STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN 47304

(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: 01/19/17 Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970 At this Life Safety Code survey, Golden Living Center-Muncie 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 (111) construction and was fully sprinklered. 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 117 and had a census of 92 at the time of this survey.	K 0000	This plan of correction constitutes the facility's written allegation of compliance; however, the is not an admission that a deficiency existed or that one was cited. The plan of correction is being submitted to meet the requirements of state and federal law.	

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

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage for facility storage which was not sprinklered. Quality Review completed on 02/02/17 - DA			
K 0325 SS=B Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418,			

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	460, 482, 483, and 485 Based on observation and interview, the facility failed ensure alcohol-based hand-rub dispensers were not mounted directly over or adjacent to an ignition source. This deficient practice could affect as many as10 residents, 3 staff and 2 visitors. Findings include: Based on observation on 01/19/17 at 12:45 p.m. with the Maintenance Supervisor, the alcohol-based hand-rub dispenser on the wall inside the Activity room on the C wing was mounted directly over a light switch. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the aforementioned condition, and immediately moved the dispenser. The location was then rechecked prior to my exit of the facility, and the location it was moved to was found to be satisfactory. 3.1-19(b)	K 0325	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents were assessed. No residents were found to be affected by the alleged deficient practice. The Alcohol Based Hand Rub Dispenser was immediately removed from the wall while the Life Safety Code Surveyor was present in the Activity Room. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents were assessed. No residents were found to be affected by the alleged deficient practice. The Alcohol Based Hand Rub Dispenser was immediately removed from the wall while the Life Safety Code Surveyor was present in the Activity Room 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff have been in serviced on Alcohol Based Hand Rub Dispensers including corridor size, individual dispenser capacity, horizontal spacing,	02/10/2017

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			storage per smoke compartment, placement over carpeted floors, alcohol content, and compliance with standards. The Maintenance Director or designee will complete ABHR Dispenser rounds weekly for 3 months, then quarterly for 3 months. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI Committee Recommendations. If there are no trends identified this item will be reviewed on a prn basis. 4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director or designee will complete ABHR Dispenser rounds weekly for 3 months, then quarterly for 3 months. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI recommendations. If there are no trends identified this item will be reviewed on a prn basis. 5.) By what date the systemic changes will be completed? February 10, 2017	

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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 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	K 0363	1.) What corrective action(s) will	02/10/2017

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	facility failed to ensure 3 of over 100 doors to the corridor within the facility would completely resist the passage of smoke. This deficient practice could affect approximately 8 residents, 2 staff and 2 visitors. Findings include: Based on observation on 01/19/17 during a tour of the facility with the Maintenance Supervisor between the hours of 11:15 a.m. to 1:01 p.m., the following was noted: 1) the Med room door on the ACU unit had two three-eighths inch holes, one above the handle and one below the handle, to the door that opened to the corridor. 2) the shower room door on the Step-up unit had two three-eighths inch holes, one above the handle and one below the handle, to the door that opened to the corridor. 3) resident room #201 on the 200 wing had two three-eighths inch holes, one above the handle and one below the handle, to the door that opened to the corridor. Based on interview at the times of the observations, the Maintenance Supervisor acknowledged all of the aforementioned		be accomplished for those residents found to have been affected by the deficient practice? All residents were assessed with no residents found to have been affected by the alleged deficient practice. Metal door plates were ordered and placed behind the door handles to seal the openings from the prior screws to completely resist the passage of smoke. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents were assessed with no residents found to have been affected by the alleged deficient practice. Metal door plates were ordered and placed behind the door handles to seal the openings from the prior screws to completely resist the passage of smoke. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All corridor doors were inspected to verify that the doors were intact to resist the passage of smoke. No other doors were found to be affected. The Maintenance Director will complete door audits	

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	items, and gave the measurements of the holes above and below the door handles. 3.1-19(b)		weekly for one month, then monthly for 6 months to track for trends. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI Committee recommendations. If there are no trends identified this item will be reviewed on a prn basis. 4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All corridor doors were inspected to verify that the doors were intact to resist the passage of smoke. No other doors were found to be affected. The Maintenance Director will complete door audits weekly for one month, then monthly for 6 months to track for trends. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI Committee recommendations. If there are no trends identified this item will be reviewed on a prn basis. 5.) By what date the systemic changes will be completed? February 10, 2017	
K 0372	NFPA 101			

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SS=E Bldg. 01	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 5 smoke barrier walls was 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 one hour fire resistive rating. This deficient practice could affect as many as 20 residents, 4 staff and 4 visitors. Findings include: Based on observations with the Maintenance Supervisor on 01/19/17 between 1:03 p.m., a one inch diameter unsealed penetration that had four wires	K 0372	1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents were assessed with no residents found to have been affected by the alleged deficient practice. Fire Barrier Puddy was used to seal the opening around the computer wires that had been installed the prior week. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents were assessed with no residents found to have been affected by the alleged deficient practice. Fire Barrier Puddy was used to seal the opening around the computer wires that had been installed the prior week.	02/10/2017

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	passing through it and a three inch diameter unsealed penetration that had ten wires passing through it was discovered in the service hall barrier by the laundry room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement for the penetrations. 3.1-19(b)		3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The smoke barriers were inspected to verify the barriers were intact. No other breaches through the walls were found. The Maintenance Director or designee will complete smoke barrier wall audits weekly for 1 month, then monthly for 6 months to track for trends. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI Committee recommendations. If there are no trends are identified this item will be reviewed on a prn basis. 4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The smoke barriers were inspected to verify the barriers were intact. No other breaches through the walls were found. The Maintenance Director or designee will complete smoke barrier wall audits weekly for 1 month, then monthly for 6 months to track for trends. Audit results will be forwarded to the QAPI Committee each month for 6 months to track for trends. If any trends are identified in QAPI	

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			then audits will be conducted per QAPI Committee recommendations. If there are no trends are identified this item will be reviewed on a prn basis. 5.) By what date the systemic changes will be completed? February 10, 2017	