STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 01 B. WING	10/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVE LA PORTE, IN 46350

(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	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). Survey Date: 10/31/17 Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620 At this Life Safety Code survey, Golden Living Center-Fountainview Terrace was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 smoke detection in the corridors and in spaces open to the corridors with battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 176 and had	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a census of 114 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the maintenance garage and storage shed. Quality Review completed on 11/01/17 - DA			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 12 sets of smoke barrier cross corridor doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 11 residents. Findings include: Based on observation with the	K 0100	K100 1. The maintenance director inspected all doors to ensure proper function. No other residents were found to be affected by the deficient practice. 2.Other residents having the potential to be affected by this deficient practice were identified and corrective action was taken by going door to door to inspect any loose latches. No other loose latches were found during the door to door inspection. 3.To be sure the deficient practice does not recur we will monitor the doors and latches	11/30/2017

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	Maintenance Assistant #1 on 10/31/17 at 10:15 a.m., the smoke barrier cross corridor doors near resident room 202 contained latching hardware. When tested, one of the cross corridor doors failed to latch. Based on interview at the time of observation, the Maintenance Assistant #1 confirmed one of the two cross corridor doors failed to latch. 3.1-19(b)		monthly for 6 months and randomly after and the findings will be reported to QA monthly for six months. 4.Audits will be reviewed in QA monthly for six months to ensure continued compliance. 5.Deficient Practice will be remedied by November 30, 2017.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be			

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	electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation, record review, and interview, the facility failed to ensure 14 of 14 exits had a code posted. LSC	K 0222	K222 Part I	11/30/2017

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	19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:20 a.m., the entrance/exit door #5 was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. Surveyor was unable to find a code posted at the entrance/exit door. Based on an interview at the time of observation, the Maintenance Assistant #1 directed the location of the code to the code at the top of the door on the magnetic device.		1.The maintenance director inspected and corrected all doors. No other resident was found to be affected by the deficient practice. 2.Other resident having the potential to be affected by the deficient practice were identified and corrective action was taken by inspecting all exits and ensuring the exit codes are posted in a conspicuous place on the top of the door and easy to read. We have placed a sign placed on the key pads that states “the code is at top of door”. 3.The measures to be in place to ensure the deficient practice does not recur will be included in the weekly rounds of the building for six weeks then reported to QA monthly for six month. 4.The corrective actions will be monitored on weekly rounds for six weeks and monitored in QA for six months. 5.Deficient Practice will be remedied by November 30, 2017. Part II 1.The maintenance director checked all other doors to ensure proper function and full opening of the doors. No other resident was found to be affected by the deficient practice. 2.Other residents and staff having the potential to be affected by the deficient practice were	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 14 exits were readily accessible for residents. This deficient practice could affect staff and up to 63 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:35 a.m., the Maintenance Assistant #1 was unable to open the Memory Sitting Room exit door. Based on interview at the time of the observations, the Maintenance Assistant #1 confirmed the door would not open. 3.1-19(b)		identified and corrective action is being taken to ensure the door will open freely as we are installing a new door and threshold to elevate the door to keep it from catching on the concrete. The door will need to be a custom door and is being ordered. 3.The measures to be in place to ensure the deficient practice does not recur will be included in the weekly round of the building for six weeks and randomly after then report to QA monthly for six months to ensure the problem does not recur. 4.The corrective actions will be monitored on weekly rounds for six weeks then reported to QA for six months on the findings ensuring the door is continuing to work correctly. The Deficient Practice will be remedied by November 30, 2017.	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of 79 of 79 battery operated	K 0300	K300 1.No other resident was found to be affected by the deficient practice.	11/30/2017

