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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/12/19 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Golden Living Center - Bloomington was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 153 certified beds. At the time of the survey, the census was 122. Quality Review completed on 08/13/19 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	The submission of this *Plan of Correction* does not indicate an admission by Golden Living of Bloomington (the "Facility") that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living (of Bloomington). The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities (for Title 16/17 programs). To this end, this *Plan of Correction* shall serve as a **credible allegation of compliance** with all state and federal requirement governing the management of this Facility. It is thus submitted as a matter of statute *only*.	
E 0031 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants.	E 0031	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:**	09/11/2019

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on review of "Emergency Action Plan" and "Facility Wide Assessment" documentation with the Executive Director and the Director of Maintenance during record review from 9:55 a.m. to 1:45 p.m. on 08/12/19, the emergency preparedness plan did not include contacting the Indiana State Department of Health (ISDH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. Based on interview at the time of record review, the Director of Maintenance agreed the plan did not include the correct telephone contact information for the aforementioned emergency preparedness source of assistance for emergency incidents that require a full or partial evacuation.		**E 031:** It shall be the policy of Golden Living (of Bloomington) to insure there is an “Emergency Preparedness Communication Plan” that complies with all current regulatory requirements. I-II) The “Emergency Action Plan” will be revised to include contact with the Indiana State Department of Health when a full and/or partial evacuation is required. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Action Plan" and "Facility Wide Assessment" documentation with the Executive Director and the Director of Maintenance during record review from 9:55 a.m. to 1:45 p.m. on 08/12/19, documentation on staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Executive Director and the Director of Maintenance stated staff training on emergency preparedness is done at the time of orientation for new hires and annually for existing employees on computer but training log documentation on the emergency preparedness program within the most recent twelve month	E 0037	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **E 037** It shall be the policy of Golden Living (of Bloomington) to insure that “Emergency Preparedness Training” is conducted according to all current regulatory requirements with full evidentiary documentation available to demonstrate manifest compliance. I-II) All staff will be trained on “Emergency Preparedness” and/or related policies, procedures and protocols within a 12-month practicing interval. Evidentiary documentation will be prepared and available to demonstrated staff participation and ascertation of applicable skill set. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	period was not available for review at the time of the survey.		similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B)	E 0039	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 039:** It shall be the policy of Golden Living (of Bloomington) to test all emergency planning contingencies according to all regulatory parameters, requirements and guidelines. I-II) The Facility will conduct “Emergency Preparedness” drills at least twice annually. Staff participation will be documented	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Action Plan" and "Facility Wide Assessment" documentation with the Executive Director and the Director of Maintenance during record review from 9:55 a.m. to 1:45 p.m. on 08/12/19, documentation for testing the facility's emergency preparedness program twice within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility did a community based disaster drill with Lawrence County emergency management officials but a documented community based disaster drill, tabletop exercise or a documented natural or man-made emergency that requires activation of the emergency plan within the most recent twelve month period was not available for review at the time of the survey.		forthwith. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
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 483.90(a).	K 0000	The submission of this *Plan of Correction* does not indicate an admission by Golden Living of Bloomington (the "Facility") that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Survey Date: 08/12/19 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Golden Living Center-Bloomington was found not in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 122 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/13/19		the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living (of Bloomington). The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities (for Title 16/17 programs). To this end, this *Plan of Correction* shall serve as a **credible allegation of compliance** with all state and federal requirement governing the management of this Facility. It is thus submitted as a matter of statute *only*.	
