

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 02/20/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203
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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: 02/20/13</p> <p>Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Indianapolis 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 basement was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated</p>	K010000	<p>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 continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
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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>smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 86 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010020 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 vertical stairwell openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.3.2.1 requires a one hour rated door in a one hour vertical opening. This deficient practice could affect all residents, staff and visitors in the vicinity of the stairwell door by the resident dining rooms.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, the door at the top of the stairwell by the resident dining rooms had no fire rating affixed to the door. Based on interview at the time of observation, the Maintenance Director stated</p>	K010020	<p>K020 F</p> <p>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The door at the top of the stairwell by the resident dining rooms will have a fire resistant rating of at least one hour.</p> <p>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>There were no other doors needing replaced.</p> <p>III. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Two quotes received on 3/7/13 to replace the stairwell door.</p>	03/22/2013			

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	documentation of the fire rating for the aforementioned door was not available for review and acknowledged the door at the top of the stairwell by the resident dining rooms had no fire rating affixed to the door. 3.1-19(b)		IV. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The fire rated door was ordered 3/11/13. The repair company is awaiting additional materials to arrive to begin installation. Pending arrival of all material the completion date may extend beyond 3/22/13.		

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K010046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 battery powered lights was in accordance with LSC 7.9. LSC 7.9.2.5 states emergency lighting systems shall be either continuously in operation or capable of repeated automatic operation without manual intervention. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, the battery powered emergency light located in the kitchen failed to illuminate when the test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the battery powered emergency light located in the kitchen failed to illuminate when the test button was pressed five times.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to</p>	K010046	<p>K046 D</p> <p>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The kitchen battery powered emergency light will illuminate when the test button is pressed five times.</p> <p>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>There were no battery powered emergency lights needing replaced.</p> <p>III. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>The battery in the kitchen battery powered emergency light was replaced during the Life Safety inspection on 2/20/13. It illuminated when the</p>	03/22/2013			

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	<p>document testing for 1 of 3 battery powered lights in accordance with LSC 7.9 for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Direct Supply: TELS" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:35 a.m. on 02/20/13, documentation of annual ninety minute testing and functional testing at 30 day intervals for the battery powered light located in the kitchen was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, a battery powered emergency light was located at the emergency generator, in the basement corridor and in the kitchen. During the</p>		<p>test button was pressed five times.</p> <p>IV. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The kitchen battery powered emergency light was added to the Building Engines preventative maintenance schedule monthly & annually. The Maintenance Director and/or designee will complete the preventative maintenance check on kitchen battery powered emergency light per the schedule. QAPI to monitor for 3 months.</p>				

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	<p>tour, each light was tested and was observed to function except for the battery powered light in the kitchen. Based on interview at the time of record review and at the time of observation, the Maintenance Director stated there are three battery powered lights located in the facility and acknowledged documentation of annual ninety minute testing and functional testing at 30 day intervals for the battery powered light located in the kitchen was not available for review.</p> <p>3.1-19(b)</p>			

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K010052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K010052	<p>K052 C</p> <p>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The fire alarm system breaker located in the electrical panel in the mop closet for the kitchen will be locked.</p> <p>Three smoke detectors will be moved beyond 3' from the air handling systems where airflow prevents operation of the detectors.</p> <p>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>There were no other electrical panels needing locked.</p> <p>There were no other smoke detectors needing moved.</p>	03/22/2013			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, access to the fire alarm system breaker located in the electrical panel in the mop closet for the kitchen was not locked. Based on interview at the time of observation, the Maintenance Director acknowledged access to the fire alarm system breaker was not locked.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 3 of 48 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 66 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the</p>		<p>III. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>There was a lock placed on the electrical panel containing the fire alarm system breaker during the Life Safety inspection on 2/20/13.</p> <p>A quote was received on 3/12/13 to move the smoke detectors.</p> <p>IV. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The electrical panel containing the fire alarm system breaker was added to the daily interior rounds schedule. The Maintenance Director and/or designee will complete the check on locked fire alarm system breaker panel 5 x week. QAPI to monitor for 3 months.</p> <p>The quote was submitted to corporate to be processed through the capital expenditure</p>				

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	<p>facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, the following smoke detector locations were each located less than three feet from an air supply vent:</p> <p>a. the smoke detector on the ceiling in the corridor outside the Rehab room was located two feet from an air supply vent.</p> <p>b. the smoke detector on the ceiling in the corridor outside Room 38 was located two feet from an air supply vent.</p> <p>c. the smoke detector on the ceiling in the corridor outside Room 48 was located two feet from an air supply vent.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detector locations were each installed less than three feet from an air supply vent.</p> <p>3.1-19(b)</p>		<p>process on 3/12/13. The repair company is awaiting corporate approval to begin the smoke detector move process. This may extend beyond 3/22/13.</p>		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two staff and visitors in the B Wing Nurses' Station Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 3:30 p.m. on 02/20/13, a refrigerator was plugged into a power strip in the B Wing Nurses' Station Office. Based on interview at the time of observation, the Maintenance Director acknowledged a refrigerator was plugged into a power strip in the B Wing Nurses Station Office.</p> <p>3.1-19(b)</p>	K010147	<p>K147 D</p> <p>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The refrigerator at B wing nurses station will be plugged in an electrical outlet (fixed wiring).</p> <p>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All refrigerators will be plugged into an electrical outlet (fixed wiring).</p> <p>III. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>The B wing nurses station refrigerator cord was moved from the power strip to the electrical outlet (fixed wiring) during the Life Safety inspection on 2/20/13.</p>	03/22/2013			

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			<p>IV. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Refrigerators were added to the daily interior rounds schedule. The Maintenance Director and/or designee will complete the check on the refrigerators being plugged into the electrical outlet (fixed wiring). QAPI to monitor for 3 months</p>		