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	smoke alarms in resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 9:30 a.m., the last two months of battery operated smoke alarm documentation was not available for review. Based on interview at the time of record review, the Maintenance Assistant #1 acknowledged the lack of documentation. 3.1-19(b)		2.Anyone having the potential to be affected by this deficient practice has been identified as the maintenance director will ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms are complete. Fire warning equipment will be maintained and tested and documented in accordance with manufactures published instructions per the requirements. 3.The measures taken are a monitoring the check off lists by the Executive Director or designee then report to QA for six months and randomly after to show and ensure the documentation has been completed. 4.The Maintenance Director or designee will monitor then report to QA for six months to ensure the documents have been checked off showing the battery smoke alarms have been tested monthly. 5.The deficient practice will be remedied by November 30, 2017.	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is			

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	used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 11:18 a.m., the Laundry contained	K 0321	K321 1.The identified door was adjusted to ensure the latch works correctly and to ensure compliance. 2.The maintenance director checked all doors throughout the facility to ensure proper function and to be sure no one would be affected by the deficient practice. 3.Measures in place include monitoring the door weekly for six weeks and randomly after to ensure the door does not have the same recurring problem then	11/30/2017

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	fuel-fire equipment. The corridor door hit the frame and failed to latch when tested. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the corridor door did not fully close and latch. 3.1-19(b)		reporting the doors function to QA for six months. 4.The Maintenance Director or designee will monitor the door weekly for six weeks included in a monitoring tool for this Plan of Correction and then reported to QA for six months to ensure compliance and proper function of the door. The deficient practice will be remedied by November 30, 2017	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review and interview, the facility failed to ensure 1 of 1 Activities kitchen was provided with a	K 0324	K324 Part I	11/30/2017

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	fire suppression system per NFPA 96. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 4.1.1 requires cooking equipment that produces grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. This deficient practice affects staff and at least 18 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 11:31 a.m., the Activities kitchen had a residential stove without a fire suppression system. Based on interview at the time of observation, the Activity Assistant #1 confirmed that bacon has been cooked on the stovetop before. The Maintenance Assistant #1 acknowledged the aforementioned condition and was unaware of the regulation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system		1.The Executive Director and Maintenance Director have adopted a policy that No Grease-Laden Vapors will be permitted in the residential activity department. We have also added a “K” Fire Extinguisher to the Activity area close to the residential stove. 2.We have identified the problem and corrected by a policy change for No Grease-Laden Vaporous foods to be cooked in the residential activity kitchen so no resident has the potential to be affected by the deficient practice. 3.The systemic changes are in-services for Activity staff to understand the new policy related to Grease-Laden Vapors and to monitor the Activity staff and residential kitchen for six weeks to ensure compliance and understanding then report to progress in QA for six months and randomly after to ensure compliance and the deficient practice does not recur. 4.The maintenance director or designee will monitor and report to QA for six months to ensure the deficient practice does not recur. 5.The deficient practice will be remedied by November 30, 2017. Part II 1.The maintenance director surveyed the area in the Kitchen to determine a conspicuous area to place a red and white sign to	

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	shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 11:23 a.m., the Kitchen contained a UL 300 hood system. Based on interview, a staff member was asked what she would do if there was a fire underneath the hood. She replied she would leave the area immediately. She failed to indicate pulling the hood pull station. Based on interview, the Maintenance Assistant #1 acknowledged her response and was unable to confirm that kitchen staff has had training or a fire drill recently. 3.1-19(b) 3. Based on record review and interview, the facility failed to maintain 1 of 1 UL 300 system in accordance with 19.3.2.5.1. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.2 requires all such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking		show where the pull station is located to ensure no residents or staff would be affected by the deficient practice. 2.The maintenance director placed the red and white sign locating the fire pull stations in the kitchen. The maintenance director has in-service the kitchen staff to ensure understanding, location and use of the pull stations in the kitchen to ensure safety for any potential negative affects. 3.The systemic changes to ensure the deficient practice does not recur are the in-servicing of kitchen staff on the location of the pull stations and proper use of the fire pull stations and when to use the fire pull stations. The Maintenance director or designee will monitor for six months and randomly after to ensure understanding by the staff and to ensure posted signage still in good repair then monitor monthly for six months in QA. (Please see attached in-service.) 4.The maintenance director or designee will monitor for six months and report to QA to ensure the deficient practice doe not recur. 5.The deficient practice will be remedied by November 30, 2017. Part III 1.The maintenance director or designee will ensure documentation is readily available	

