

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630
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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: 04/21/14</p> <p>Facility Number: 000155 Provider Number: 155252 AIM Number: 100266830</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Woodlands 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 107 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except three detached structures; one plastic shed,</p>	K010000	<p><i>Preparation and submission of this Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible.</i></p>	

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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K010045 SS=E	<p>one wood framed shed, and one wood framed garage with vinyl siding used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 2 of 11 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect the 16 residents, as well as staff and visitors from the Alzheimer's Unit while in their dining room/activity room.</p> <p>Findings include:</p> <p>Based on observation on 04/21/14 at 11:40 a.m. during a tour of the facility with the Maintenance Director, the two exit means of egress outside the Alzheimer's Unit dining room/activity room exits were not equipped with any light fixtures. Both exit doors entered a fenced in area with two gates to exit. In the event residents had to exit the Alzheimer's Unit dining room/activity room at</p>	K010045	<p>What corrective actions will be accomplished for those residents found to have been effected by the deficient practice: Both exit doors in the Alzheimer's Care Unit dining/activity room have had exterior fixtures installed. --How other residents have the potential to be affected will be identified: All residents on the Alzheimer's Care Unit had potential to be affected. --What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Exterior lighting fixtures installed. No further corrective actions required. --How the corrective action will be monitored to ensure the</p>	05/16/2014

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	<p>night there would be no light source outside these two exit doors to a public way. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>deficient practice will not recur, what QA program will be put into place: No further corrective actions required. --Systemic changes will be completed by: May 16th, 2014 We are requesting paper compliance for tag K045E.</p>		