

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/06/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 09/06/12</p> <p>Facility Number: 000031 Provider Number: 155076 AIM Number: 100266150</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Golden Living Center-Brookview was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This facility with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement was determined to be of Type V (000) construction and 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 has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 136 and had a census of 114 at the time of this visit.</p> <p>The facility was not in compliance with</p>	K0000	<p>September 21, 2012 Golden Living Center - Brookview Provider #155076 Quality Assurance Walk-Thru Survey Plan of Correction Survey Date: September 6, 2012 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. All corrections will be completed by October 6, 2012.</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>state law in regard to sprinkler coverage. The facility was not in compliance with the state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/07/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date of this rule.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 Therapy Dining Room smoke detectors and 1 of 2 Therapy Room 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 20 residents, staff or visitors in the Therapy Dining Room and the Therapy Room.</p>	K9999	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 09/07/12, 2 of 2 smoke detectors that were found to be too close to an air conditioning vent in the therapy room and the therapy dining room were moved to an area not closer than 3 feet from air handling systems that could potentially prevent their operation per NFPA 72. On 10/02/12, the exterior canopy at the Therapy room exit which extends more than 4 feet from the building will be sprinkled according to the specifications listed in the 1999 NFPA 13 code book.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All staff or visitors in the therapy room, therapy dining room, or at the therapy room exit canopy have the potential to be affected in the event of a fire or smoke in the therapy room, therapy dining room, or at the therapy room exit canopy. The area now has proper smoke detector coverage and will have full sprinkler coverage on 10/02/12. The corrective action is as stated above.</p>	10/06/2012			

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	<p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 12:35 p.m. to 2:15 p.m. on 09/06/12, the smoke detector in the Therapy Dining Room and the smoke detector in the Therapy Room identified as # 47 were each located on the ceiling 18 inches from an air supply vent. Based on interview at the time of the observations, the Director of Maintenance acknowledged the aforementioned smoke detectors were each installed less than three feet from an air supply vent.</p> <p>3.1-19(b)</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The Maintenance Director or designee will notify the Executive Director of any changes to the sprinkler or fire alarm system which would fail to meet the code requirements in the 2000 edition of the Life Safety Code of the National Fire Protection Association. With the corrections listed above, the building will meet current code requirements. Quarterly testing of the sprinkler system will continue as scheduled, and semi-annual inspections of the smoke alarm system will continue as scheduled insuring that the facility remains in compliance with current Life Safety Code thus ensuring the deficient practice does not recur.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Contracted sprinkler inspectors will assess the sprinkler systems quarterly to ensure they remain in working order and provide proper coverage as stated in the NFPA 13 1999 edition. Results will be recorded in the Quarterly report and any deficiency found will be reported to the Executive Director for immediate repair. Contracted alarm system inspectors will</p>				

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	<p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 5 combustible exterior canopies which was each wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Therapy Room exit.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 12:35 p.m. to 2:15 p.m. on 09/06/12, the exterior canopy at the Therapy Room exit extended four and one half feet from the building, was not provided with automatic sprinklers and was of wood construction. Based on interview at the time of observation, the Director of Maintenance acknowledged the exterior canopy at the Therapy Room exit was of combustible construction, extended more than four feet from the building and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>asses the systems annually to ensure they are properly in place and functioning per NFPA 72. The Director of Maintenance or designee will ensure all testing documentation is maintained in the Life Safety Documentation binder for review. These quality assurance programs will ensure the deficient practice will not recur.</p>		

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