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	equipment. This deficient practice could affect staff only. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 between 8:45 a.m. and 10:00 a.m., the most recent hood cleaning performed on 07/24/17 by Hoodz indicated in the "Noticed Areas of Concerns/Deficiencies" that "Need to replace exhaust fan belt" was checked off. Based on interview at the time of record review, the Maintenance Assistant #1 was unaware of the deficiency and was unable to provide further documentation. 3.1-19(b)		and complete meeting the requirements showing the date and time along with the parts that were replaced documented to ensure no residents will be affected by this deficient practice. 2.Corrective action will be that the maintenance director or designee will monitor the inspections monthly to ensure the documentation of replacement parts are complete and readily available so no resident will have the potential to be affected by this deficient practice. 3.The maintenance director or designee will monitor the inspection reports and documentation monthly for six months and randomly after and report the findings to QA monthly to ensure compliance. 4.The maintenance director or designee will continue to monitor and report to QA for six months to ensure the deficient practice does not recur. 5.The deficient practice will be remedied by November 30, 2017.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			

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	9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 12:45 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Maintenance Assistant #1 acknowledged the fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)	K 0346	K346 1.The maintenance director or designee checked all the disaster manuals and emergency plan manuals in the facility and updated the manuals to ensure the Indiana State Department of Health's Web Portal is included in the manuals to ensure the deficient practice does not affect any residents negatively. 2.The maintenance Director updated all manuals with the ISDH Web Portal to ensure no other residents would be affected by the deficient practice. The updated manual includes reporting any outages for more than 4 hours in a 24 hour period to the ISDH Web Portal as well as the Executive Director and the Director of Nursing. The maintenance director or designee checked all the disaster manuals and emergency plan manuals in the facility and updated the manuals to ensure the Indiana State Department of Health's Web Portal is included in the manuals to ensure the deficient practice does not affected any residents negatively. (please see attached) 3.The maintenance director or designee will monitor the manuals for six months and randomly after and report to QA monthly for six months to ensure the deficient practice does not recur. 4.The maintenance Director of	11/30/2017

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			designee will monitor the manuals for six months and report to QA their finding for six months to ensure this deficient practice does not recur 5.The deficient practice will be remedied by November 30, 2017.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 7.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the	K 0353	K353 1.To ensure all occupants will not be affected by this deficient practice the maintenance director or designee will ensure the quarterly inspects documentation and reports will be readily available and in a secure location with: 1.Dates the sprinkler system was last checked.	11/30/2017

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	required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 12:45 p.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly control valves, weekly dry system gauge and monthly wet system gauge inspection. Based on interview at the time of record review, the Maintenance Assistant #1 acknowledged the lack of documentation. 3.1-19(b)		2.Who provided the system check. 3.Water system supply source. 4.Monthly control valves 5.Monthly we system gauge inspection 2.The maintenance director will have a binder to compile all information pertaining to the sprinkler system check readily available and complete and compliant to ensure no resident has the potential to be affected by the deficient practice. 3.The maintenance director will monitor the binder for readily available and complete information pertaining to the sprinkler system check for six month and randomly after to be sure the deficient practice does not recur. (please see attached) 4.The maintenance director will monitor and report to QA for six month to ensure compliance. 5.The deficient practice will be remedied by November 30 2017.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is			

