STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	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: 05/21/12 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Fountainview Place 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), and 410 IAC. Building 0102 built prior to March 1,2003 was surveyed with Chapter 19, Existing Health Care Occupancies. This facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0102 was built prior to March,1 2003, was determined to be of Type V (111)	K0000	**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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility does not have smoke detectors in resident rooms. The facility has a capacity of 186 and had a census of 173 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to ensure materials used as an interior finish for 1 of 11 corridors had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.	K0014	The area will be painted with a fire retardent paint that meets all of the specifications needed to comply with the flame spread ratings.No other areas in the center are effected by this finding.The Maintenance Department will maintain the area so that it will meet the flame spread ratings in the future.Any concerns with the area in question will be discussed at the monthly saftey committee meeting and at the monthly Q.A. meetings.The Director of Maintenance is responsible for monitoring the area for compliance with the Plan of Correcion.	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368	

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	(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident, staff or visitor in the vicinity of the B Wing Nurses' Station. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, the two walls of the B Wing Nurses' station had wood paneling on each wall from the floor to the ceiling. Based on interview at the time of observation, the Maintenance Supervisor stated no documentation of the flame spread rating of the wood paneling was immediately available nor was any documentation available for review to demonstrate the wood paneling had been treated with a flame retardant material. 3.1-19(b)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0029 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 16 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 301. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, the access door to Room 301 is not equipped with a self closing device to cause the door to latch into the door frame. Room 301 measures 240 square feet and is used to store wood furniture and combustible boxes containing nursing	K0029	The maintenance department will install a self closing device door on RM 301.No other rooms were found to need a self closing device.The maintenance department will monitor room usage going forward to see that any area that is used for storage has a self closing device.The Director of Maintenance will report to the Safety Committee and the Q.A. Committee monthly regarding any changes in room useage.The Director of Maintenance is responsible for monitoring this area for compliance with the Plan of Correction.	06/20/2012

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	supplies. Based on interview at the time of observation, the Maintenance Supervisor stated the former resident room is being utilized as a temporary storage room and acknowledged Room 301 measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a self closing device. 3.1-19(b)			

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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K0038 SS=E	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 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 15 exits were readily accessible for residents. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock which requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor if exiting the facility from the memory care wing at the exit by Room 313. Findings include: Based on observation with the Maintenance Supervisor and the memory care Director of Nursing during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, three of three exit doors in the memory care wing were magnetically locked and could be opened by entering a	K0038	The defective Key Pad will be replaced by 6/20/12.No other areas in the center were found to be deficient.The Maintenance Department or his designee will conduct 5 days a week checks on all egress doors on the Special Care Unit. All Main Egress Doors are checked daily. All other units egress doors will be checked weekly. A log will be maintained by the maintenance department. Any irregulatities will be discussed in Safety Committee and Q.A. Committee monthly.The Director of Maintenace is responsible for compliance with the Plan of Correction.	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
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	four digit code, but the four digit code unlocking device in the memory care wing exit by Room 313 was inoperable and would not unlock the door after ten attempts of entering the code. The memory care Director of Nursing and the Maintenance Supervisor stated they were entering the correct four digit code to unlock the door. The magnetic locking device on the memory care wing exit door by Room 313 did unlock the door when the fire alarm system was activated at 2:03 p.m. on 05/21/12. Based on interview at the time of observation, the Maintenance Supervisor and the memory care Director of Nursing stated the four digit code unlocking device malfunctioned and acknowledged the memory care wing exit by Room 313 could not be opened by entering a code into the device. 3.1-19(b)			

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K0052 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 15 manual fire alarm pull station boxes at facility exits was unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect residents, staff and visitors exiting the facility from the front lobby. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, the manual fire alarm pull station box at the front lobby exit was located in the exit foyer which had to be accessed through a magnetically locked door. Activation of the pull station would automatically disengage the magnetically locked door, however, access to the pull	K0052	The Manual Pull Fire Alarm Station in the main foyer has been relocated to the main lobby.No other fire pull stations were affected by this finding.The Director of Maintnance will monitor for continued compliane.Any concerns will be brougt to the Safety Committee and the Q A Committee monthly.The Director of Maintenance is responsible for compliance with the Paln of Correction,.	06/20/2012

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	station required unlocking the foyer access door at the front lobby exit with a keypad access code which would delay alarm notification to facility occupants. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the location of the front lobby exit manual fire alarm box was in a magnetically locked foyer and not readily accessible. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 05/21/2012
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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 4 of 4 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of each of the four oxygen storage and transfilling rooms. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, there is an oxygen storage room in each wing of the facility. Each oxygen storage room contained at least one liquid oxygen canister and each room's ceiling consisted of one layer of five eighths inch thick drywall. Based on interview at the time of the observations, the Maintenance Supervisor	K0076	We will add a layer of 5/8" fire retardent Gypsum Board to the ceiling which will bring the areas into compliance.Our center only has 3 oxygen storage rooms (B Wing, C Wing,and our Short Term Rehab Unit) not 4 as indicated in the finding. The 4th Unit is a designated Alzheimer Unit and does not have an oxygten storage room. If we decide that an additional oxygen storage room is needed we will comply with the requiremens in place at that time.There are no other areas affected by this practice.The Mainntenance Director is responsible for monitioring the integrity of the oxygen rooms. Any concerns will be brought to the Safety and Q.A. Committees Monthly.The Director of Maintenance is responsible for compliance with this Plan of Correction.	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
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	acknowledged the ceiling in each of the four oxygen storage rooms did not provide one hour fire resistive construction. 3.1-19(b)			

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 4 of 4 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of each of the four oxygen storage and transfilling rooms. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:15 p.m. on 05/21/12, there is an oxygen storage and transfilling room in each wing of the	K0143	We will add a layer of 5/8" fire retardent Gypsum Board to the ceiling which will bring the areas into compliance.Our center only has 3 oxygen storage rooms (B Wing, C Wing,and our Short Term Rehab Unit) not 4 as indicated in the finding. The 4th Unit is a designated Alzheimer Unit and does not have an oxygten storage room. If we decide that an additional oxygen storage room is needed we will comply with the requiremens in place at that timeThere are no other areas affected by this practice.The Mainntenance Director is responsible for monitioring the integrity of the oxygen rooms. Any concerns will be brought to the Safety and Q.A. Committees Monthly.The Director of Maintenance is responsible for compliance with this Plan of	06/20/2012

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	facility. Each oxygen storage and transfilling room contained at least one liquid oxygen canister and each room's ceiling consisted of one layer of five eighths inch thick drywall. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the ceiling in each of the four oxygen storage and transfilling rooms did not provide one hour fire resistive construction. 3.1-19(b)		Correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
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K0000	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: 05/21/12 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Golden Living Center-Fountainview Place 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), and 410 IAC 16.2. Building 0202 consisting of 14 additional rooms in a south wing which was referred to as Rehab wing, was surveyed in accordance with LSC Chapter 18, New Health Care Occupancies. This facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building	K0000	**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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012
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	0202 built in 2005 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility does not have smoke detectors in resident rooms. The facility has a capacity of 186 and had a census of 173 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			