

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2017
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/24/17</p> <p>Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260</p> <p>At this Life Safety Code survey, Golden Living Center-Knox was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms were provided with battery powered smoke detectors. The facility has the capacity for 57 and had a census of 48 at the time</p>	K 0000	This Plan of Correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0374 SS=E Bldg. 01	<p>f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)</p> <p>Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/24/17 at 11:31 a.m., the Laundry room contained fuel-fire dryers. When the Laundry corridor door was tested, the door failed to latch into the frame. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING</p>	K 0321	<p>1. Laundry Room door was repaired to latch into the door frame on 1-24-2017.</p> <p>2. All service area self-closing doors were checked to ensure proper latching into door frames with no additional findings. (Attachment 1) Maintenance and Housekeeping staff was in-serviced on regulation K321. (Attachment 2)</p> <p>3. Service area self-closing doors will be checked by Maintenance Director or Designee 1 time a week for 2 months, then 2 times monthly for 2 months, then 1 time monthly for 2 months.</p> <p>4. Results of the audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends, then will review on PRN basis.</p> <p>5. Completion date: February 23, 2017.</p>	02/23/2017	

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	<p>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.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 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 restrict the movement of smoke. This deficient practice could affect staff and at least 35 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/24/17 at 11:01 a.m., the set of smoke barrier doors by resident room 10 got caught on the coordinating device when tested. Based on interview at the time of</p>	K 0374	<p>374 1. Coordinating devise on the identified door was repaired on 1-24-2017.</p> <p>2. The additional 2 sets of Smoke Barrier door coordinating devises were checked and were functioning properly. (Attachment 3) Maintenance Director was in-serviced on K 374. (Attachment 4)</p> <p>3. Functioning of the 3 sets of Smoke Barrier door coordinating device will be checked by Maintenance Director or Designee 1 time a week for 2 months, then 2 times monthly for 2 months, then 1 time monthly for 2 months.</p> <p>4. Results of the audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends, then will review on PRN basis.</p> <p>5. Completion date: February</p>	02/23/2017

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K 0753 SS=E Bldg. 01	<p>observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>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 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Activities 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 31 residents.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director on</p>	K 0753	<p>23, 2017.</p> <p>1. The identified candle in the Activity area was removed from the facility on 1-24-2017.</p> <p>2. All resident rooms, staff and service areas were checked for candles on 1-25-2017 and no additional candles were located. (Attachment 5) All staff was in-serviced on K 753 combustible decorations. (Attachment 6)</p> <p>3. Maintenance Director or Designee will check all staff and services areas for combustible</p>	02/23/2017			

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K 9999 Bldg. 01	<p>01/24/17 at 11:51 a.m., the Activities room contained a candle with a wick. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>				<p>decorations 1 time a week for 2 months, then 2 times monthly for 2 months, then 1 time monthly for 2 months. Department Heads or Designee will check resident rooms via Guardian Angel Program 1 time a week for 2 months, then 2 times monthly for 2 months, then 1 time monthly for 2 months.</p> <p>4. Results of the audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends, then will review on PRN basis.</p> <p>5. Completion date: February 23, 2017</p>		
	<p>Based on observation and interview, the facility failed to maintain 2 of 20 single station smoke detectors per manufacturer's recommendation. 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not</p>			K 9999	<p>1. Smoke detectors were ordered and installed immediately upon receipt on 1-26-2017.</p> <p>2. 100 % audit of all resident rooms was completed on 1-25-2017 and all have the required smoke detectors. (Attachment 7) All staff was in-serviced regarding the requirement for resident room smoke detectors. (Attachment 6)</p> <p>3. Resident rooms will be checked via the Guardian Angel Program 2 times a month for 4</p>		02/23/2017

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	<p>installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident ' s room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to install smoke detectors in each of the 55 resident ' s room. This deficient practice could affect staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Director on 01/24/17 at 11:12 a.m. then again at 12:00 p.m., resident room 13 did not have a smoke detector or smoke alarm installed. Then again, resident room 30 did not have a smoke detector or smoke alarm installed. Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned condition.</p>		<p>months, then 1 time monthly for 2 months.</p> <p>4. Results of the audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends, then will review on PRN basis.</p> <p>5. Completion date: February 23, 2017.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-19(b)				