

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 09/29/2016
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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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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: 09/29/16</p> <p>Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490</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, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 69 at the time of this visit.</p>	K 0000	<p>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. Golden Living Center Richmond respectfully requests a paper compliance desk review.</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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K 0021 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 14 combustibile storage rooms over 50 square feet were only held open by a releasing device that automatically closed the door upon activation of the fire alarm</p>	K 0021	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the</p>	10/07/2016

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K 0027	<p>system, local smoke detectors designed to detect smoke passing through the opening or the automatic sprinkler system. This deficient practice could affect 36 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 09/29/16 at 11:10 a.m. with the administrator and maintenance supervisor, the kitchen combustible food storage room, which measured two hundred square feet and stored sixteen shelves of food supplies in cardboard boxes and paper containers, had the door propped open with a rubber wedge and two plastic carts. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/29/16 at 1:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>same alleged deficient practice will be identified and what corrective action(s) will be taken: The Living Center realizes that residents who use the main Dining Room have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>The dietary staff have been re-educated on the regulatory requirement and have been instructed that the door may not be propped open. The Maintenance Director has obtained a quote from SafeCare for a manual closer. The necessary parts have been ordered. The Maintenance Director/designee will ensure that no doors are being propped open by use of an Audit tool five (5) times weekly for the next thirty (30) days; then, three (3) times weekly for the following sixty (60) days; then, weekly for the following ninety (90) days.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>All audits will be forwarded to the Quality Assurance Process Improvement Committee monthly for the next six(6) months.</p>				

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-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</p> <p>Based on observation, the facility failed to ensure 1 of 10 sets of smoke barrier doors was equipped with the appropriate hardware to allow the door which must close first, always close first so both doors always close completely. LSC, Section 19.3.7.6 requires that 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. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door that must close first always closes first. This deficient practice affects 36 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 09/29/16 at 12:10 p.m. with the administrator and</p>	K 0027	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken: The Living Center realizes that residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: The Maintenance Director adjusted the coordinator on the fire doors enabling the doors to shut completely with no gaps. There were no issues with any other smoke barrier doors. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance</p>	10/07/2016			

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K 0062 SS=F Bldg. 01	<p>maintenance supervisor, the Dining Room Hall set of smoke barrier doors, which swung in the same direction, had a coordinator which failed to allow the astragal side of the door to close first on three separate attempts to close the set of smoke barrier doors. Furthermore, there was a three inch gap where the doors came together. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/29/16 at 1:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Post Indicator Valve was provided with a sign indicating the valve is in the open position. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 9-4.1 requires</p>	K 0062	<p>program will be put into place: The Maintenance Director will conduct inspections of the doors by use of an Audit tool five (5) times weekly for the next thirty (30) days; then, three (3) times weekly for the following sixty (60) days; then, weekly for the following ninety (90) days. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place: All audits will be forwarded to the Quality Assurance Process Improvement Committee monthly for the next six(6) months.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affect No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken: The Living Center realizes that residents have the potential to be affected by the alleged deficient practiced.</p>	10/07/2016			

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	<p>alarm valves shall be externally inspected monthly. The valve inspection shall verify the following;</p> <p>(a) The gauges indicate normal supply water pressure is being maintained. (b) The valve is free of physical damage. (c) All valves are in the appropriate open or closed position. (d) There is no leakage from the retarding chamber or alarm drains.</p> <p>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 09/29/16 at 12:20 p.m. with the maintenance supervisor, the Post Indicator Valve (PIV), which was located outside and along the eastern property line, failed to be supplied with an internal sign indicating the valve was in the open position. Based on an interview with the maintenance supervisor on 09/29/16 at 12:30 p.m., when asked if the valve as inspected monthly, the maintenance supervisor indicated the valve is only inspected quarterly by the sprinkler inspection company. The lack of a sign indicating the Post Indicator Valve was in the open position was verified by the maintenance supervisor at the time of observation and interview and acknowledged by the administrator at the</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: the Post Indicator Valve (PIV), which was located outside and along the eastern property line now has been supplied with an internal sign indicating the valve was in the open position. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director will inspect the Post Indicator Valve monthly for the next six (6) months All audits will be forwarded to the Quality Assurance Process Improvement Committee monthly for the next six(6) months.</p>	

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K 0069 SS=E Bldg. 01	<p>exit conference on 09/29/16 at 1:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, review and interview, the facility failed to ensure 1 of 1 fire extinguishing systems for commercial cooking operations was maintained in accordance with the applicable requirements of NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation. NFPA 96, Section 7-5.1 requires a readily accessible means for manual activation located in the path of exit or egress. This deficient practice could affect 36 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 09/29/16 at 12:20 p.m. with the administrator and maintenance supervisor, the kitchen overhead range hood suppression system manual pull station box was located on the center wall across from the walk in cooler and freezer and not in a path of egress from the range. Furthermore, to activate the pull station box in the event</p>	K 0069	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken: The Living Center realizes that residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: The kitchen overhead range hood suppression system manual pull station box has been re-located in the path of exit or egress. The Dietary staff has been educated on the relocation of the pull station and its function and their responsibilities on using it in the event of a fire. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>	10/07/2016

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K 0147 SS=E Bldg. 01	<p>of a fire, the activation would require a ten foot distance in the opposite direction of the exit door from the range. The lack of the range hood suppression system manual pull station box located in the path of travel from the range was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/29/16 at 1:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 63 resident rooms did not use flexible cords as a substitute for fixed wiring to provide power for medical equipment electrical devices. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 4 resident in the facility. Findings include: Based on observations on 09/29/16</p>	K 0147	<p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place: All dietary employees will receive education regarding the kitchen overhead range hood suppression system manual pull station box upon new hire orientation with documentation of such and acknowledgement of such. The documented acknowledgements will be forwarded to the Quality Assurance Process Improvement Committee monthly for the next six(6) months.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The two resident rooms no longer have flexible cords as a substitute for fixed wiring to provide power for medical equipment electrical devices. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken: All resident rooms in the Living Center have been inspected and/or corrected of this practice.</p>	10/07/2016	

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	<p>during a tour of the facility with the administrator and maintenance supervisor from 10:07 a.m. to 1:10 p.m., the following resident rooms used power strips or multiplex outlets to power medical equipment;</p> <p>a. Resident room #58 had a power strip used to power a nebulizer for bed #2.</p> <p>b. Resident room #54 had a power strip used to power a nebulizer for bed #1.</p> <p>The power strips used for medical equipment in resident room #58 and #54 was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/29/16 at 1:10 p.m.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>Staff have been re-educated on the appropriate practice going forward. The Maintenance Director is placing additional electrical outlets in the resident rooms over a period of time. How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Director will conduct inspections of the resident rooms by use of an Audit tool five (5) times weekly for the next thirty (30) days; then, three (3) times weekly for the following sixty (60) days; then, weekly for the following ninety (90) days.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>All audits will be forwarded to the Quality Assurance Process Improvement Committee monthly for the next six(6) months.</p>	