

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 07/18/2012
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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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K0000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/21/12 and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/18/12</p> <p>Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview Place was found in substantial 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.</p> <p>This facility was surveyed as two separate buildings due to the construction dates of</p>	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 comply with all applicable state and federal regulatory requirements	

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>two sections of the building. Building 0102 was built prior to March 1, 2003 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 had battery powered smoke detectors in all resident rooms. The facility has a capacity of 186 and had a census of 164 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to smoke detector coverage, but not in compliance with state law in regard to sprinkler coverage</p> <p>All areas where the residents have customary access were sprinklered, except the gazebo which was open on all sides. All areas providing facility services were sprinklered except for the 10 by 20 storage shed and two car sized garage both of which were used to store facility supplies and equipment.</p> <p>Quality Review by Dennis Austill, Life Safety Code Supervisor on 07/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0038 SS=B	<p>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</p> <p>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.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance staff # 1 during a tour of the facility from 1:25 p.m. to 3:15 p.m. on 07/18/12, the exit door next to room 313 was locked with a magnetic locking devices and the adjacent keypad was inoperable and would not</p>	K0038	The keypad by room 313 that controls the magnetic locking device has been replaced. It was determined that the keypad malfunctioned as the result of the electrical storm on the evening of July 19, 2012. An audit revealed that all other keypads are functioning properly. The Director of Maintenance has established an audit tool to be used during his daily rounds to verify the operational status of all exit doors and magnetically controlled doors in the center. All doors will be checked at least 5 days per week and documented in the log by the maintenance department. The Director of Maintenance will review the results of his audit monthly with the safety committee and report any problems to the QA Committee Monthly. Any magnetic doors or keypads that are not functioning properly will also be reported to the Administrator immediately.	07/20/2012			

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	<p>unlock the door after several attempts attempts at entering the code. During record review during the tour, the Administrator presented documentation to show this keypad had been replaced.</p> <p>This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>				

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K0056 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 5 of 9 exits with exterior overhangs constructed with plywood eaves were sprinklered. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice could affects residents needing to evacuate from the B, C, D and E halls.</p> <p>Findings include:</p> <p>Based on observation with Maintenance staff # 2 during a tour of the facility from 1:25 p.m. to 3:15 p.m. on 07/18/12, the exterior overhangs on five exits located on the B, C, D and E wings measured six feet from the door to the edge of the overhang, then five and one half feet along the end of the building with a four</p>	K0056	All exit overhangs in excess of 48 inches will have a sprinkler head installed in compliance with all applicable state and federal regulations. In addition all other overwhang areas that are not in compliance with the overhang regulations will have sprinkler heads installed.All residents would be affected by the center not having sprinkler heads located on the over hangs in the proper locations.A Fire Safety Engineer has been contacted and is expected to be in the center by August 12, 2012. The engineer will then work on presenting a plan and getting drawings made for all needed approvals. However, based on the nature and the scope of the project, I am not able to give a specific completion date. I understand that we may need approvals from the state and or local government prior to the work	08/17/2012	

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	<p>and one half foot overhang where it wrapped around the corner of the building. The eaves of the overhangs were constructed of sheets of plywood. Based on interview with the Administrator during the exit interview at 3:20 p.m. on 07/18/12, all the overhangs which had been cited in the past had sprinklers installed, including the covered ambulance entrance, which had not been cited.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>being started..The Director of Maintenance and the Executive Director are responsible for compliance with this item. Monthly and thru outside contracts with our Fire Safety Contractor the Maintenance Director will be making regular reports to the Safety Committee and the QA Committee on the status of our Sprinkler System project. Any problems will be reported and corrected immediately.</p>	

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