K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. 1. Based on observation and interview, the facility failed to maintain protection of 2 of 2 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the following was noted: a. a two inch by one inch rectangular shaped hole was noted in the stairwell ceiling above the main fire panel in the stairwell by Room 116. In addition, the annular space surrounding sprinkler piping which penetrated the ceiling of the stairwell above the fire panel was not firestopped. The ceiling of the stairwell consisted of two layers of five-eighths inch thick drywall. b. the wall above the suspended ceiling above the corridor door set by Room 143 did not extend to the roof deck above. The door set and the cross corridor wall is part of the stairwell. In addition,	K 0311	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K311:** It shall be the policy of Golden Living (of Bloomington) to insure that all stairways, elevator shafts, ventilation shafts, chutes and other vertical openings are enclosed with materials having at least a 1-hour fire resistance rating. I-II) All identified failures (of this regulatory requirement), including the interior stairwells, and areas adjacent to room # 143 will be repaired and/or replaced with materials having at least a 1-hour fire resistance rating. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the ceiling of the stairwell consisted of suspended ceiling tiles and exposed the metal decking and unprotected structural supports of the stairwell vertical opening. Based on interview at the time of the observations, the Director of Maintenance stated he may have fire resistance rating documentation for the suspended ceiling tiles in a box but it was not available for review at the time of the survey and agreed the aforementioned openings in the stairwells wall did not enclose the vertical openings with a minimum 1-hour fire resistance rating. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 4 vertical openings. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the stairwell by Room 116. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the following was noted inside the dumbwaiter vertical opening which is inside the stairwell by Room 116: a. three holes were noted in the ceiling of the dumbwaiter shaft which exposed the metal		Assurance Committee will be informed as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	decking of the roof. b. the annular space surrounding a horizontal sprinkler pipe which penetrated the east wall of the dumbwaiter vertical opening near the top of the shaft was not firestopped. c. a two foot by two foot section of the ceiling of the dumbwaiter vertical opening was missing one layer of five-eighths inch thick drywall which exposed the wood studs for the ceiling construction. Except for this missing section of drywall, the ceiling of the dumbwaiter shaft consisted of two layers of five-eighths inch thick drywall. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned openings and missing drywall in the dumbwaiter did not enclose the vertical opening with a minimum 1-hour fire resistance rating. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 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 or 19.3.5.9. When the approved automatic fire extinguishing system option is 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation 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 K322)			
	Based on observation and interview, the facility failed to ensure 1 of 9 hazardous areas such as trash collection rooms exceeding 64 gallons were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the Main Dining Room. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the entrance door to the kitchen from the Main Dining Room was equipped with a self closing device but the door failed to self close when tested to close multiple times. The bottom of the door hit the threshold on the floor on the hinge side of the door and was stuck to the floor for half the entire swing of the door when forcibly tested to close. In addition, air	K 0321	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K321:** It shall be the policy of Golden Living (of Bloomington) to insure that all hazardous areas are protected by a 1-hour fire resistance barrier and/or an approved automatic fire extinguishing system. Self-closing smoking partitions may be used as permitted by regulatory requirement. I-II) The self-closing door (in the kitchen) will be adjusted and/or repaired so that it effectively closes as per regulatory	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	flow through the opening for the kitchen door also caused the door to not self close when tested to close multiple times. The kitchen contained over two 44 gallon carts for trash. Based on interview at the time of the observations, the Director of Maintenance agreed the bottom of the door hit the threshold on the floor and had an impediment to closing, latching and did not separate this hazardous area from other spaces by smoke resistant partitions and doors. 3.1-19(b)		requirement. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
