

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401
--	--

(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
K0000	<p>A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/28/12</p> <p>Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Bloomington 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 with a basement was determined to be of Type V (000) construction and was fully sprinklered except for the Generator Transfer Switch room. The facility has a fire alarm system with smoke detection in the corridors,</p>	K0000		

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:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/28/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401		
(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>spaces open to the corridors and battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 153 and had a census of 133 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, but in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the Generator Transfer Switch room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/03/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/28/2012	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401			
(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			
K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/28/12 at 2:10</p>	K0051	<p>1. Maintenance Director does know where the Fire Alarm System Circuit breaker is located. The Fire Alarm Circuit breaker is located in the Generator Transfer Switch room on east center hall adjacent to resident Main Dining room.2. This deficient practice could affect all residents as well as visitors and staff.3. Executive director will educate authorized personnel on the location of the Fire Alarm Circuit breaker.4. Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved.5. 12/28/12</p>	12/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401
--	--

(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>p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker could not be located. Based on interview on 11/28/12 at 2:15 p.m. with the Maintenance Supervisor, it was acknowledged the location of the breaker for the fire alarm panel was unknown..</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/28/2012	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401			
(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			
K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 electrical rooms was provided with an automatic sprinkler head to ensure sprinkler coverage in all portions of the building. This deficient practice could affect 10 residents in the Dining room adjacent to the Generator Transfer Switch room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/28/12 at 1:20 p.m. with the Maintenance Supervisor, the Generator Transfer Switch room on east center hall was not provided with sprinkler head coverage. Based on interview on 11/28/12 at 1:22 p.m. with the Maintenance Supervisor, it was</p>	K0056	<p>1. The generator Transfer Switch room on the East Center hall adjacent to the resident main dining room will have a sprinkler.2. This deficient practice could affect all residents as well as visitrns and staff.3. Executive Director will educate authorized personnel on the location of the new Sprinkler.4. Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved.5. 12/28/12</p>	12/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155278	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/28/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401
--	--

(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>acknowledged there was no sprinkler head present in the Generator Transfer Switch room to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b) 3.1-19(ff)</p>			