

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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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: 05/27/14</p> <p>Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Richmond 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 (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>Submission of this Plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly the facility has prepared this Plan of correction prior to the resolution of appeal of this matter solely because of the requirements under the requirements under the state and federal law that mandate submission of a plan of correction within this time frame should in not way be considered or construed a agreement with the allegation of noncompliance or admission by the facility. This Plan of Correction is submitted as this facilities credible allegation of compliance.</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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K010027 SS=E	<p>has a capacity of 122 and had a census of 88 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two detached wooden storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 13 sets of smoke barrier doors would restrict the movement of smoke for at least 20</p>	K010027	On 5-27-13 the smoke barrier door was repaired and tested to check for proper operation and full closure. All smoke barrier doors in the facility were	06/02/2014			

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K010144 SS=F	<p>minutes. LSC Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 24 residents who reside on the TCU Long Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/27/14 at 11:30 a.m. with the administrator and regional maintenance supervisor, the TCU Long Hall set of smoke barrier doors had a twelve inch gap where the door set failed to close completely. This was verified by the administrator at the time of observation and acknowledged at the exit conference on 05/27/14 at 1:45 p.m.</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.</p> <p>Based on record review and interview, the facility failed to document monthly</p>	K010144	<p>inspected to ensure proper function with no issues noted. Monthly the Maintenance supervisor will during the monthly fire drill insure that all smoke barrier doors function properly; during the monthly inspection the doors will be inspected and tested with proper records maintained and made available upon request. The maintenance Director will report to the quality assurance committee monthly for 6 months the results of the monthly Smoke barrier inspections.</p> <p>K 144</p> <p>On 06-05-14 the facility</p>	06/02/2014			

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	<p>load tests for 4 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Preventative Maintenance Log Monthly Load Tests with the administrator and regional maintenance supervisor on 05/27/14 at 1:10 p.m., the load tests documented for 02/05/14, 03/28/14, 04/07/14, and 05/16/14 each recorded a twenty six</p>		<p>Maintenance director was in serviced on how to conduct and document monthly a generator load bank test</p> <p>On 6-05-14 a generator load bank test was conducted with a 37% load test. If the facility is unable to maintain a 30% or over load bank test additional electrical equipment will be added to the emergency generator system.</p> <p>Monthly the Maintenance supervisor will conduct and document monthly a generator load bank test. Records will be maintained and made available upon request.</p> <p>The maintenance Director will report to the quality assurance committee monthly for 6 months the results generator load bank test..</p>	

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	<p>percent load test. Based on an interview with the regional maintenance supervisor on 05/27/14 at 1:20 p.m., it was stated the facility will need to add more electrical equipment to the emergency generator system to operate at a thirty percent capacity. The lack of a documented thirty percent load test for the above listed months was verified by the regional maintenance supervisor and administrator at the time of record review and acknowledged by the administrator at the exit conference on 05/27/14 at 1:45 p.m.</p> <p>3.1-19(b)</p>				