K 0324 SS=D 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 Based on observation and interview, the facility failed to ensure 1 of 8 kitchen exhaust system	K 0324	**The Facility is respectfully requesting a "Desk Review" for**	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	baffles were installed correctly. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 6.2.3.3 states grease filters shall be arranged so that all exhaust air passes through the grease filters. Section 6.2.3.5 states grease filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, one of eight baffles positioned in the middle of the horizontal row of baffles installed in the kitchen range hood was forcibly pulled upward near the top of the baffle when the kitchen range hood fan was in operation. The uplifting of the baffle by the air movement caused by fan operation created a large gap for kitchen range hood exhaust air to bypass the grease filter. When the kitchen range hood fan was turned off by the Director of Maintenance the baffle fell back into the correct position in the row of baffles. Based on interview at the time of the observations, the Director of Maintenance agreed one of eight baffles in the kitchen range exhaust hood was not aligned correctly when the kitchen range hood fan was in operation. 3.1-19(b)		**the following Plan of Correction:** **K 324:** It shall be the policy of Golden Living (of Bloomington) to insure that all cooking equipment is protected in accordance with NFPA 96: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. I-II) All kitchen exhaust system baffles will be repaired to operate according to regulatory requirements. This includes insuring all are aligned correctly with the range hood so that the range fan is fully functional. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). ______________________			
	Based on record review, observation and interview; the facility failed to ensure 2 of 9 corridors and 1 of over 50 rooms were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect over 10 residents, staff and visitors. Findings include:	K 0331	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 331:** It shall be the policy of Golden Living (of Bloomington) to insure that all interior wall and ceiling finishes have a Flame Spread rating of Class A or Class B. I-II) The identified corridors (and room) will be provided an interior finish with a Flame Spread rating of Class A or Class B. At the same time, the identified cedar shingles, wallpaper coverings, and plywood installation will be replaced and/or protected with an approved flame spread material. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review with the Executive Director and the Director of Maintenance from 9:55 a.m. to 1:45 p.m. on 08/12/19, interior finish flame spread rating documentation was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the following was noted: a. cedar wood shingles were installed on the corridor wall above the entrance door to the Alzheimer's Care Office in the Horizons Wing. b. wallpaper was installed on the corridor walls below the handrails outside Room 17 in the Horizons Wing and in the Horizons Lounge. c. plywood was installed behind a water heater on one wall from of the Station 1 Mechanical Room from the floor to the ceiling. Based on interview at the time of the observations, the Director of Maintenance stated flame spread rating documentation was not available for review, he was not aware if interior finishes in the facility had been treated with flame retardant material and agreed interior finish flame spread rating documentation for the interior finishes was not available for review. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, one ceiling mounted sprinkler in the closet of the Functional Living Center and one ceiling mounted sprinkler in the closet of the Therapy Gym were each missing its escutcheon. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned two sprinkler locations were each missing its escutcheon. 3.1-19(b)	K 0351	**K351:** It shall be the policy of Golden Living (of Bloomington) to insure that all areas are protected throughout by an approved automatic sprinkler system - in accordance with NFPA 13. I-II) Regulatory approved and required ceiling sprinkling devices will be installed in the in the Functional Living Center and the closet of the Therapy Gym as identified. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 4 of over 50 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the following was noted: a. two screws were affixed to the door stop in the door frame above and below the latching plate for the door on the room side of the door to resident Room 33 which prevented the door from fully closing and latching into the door frame. b. the latching mechanism for the corridor door to resident Room 148 failed to protrude into the latching plate when tested to close multiple times. c. the corridor door to the former Men's restroom by the Main Dining Room had two one quarter inch diameter holes above and below the door handle which would not resist the passage of smoke. d. the corridor door to the former Women's restroom by the Main Dining Room had two one quarter inch diameter holes above and below the door handle which would not resist the passage of smoke. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor doors had an impediment to closing, latching or would not resist the passage of smoke. 3.1-19(b)	K 0363	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 363:** It shall be the policy of Golden Living (of Bloomington) to insure that all doors have no impediment to closing, latching, and resist the passage of smoke. I-II) All identified doors will be affixed so that there is no impediment to free closing and that each does not enable the passage of smoke. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 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 1 of 8 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 over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, a two inch in diameter hole for the passage of cables was noted in the smoke barrier wall above the suspended ceiling above the smoke barrier door set by the E Hall nurse's station for Rooms 101 through 116. Based on interview at the time of observation, the Director of Maintenance agreed the aforementioned hole in the smoke barrier wall did not maintain the fire resistance rating of the wall.	K 0372	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 372:** It shall be the policy of Golden Living (of Bloomington) to insure that all smoke barrier walls are protected and maintain the smoke resistance of each smoke barrier. I-II) The smoke barrier wall (above the suspended ceiling) – at E Hall Nurses Station (Rooms 101-116) will be repaired to prevent the passage of smoke and insure the fire resistance rating of the same according the requirements of NFPA 101.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-19(b)		III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			