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	out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 12:45 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the	K 0354	K354 1.As K346 Plan of Correction states: The maintenance director checked all the disaster manuals and emergency plan manuals in the facility and updated the manuals to ensure the Indiana State Department of Health's Web Portal is included in the manuals to ensure the deficient practice does not affect any resident negatively. 2.The manuals were updated to include the ISDH Web Portal to ensure no other residents would be affected by this deficient practice. 3.The maintenance director or designee will monitor the manuals for six months and report to QA monthly for six months and randomly after to ensure the deficient practice does not recur. 4.The maintenance director or designee will monitor the manuals for six months to ensure compliance for the listed ISDH Web Portal and report the finding to QA for six months to ensure this deficient practice does not recur. 5.The deficient practice will be remedied by November 30, 2017.	11/30/2017

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	Maintenance Assistant #1 acknowledged the fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of			

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	steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 6 corridors in accordance of 19.3.6.3. This deficient practice could affect staff and up to 50 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 11:03 a.m., the Alzheimer's Kitchen corridor door contained two separate quarter inch penetrations around the door handle. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)	K 0363	K363 1.All other doors were inspected by the maintenance department to ensure no other doors were affected by the deficient practice so that no other residents could be affected negatively. 2.All doors were addressed and patched with fire caulk to ensure no penetrations around the doors or door handles so that no residents would have the potential to be affected by the deficient practice. 3.The maintenance director or designee will inspect all doors monthly to ensure the fire doors have no cracks for six months. 4.The maintenance director or designee will monitor all doors monthly for six months and randomly after then report findings to QA to ensure all doors are safe from penetration around the handles and doors. 5.The deficient practice will be remedied by November 30, 2017	11/30/2017

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 12 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 17 residents. Findings include: Based on observations with the Maintenance Assistant #1 on 10/31/17 at 12:05 p.m., a half inch gap around a pipe in the smoke barrier near resident room	K 0372	K372 1.The maintenance director inspected areas around the drop ceiling smoke barriers throughout the building to ensure no other residents would be affected by the deficient practice. The gap around the pipe in the smoke barrier near resident room 221 above the drop ceiling was caulked with fire caulk. 2.The maintenance director inspected the areas around the drop ceiling smoke barriers throughout the building to ensure there is no potential for residents to be affected negatively. 3.The maintenance director or designee will inspect areas around the facility above the drop ceiling to ensure any gaps are caulked with fire caulk. 4.The Maintenance director will	11/30/2017

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	221 above the drop ceiling. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)		monitor areas above the drop ceiling monthly for six months and randomly after to ensure safety and compliance and report to QA monthly on their findings. 5. The deficient practice will be remedied by November 30, 2017.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 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	K 0374	K374 1.The maintenance director replaced the closure on the smoke barrier door near resident room 229 to allow the door to close correctly and safely so no resident would be affected by this deficient practice. 2.To ensure no other residents have the potential to be affected by this deficient practice the maintenance director inspected	11/30/2017

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	restrict the movement of smoke. This deficient practice could affect staff and up to 14 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:06 a.m., the set of smoke barrier doors near resident room 229 caught up on the coordinating device when tested. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the coordinating device prevented one of the doors from closing. 3.1-19(b)		all the smoke barrier doors throughout the building to ensure proper operation and closing of smoke barrier doors. 3.The maintenance director or designee will inspect doors throughout the facility for six months and randomly after to ensure proper operation of smoke barrier doors. 4.The maintenance director or designee will monitor the smoke barrier doors throughout the facility for six months and report the findings to QA. 5.The deficient practice will be remedied by November 30, 2017.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire	K 0712	K712	11/30/2017

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	drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill GLC Fountain View" form with the Maintenance Assistant #1 on 10/31/17 at 9:32 a.m., there was no documentation for a first shift fire drill in the third quarter of 2017. There no was no documentation for a second shift fire drill in the third quarter of 2017. There no was no documentation for a third shift fire drill in the first and second quarter of 2017. Based on interview at the time of record review, the Maintenance Assistant #1 were unable to provide further documentation. 3.1-19(b) 3.1-51(c)		1.The maintenance director finished a drill on each shift at various times from the last drills to ensure all staff have participated in a fire drill to ensure no residents are negatively affected by the deficient practice. 2.The maintenance director identified the potential of other residents being affected by the deficient practice so he completed drills on each shift to ensure no other residents would be affected. (please see attached fire drills) 3.The maintenance director or designee will perform fire drills at unexpected times under varying conditions at least quarterly on each shift. 4.The maintenance director's fire drills and documentation will be monitored for 6 months in QA to ensure compliance and complete understanding of proper and timely fire drills. 5.The deficient practice will be remedied by November 30, 2017.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than			

