

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
K 0000 Bldg. 01	<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: 09/16/15</p> <p>Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280</p> <p>At this Life Safety Code survey, Golden Living Center-Petersburg 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 spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 54 at the time of this</p>	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
K 0017 SS=E Bldg. 01	<p>survey.</p> <p>All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered except:</p> <ol style="list-style-type: none"> 1. A thirty foot by eighteen foot detached garage constructed of wood framing and metal covering and storing maintenance supplies and kitchen equipment 2. A fifteen foot by twelve foot detached portable wood shed storing paper records 3. A twelve foot by nine foot detached wood shed storing the facility's water softener. <p>Quality Review completed on 09/18/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2015	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567			
(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			
	Based on observation and interview, the facility failed to ensure 1 of 4 open use areas were separated from the corridor by walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above or met an Exception. LSC 19.3.6.1, Exception #1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any number of residents, as well as staff and visitors while passing through the area around the west Nurses' Station.	K 0017	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>An electrical hard-wire smoke detector was installed on 9/23/15 at West End Nurses Station.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents or visitors/staff have the potential to be affected by this deficient practice. Maintenance Director or designee will monitor monthly or as needed for any open areas that are not in direct supervision by facility staff to ensure proper electrical smoke detectors are installed.</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>Maintenance Director or designee will monitor monthly or as needed for any open areas that are not in direct supervision by facility staff to ensure proper electrical smoke</p>	09/23/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
K 0038 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation on 09/16/15 at 11:40 a.m. during a tour of the facility with the Maintenance Director, the west Nurses' Station was open to the corridor. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The west Nurses' Station was not protected by an electrically supervised automatic smoke detection system, or the entire space was not arranged and located to allow direct supervision by the facility staff from another nurses' station or similar staffed space. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director said the west Nurses' Station was not currently being used by facility nursing staff at all times.</p> <p>3-1.19(b)</p> <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 a handrail was provided for 1 of 4 exits with ramps. LSC 19.2.1 refers to Chapter 7. LSC</p>	K 0038	<p>detection systems are installed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:</p> <p>Maintenance Director or designee will monitor monthly or as needed for any open areas that are not in direct supervision by facility staff to ensure proper electrical smoke detection systems are installed.</p> <p>This will be reviewed during the facility QAPI monthly meeting for 4 months, then quarter times 3.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	<p>7.2.5.4 states handrails shall be provided along both sides of a ramp run with a rise greater than six inches. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. Exception No. 3 says existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect any number of residents, as well as staff and visitors while exiting to the outside from the main Dining Room.</p> <p>Findings include:</p> <p>Based on observation on 09/16/15 at 11:20 a.m. during a tour of the facility with the Maintenance Director, the south exit from the main Dining Room had a 20 foot ramp which had a grade change of over one foot from top to bottom. There was no handrail on either side of the ramp.</p> <p>This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>A hand rail will be installed on the ramp outside of the main Dining Room.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>Resident/Visitors have the potential to be affected by the same deficient practice. A hand rail will be installed on the ramp outside of the main Dining Room.</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>Maintenance Director or designee will visually inspect all ramps outside the facility to ensure that a hand rail is installed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:</p> <p>Maintenance Director or designee</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Code Documentation Binder on 09/16/15 at 9:30 a.m. with the Maintenance Director present, the following was noted:</p> <p>a. three of four first shift (day) fire drills were performed between 1:30 p.m. and</p>	K 0050	<p>will visually inspect all ramps outside the facility to ensure that a hand rail is available for all residents/visitors on a monthly basis. This will be reviewed during facility QAPI monthly meeting times 4 months, then quarter times 3.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Facility will vary times of Fire Drills for 1st and 2nd shifts.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents have the potential to be affected by this deficient practice.</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567		
(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	
K 0144 SS=C Bldg. 01	<p>2:25 p.m. b. three of four second shift (evening) fire drills were performed between 3:30 p.m. and 4:45 p.m. During an interview at the time of record review, the Maintenance Director acknowledged the times the first and second shift fire drills were performed were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview,</p>	K 0144	<p>Fire Drills will be varied at different times and recorded for 1st and 2nd shifts.</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>Maintenance Director or designee will record times of Fire Drills and review with Executive Director/DNS to ensure times are varied during the 1st and 2nd shifts.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:</p> <p>Executive Director/DNS will review during the facility QAPI meeting monthly to ensure times are varied for facility Fire Drills. This will be monitored monthly for 6 months then quarterly times 2.</p> <p>What corrective action will be</p>	09/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	<p>the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 110, 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>		<p>accomplished for those residents found to have been affected by the deficient practice:</p> <p>Load bank test is scheduled to be completed on 9/30/15.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:</p> <p>All residents/staff and visitors have the potential to be affected by this deficient practice. Facility will schedule a load bank test to be completed on a yearly basis.</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>Maintenance Director will continue to test and document the generator monthly under load. A load bank test will be scheduled and completed on a year basis.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155375	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 309 W PIKE AVE PETERSBURG, IN 47567
---	---

(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
	<p>Findings include:</p> <p>Based on review of the facility's emergency generator monthly load test documentation on 09/16/15 at 10:35 a.m. with the Maintenance Director present, the generator log form documented the generator was tested monthly under load, however, the documentation did not show the generator was exercised under operating temperature conditions or did not document the percentage of load at which the generator was exercised during the past twelve months. The most recent load bank test documentation for this diesel generator was dated 10/31/13. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>		<p>put into place:</p> <p>Maintenance Director or designee will review the monthly testing during facility monthly QAPI meeting for 6 months then every 3 months times 2 then report on yearly testing.</p>	