	1. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors.	K 0511	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 511:** It shall be the policy of Golden Living (of Bloomington) to insure that all energized electrical parts and/or panels are secured from non-authorized personnel. I-II) All identified electrical panels will be secured from non-authorized personnel. At the same time, all resident sleeping	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, electrical panels in the corridor outside the Horizon Television Lounge, outside Room 4, Room 19, Room 117, Room 119, Room 135 and Room 145 were not locked. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned electrical panels in the corridor were not secured from non-authorized personnel. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure receptacles in 1 of over 50 resident sleeping rooms did not have reversed polarity in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 200.11 states no grounded conductor shall be attached to any terminal or lead so as to reverse the polarity. This deficient practice could affect two residents in Room 22. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, two of two electrical receptacles in the wall mounted outlet box nearest the resident bed by the window in Room 22 were found to have reversed polarity when tested with an Etcon UL listed circuit tester testing device. Based on interview at the time of the		rooms will not utilize reverse polarity receptacle devices. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	observations, the Director of Maintenance stated he has a similar receptacle testing device and agreed the aforementioned receptacle location had reversed polarity when tested with the Etcon device. 3.1-19(b)			
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 expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first, second and third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Executive Director and the Director of Maintenance from 9:55 a.m. to 1:45 p.m. on 08/12/19, documentation of a fire drill conducted on the first, second and third shift in the third quarter (July, August, September) 2018 and fourth quarter (October, November, December) 2018 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the	K 0712	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 712:** It shall be the policy of Golden Living (of Bloomington) to conduct fire drills at unexpected times and under various conditions. I-II) The Facility will conduct fire drills on various shifts and thereafter maintain documentation of the same as required.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	facility conducted fire drills on each shift in the third and fourth quarter 2018 but stated documentation of a fire drill conducted on the aforementioned shifts and quarters was not available for review at the time of the survey. 3.1-19(b)		III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	**K 761:** It shall be the policy of Golden Living (of Bloomington) to insure all fire doors are inspected, tested and maintained (for full functionality) as directed by NFPA 80. I-II) All rated fire doors will be inspected at least annually with requisite and supporting documentation maintained therein. This includes the rolling fire door at the kitchen serving window. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Executive Director and the Director of Maintenance from 9:55 a.m. to 1:45 p.m. on 08/12/19, annual fire door inspection documentation for the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	stated the facility has one rolling fire door in a kitchen serving window, annual inspection documentation is kept at the window, a contractor performs other annual fire door inspections but agreed annual fire door inspection documentation for the facility within the most recent twelve month period was not available for review at the time of the survey. Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the facility has one rolling fire door in a kitchen serving window for the Main Dining Room. The Main Dining Room was open to the corridor. Annual inspection documentation within the most recent twelve month period was not affixed to the rolling fire door. In addition, the facility also has rated fire doors for 2 of 2 oxygen storage and transfilling rooms and all stairwell entry doors. Based on interview at the time of the observations, the Director of Maintenance agreed the facility had fire doors located in the facility and fire door inspection documentation within the most recent twelve month period was not available for review at the time of the survey. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all patient bed locations in all resident sleeping rooms within the most recent twelve month period was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter.	K 0914	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction**: **K 914:** **It shall be the policy of Golden Living (of Bloomington) to insure energized bed side receptacles are inspected and tested in accordance with the regulatory parameters articulated in NFPA 101.** I-II) All energized bed side receptacles will be inspected and tested at least annually with requisite and supporting documentation maintained therein. At the same time, hospital-grade receptacles will be provided in resident sleeping areas where required. