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	07/20/2015

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: 07/20/15 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 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. 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	This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in 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 requirmements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey. Respectfully Submitted, Jerrell Harvillle, HFA, MSW Executive Director	

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

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	a census of 130 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.			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 3 of 13 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect up to 46 residents and 4 out of 14 smoke compartments. Findings include: Based on observations with the	K 0025	1. Identified Smoke barriers repaired in accordance with Life Safety Guidelines. 2. Smoke Barriers throughout the facility will be reviewed and inspected by Maintenance Director or his designee. 3. Maintenance Director or his Designee will inspect smoke barriers weekly. x 4 weeks, then monthly thereafter. 4. Maintenance Director or designee will continue to inspect and review smoke barriers monthly to ensure compliance. Results will be reviewed monthly during Performance Improvement Meeting x 6 months. 5. Smoke	08/03/2015

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	Maintenance Director on 07/20/15 from 12:45 p.m. to 3:07 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted: a) there was a one half inch ceiling penetration at the Nurse's station in Rainbow. b) there was a one quarter inch ceiling penetration in the Janitor's room in Rainbow. c) there was a three quarter inch penetration in the smoke barrier above the drop ceiling by resident room twenty nine. d) there was a three quarter inch penetration in the smoke barrier above the drop ceiling by resident room ten. e) there was a one half inch penetration in the smoke barrier above the drop ceiling by resident room two. Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration. 3.1-19(b)		barriers will be compliant by 8-3-15.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the			

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	approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 Business Administration office, a hazardous area, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff, visitors, and any residents near the Main Entrance. Findings include: Based on observation on 07/20/15 at 2:33 p.m. with the Maintenance Director, the Business Administration room contained 10 boxes of 5000 sheets of paper, at least 50 binders containing papers, 8 files trays with stacks of paper, and other miscellaneous combustibles. The only door for the Business Administration office contained a self closure, but was held open at the time. Based on interview at the time of observation, the Maintenance Director confirmed that the door does not release with the fire alarm. The Maintenance Director acknowledged the aforementioned condition.	K 0029	1. Business Administration area that was identified will have closure installed that will meet life safety guidelines. 2. All residents and visitors have access to affected area, door closure will remedy this issue for all residents and visitors. 3. No systemic changes were necessary. 4. Door Closure will be included in monthly fire drills to ensure it is functioning properly. 5. Door closure will be installed by independent contractor. Date of compliance will be 8-3-15.	08/03/2015

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	3.1-19(b)			
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill GLC" forms with the Maintenance Director on 07/20/15 at 11:19 a.m., three sequential first shift fire drills took place between 10:04 a.m. and 10:30 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)	K 0050	1. All residents are potentially affected by this deficiency. Fire Drills will be held in accordance with Life Safety Standards. Fire Drills will be held monthly on alternating shifts. 2. Fire Drills will be held in accordance with Life Safety Standards. Fire Drills will be held monthly on alternating shifts. 3. Maintenance Director or his designee will conduct and record fire drills on alternating times and shifts. 4. Fire drills will be reviewed monthly in Performance improvement meeting x 6 months to ensure compliance with regulation. 5. These changes will be implemented by 8/3/15.	08/03/2015

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K 0062 SS=E Bldg. 01	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 Based on record review, observation and interview, the facility failed to replace 50 of 60 corroded sprinklers located outside under the facility's overhung roofs. 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, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect any number of residents, as well as staff and visitors while outside the facility and under the overhung roofs. Findings include: Based on record review with the Maintenance Director on 07/20/15 during paperwork review time between 10:37 a.m. and 12:24 p.m., the Maintenance Director provided documentation with a price quote to replace corroded sprinkler heads. Based on observation between	K 0062	1. Sprinkler systems will be continually maintained in reliable operating condition and will be tested and inspected to ensure compliance. 2. All residents are potentially affected, therefore Sprinkler systems will be continually maintained in reliable operating condition and will be tested and inspected to ensure compliance. 3. Facility will contract for sprinkler system inspection and replacement of all identified deficiencies. (see attached documentation) 4. Maintenance director or his designee will perform monthly inspections of sprinkler system to ensure compliance with regulations. These inspections will be reviewed monthly in Performance Improvement meeting x 6 months to ensure compliance. 5. These changes will be completed by 9/4/15. As this is first availability of contractor.	09/04/2015