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	100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 11 of 11 candles was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 63 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 between 10:00 a.m. and 11:30 a.m., the following was discovered: a) the Front Lobby contained a candle with a wick b) the Business office contained a candle with a wick c) the Laundry office contained eight separate candles with wicks d) the Activities room contained a candle with a wick Based on interview at the time of observation, the Maintenance Assistant #1 confirmed a wick was in each of the candles.	K 0753	K753 1.The maintenance director and his assistant ensured all wick were removed from all candles in the facility. The front lobby wicks were pulled out, the business office candle was thrown out, the laundry room office candle was thrown away and the activities candle removed the wick to ensure safety for residents that may be affected by the deficient practice. 2.The maintenance director and his designee rounded to whole building to ensure no candles with wicks exist in our facility. The staff has been in-serviced on a "Standard of Practice" that candles with wicks must not be in the facility. If they should find a candle with a wick it must be reported to the Executive Director or maintenance department immediately bringing the candle with them to ensure no other resident has the potential for harm. (Please see attached in-service.) 3.Measures in place are the "Standard of Practice" and in-service along with monthly	11/30/2017

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	3.1-19(b)		inspection rounds of building ensuring no such candles is found. Findings will be reported to QA for six months. 4.The maintenance director or designee will complete rounds monthly adding candles/wicks to their inspections for six months and randomly after. They will report the findings to QA for six months to ensure the deficient practice does not recur. 5.The deficient practice will be remedied by November 30, 2017.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 2012 Edition, Health Care Facilities Code. NFPA 99, Table 6.4.1.1.16.2(p) requires the control panel-mounted visual safety indicators to illuminate. This deficient practice could affect all occupants. Findings include:	K 0916	K916 1.To ensure residents who were affected by the deficient practice are safe the maintenance director called a professional contractor. Herman and Goetz form South Bend have investigated and are working on an appropriate annunciator panel to be able to check if the indicator lights are burnt out.	11/30/2017

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	Based on an observation with the Maintenance Assistant #1 on 10/31/17 at 10:55 a.m., the generator annunciator panel at the Alzheimer Nurse's station did not have a means to check if indicator lights are burnt out. Based on an interview at the time of observation, the Administrator could not confirm the panel was for the generator and was unaware of a generator annunciator panel in the facility. 3-1.19(b)		2.All resident have the potential to be affected. The professional contractors are involved and working on a solution to ensure there is no more potentially negative affect for the resident and staff. 3.Herman and Goetz will install a new appropriate annunciator panel to be able to check if the indicator lights are burnt out. 4.The maintenance director or designee will monitor the new system for six months reporting there finding of the new annunciator panel to QA. It will be decided after the six months if continued monitoring is needed. 5.The deficient practice will be remedied by November 30, 2017.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	155136	A. BUILDING 01 B. WING	10/31/2017

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This	K 0918	K918 1.The maintenance director or designee will complete and print written record of monthly generator load testing for 12 of the last 12 months and all weekly inspection checks for defective batteries will be readily available to ensure no occupant will be affected by this deficient practice. 2.The maintenance director of designee will complete and print written record of monthly generator lead testing for 12 of the last 12 months and all weekly inspection checks for deficient batteries reports will be readily available to ensure no occupant can be potentially affected by this deficient practice. (please see attached) 3.The maintenance director or designee will complete the	11/30/2017

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	deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 12:45 p.m., no documentation was not available for review. Based on an interview at the time of record review, the Maintenance Assistant #1 acknowledged the lack of documentation. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 52 of 52 weeks. Chapter 8.3.7 of NFPA 99 requires storage batteries, including electrolyte levels or battery voltage, used in connection with essential electrical systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 requires defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection		reports for both concerns above and have written reports printed and readily available for inspection by the authority having jurisdiction. 4.The process of printing reports and having them readily available will be brought to QA by the maintenance director or the designee to ensure the printed copies of both reports are readily available for inspection for six months. 5.The deficient practice will be remedied by November 30, 2017.	

