowledged at the exit conference on 10/22/14 at 2:25 p.m.		The seven sprinkler heads identified in the Life Safety Survey of 10-22-14 were repaired or replaced on 11-4-14. A tour of the facility by our contracting agent VFP Fire Systems and the Regional Maintenance Supervisor was conducted on 11-4-14 no other sprinkler heads not in compliance with Life Safety Code 9.7.5 and NFPA 25 were found. An inservice on identification of sprinkler heads that do not meet standards was conducted by the Regional Maintenance Supervisor on 11-4-14 for all maintenance staff. The sprinkler heads in the facility will be inspected quarterly to meet compliance with LSC 9.7.5 and NFPA 25. Any non-compliance identified in the quarterly inspections will be reported to the Executive Director. The E. D. will inform the QAPI Committee of any continuing non-compliance and the Committee will develop and execute of plan for compliance to standards.	

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