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	1:12 p.m. and 3:41 p.m., each exterior exit observed had sprinkler heads that were corroded with a green substance. Based on interview at the time of the observations, the Maintenance supervisor acknowledged the condition of the sprinkler heads. 3.1-19(b)			
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 Memory Dining Hall portable fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect up to 18 residents and staff in Memory Dining Hall. Findings include:	K 0064	1. The identified extinguisher was replaced immediately by a extinguisher that was in compliance with regulations. 2. All residents were potentially affected, therefore all extinguishers were checked to ensure compliance with regulations. 3. All fire extinguishers are inspected monthly to ensure regulatory compliance. 4. Maintenance Director or his Designee will report findings monthly x 6 months to the performance improvement committee. 5. These changes will be completed and in place by 8/3/15.	08/03/2015

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	Based on observation with the Maintenance Director on 07/20/15 at 2:15 p.m., the gauge on the portable fire extinguisher located in the Memory Dining Hall indicated the extinguisher was overcharged. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0067 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure 3 of 3 fire/smoke dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers	K 0067	1. SafeCare, and independent contractor repaired identified Smoke Dampers.2. SafeCare inspected all smoke dampers to ensure compliance with life safety code. 3. Smoke dampers are scheduled to be inspected by SafeCare every 4 years in order to maintain compliance with Life Safety Code.4. Maintenance Director or his Designee will record and maintain records related to damper inspections. 5. These changes will be complete by 8/3/15.	08/03/2015

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	shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility. Findings include: Based on record review with the Maintenance Director on 07/20/15 at 10:48 a.m., the last inspection for the three dampers in the facility was 01/14/11. Based on an interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0076 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen containers in Rainbow was stored	K 0076	1. Liquid oxygen tanks were removed from identified areas and placed in Oxygen room that	08/03/2015

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	in a protected enclosure with continuous mechanical ventilation. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)requires at least one hour fire-resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice could affect up to twenty residents and staff. Findings include: Based on an observation with the Maintenance Supervisor on 07/20/15 at 12:43 p.m., a stationary liquid oxygen unit was observed in the soiled utility room. The soiled utility room was not provided with a mechanically operated fan/vent. Based on interview at the time of observation, the Maintenance Supervisor immediately wheeled the liquid oxygen container out of the room into the liquid oxygen storage room while telling me that the oxygen container should not be in the soiled utility room. 3.1-19(b)		meets Life Safety Code regulations. 2. Facility rounds conducted to ensure that oxygen canisters were stored in approved location. 3. Oxygen tanks, not in use, will be stored in approved locations. Staff members will be provided with inservice training related to proper storage of Oxygen. 4. Maintenance Director or designee will make weekly rounds to ensure proper oxygen storage. Rounds will be reviewed monthly x 6 months in Performance improvement meeting to monitor compliance. 5. Systemic changes will be complete by 8/3/15	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the	K 0147	1. identified flexible cords have	08/03/2015

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	facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 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 up to 2 residents as well as staff and visitors in the Social Services office and MDS office. Findings include: Based on observation with Maintenance Director on 07/20/2015 between 1:05 p.m. to 1:46 p.m. the following was discovered: a) an extension cord powering a fan in resident room ten. b) a coffee pot plugged into a power strip in the Social Services office c) a refrigerator plugged into a power strip in the MDS office. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		been removed. 2. Maintenance Director or designee will make rounds weekly x 6 weeks to monitor for use of flexible cords as fixed wiring. Any identified cords will be removed. 3. Maintenance Director or designee will make rounds weekly x 6 weeks to monitor for use of flexible cords as fixed wiring. 4. Rounds will be reviewed in Performance Improvement meeting x 6 months to ensure continued compliance. 5. These changes will be complete by 8/3/15.	