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	This could affect all residents. Findings include: Based on record review with the Executive Director and the Director of Maintenance from 9:55 a.m. to 1:45 p.m. on 08/12/19, documentation of an itemized listing of electrical outlet receptacle testing at all patient bed locations within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated receptacle testing was performed within the last year and documented on a computer database but agreed documentation of an itemized listing of electrical outlet receptacle testing at all patient bed locations within the most recent twelve month period was not available for review at the time of the survey. Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, electrical receptacles installed in resident sleeping rooms at patient bed locations were nonhospital-grade receptacles. Based on interview at the time of the observations, the Director of Maintenance agreed nonhospital-grade receptacles were installed in the patient care vicinity in each resident sleeping room. 3.1-19(b)		Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 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, readily identifiable, and separate from normal power circuits. 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) Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors.	K 0918	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 918:** **It shall be the policy of Golden Living (of Bloomington) to insure current protective devices - in the Emergency Power Supply Systems (EPPS) -**	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, one of one emergency generator transfer switches located outside the facility on the west side of the building near the parking lot was in an unlocked detached weatherproof storage cabinet. Based on interview at the time of the observations, the Director of Maintenance agreed the emergency generator transfer switch was in an unlocked detached weatherproof storage cabinet outside the facility. 3.1-19(b)		**are accessible to authorized only.** I-II) The detached weatherproof storage cabinet - in which the Emergency Generator Transfer switch is located - will be secured as required. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	wiring of a structure. Extension cords used 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 8 of 8 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 30 residents, staff and visitors. Findings include:	K 0920	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 920:** It shall be the policy of Golden Living (of Bloomington) to insure that electrical power strips - in patient care vicinities - are used exclusively for components of movable patient-care-related equipment (PCREE). I-II) The identified power strips will be re-evaluated and utilized for PCREE tasks only. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, the following was noted: a. an operating oxygen concentrator, a fan and a television were plugged into a power strip on the floor within three feet of the resident bed nearest the window in Room 2. The UL listing of the power strip could not be determined. b. a power strip was affixed to the wall one foot from the resident bed nearest the window in Room 24. The UL listing of the power strip could not be determined. c. a refrigerator was plugged into a power strip on the floor in Room 135 within six feet of the resident bed in Room 135. The UL listing of the power strip could not be determined. d. two cell phone chargers were plugged into a power strip placed on top of a chest of drawers one foot from the resident bed nearest the corridor door in Room 137. Two televisions were also plugged into a power strip on the floor three feet from the resident bed nearest the window in Room 137. The UL listing of the power strips could not be determined. e. an Omnicycle therapy machine was plugged into a power strip placed on a stand in the Therapy Gym near the Functional Living Center. The UL listing of the power strip could not be determined. f. a microwave oven and a coffee pot were plugged into a power strip which was plugged into a second power strip in the pantry by the Alzheimer's Care Office. g. two of three hair dryers were plugged into a power strip which was plugged into the wall in the Salon. Based on interview at the time of the observations, the Director of Maintenance stated resident families keep bringing in power strips and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	extension cords which he removes but agreed power strips were being used in the patient care vicinity and as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 2 oxygen storage and transfilling rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by Room 13. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:45 p.m. to 4:20 p.m. on 08/12/19, six of 24 'E' type oxygen cylinders were freestanding on the floor inside the oxygen storage and transfilling room located near Room 13 and were not supported in a proper cylinder stand or otherwise secured from falling. Six liquid oxygen containers and 24 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the	K 0923	**The Facility is respectfully requesting a "Desk Review" for the following Plan of Correction:** **K 923:** It shall be the policy of Golden Living (of Bloomington) to insure all storage units - of nonflammable gases – are secured and stored according to the parameters articulated through NFPA 101. I-II) All oxygen storage cylinders will be supported and maintained in an appropriate security device throughout. III-IV) The Executive Director will report to the Quality Assurance Committee that this deficient practice has been resolved. The Maintenance Director will monitor similar occurrences in the future and report the same to the Executive Director. The Quality Assurance Committee will be informed as needed.	09/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 01 B. WING	08/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	observations, the Director of Maintenance agreed the aforementioned oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling. 3.1-19(b)			