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	by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Assistant #1 on 10/31/17 at 12:45 p.m., no documentation was not available for review. Based on an interview at the time of record review, the Maintenance Assistant #1 acknowledged the lack of documentation. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used			

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	temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug and 5 of 5 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and at least 22 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 between 10:05 a.m. and 11:45 a.m., the following was discovered: a) a surge protector was powering a refrigerator in the MDS office b) an extension cord was powering a laptop in resident room 202 c) an extension cord was powering a television in resident room 205 d) an extension cord was powering a nebulizer in resident room 227	K 0920	K920 1.The maintenance director and the assistant rounded the facility to inspect all resident rooms and common areas to ensure all extension cords or surge protectors used improperly were removed for the safety of all occupants affected by this deficient practice. 2.All surge protectors and extension cords being used inappropriately were removed to ensure no further potential for any occupant to be negatively affected by the deficient practice. 3.The maintenance department will do rounds monthly for six months and randomly after to ensure no extension cords or surge protectors are being used inappropriately throughout the facility but are in accordance to life safety requirements. 4.The maintenance director or designee will report the findings, if any to QA monthly for six months to ensure the deficient practice does not recur. 5.The Deficient practice will be remedied by November 30, 2017.	11/30/2017

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	e) a multiplug adapter powering a cell phone charger in the Central Supply room f) a surge protector was powering a refrigerator in resident room 20 Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged each improper wiring situation. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1. Based on observation and interview, the facility failed to protect 1 of 1 liquid oxygen transfill room. 2012 NFPA 99, Health Care Facilities Code, 11.5.2.3.1(2) states the area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. This deficient practice could affect staff and up to 63 residents open to the 200 Hall Dining room.	K 0927	K927 1.The maintenance director and the assistant completed work on the oxygen transfill room to remedy the three inch by seven feet of laminate flooring coming in from the corridor. A fan was ordered through Granger Supply Company and installed for the oxygen transfill room. The oxygen	11/30/2017

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	Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:25 a.m., the oxygen transfill room contained three inches by seven feet of laminate flooring coming in from the corridor. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the laminate flooring was inside the oxygen transfill room and provided the measurement. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfill room was protected in accordance with 9.3.7.5.3.1. 2012 NFPA 99 9.3.7.5.3.1 requires oxygen transfill mechanical exhaust rooms to maintain a negative pressure continuously. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:14 a.m., the oxygen transfill room fan was not running. The fan was checked with a piece of paper. Based on interview at the time of observation, the Maintenance Assistant #1 was unaware		rooms have been monitored for any free standing oxygen cylinder tanks to ensure occupants were safe from these deficient practices. 2.The maintenance director and the assistant completed the work above to ensure there would be no potential negative affects for occupants. 3.The maintenance director has in-serviced the nursing staff and the central supply staff to ensure understanding of no free standing oxygen cylinders and to be sure they are properly positioned and anchored, the floor is free of any laminate flooring and the fan has been ordered to make sure these deficient practices do not recur. 4.The corrective actions will be monitored for six months and randomly after. The corrective actions will be reported to the QA monthly to ensure the deficient practices do not recur. 5.The deficient practice will be remedied by November 30, 2017	

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	the fan was not working. 3.1-19(b) 3. Based on observation and interview, the facility failed to protect 1 of 3 oxygen cylinders in the oxygen transfill room. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Assistant #1 on 10/31/17 at 10:14 a.m., oxygen transfill room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the unprotected cylinder. 3.1-19(b)			