STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155138	A. BUILDING -- B. WING	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/12/21 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Emergency Preparedness survey, Golden Living Center - Indianapolis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 115 certified beds. At the time of the survey, the census was 62. Quality Review completed on 08/25/21	E 0000	Please accept this plan of correction as our facility's credible allegation of compliance for our life safety code and emergency preparedness survey conducted on August 12th, 2021. Submission of this plan of correction is not an admission by Golden LivingCenter-Indianapolis that the deficiencies alleged in the survey are accurate or that they depict the quality of care and service provided to the residents of our facility. This plan of correction is submitted solely because doing so is required by the state and federal law. Golden Living Centers – Indianapolis is respectfully requesting paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/12/21 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Life Safety Code survey, Golden Living	K 0000	Please accept this plan of correction as our facility's credible allegation of compliance for our life safety code and emergency preparedness survey conducted on August 12th, 2021. Submission of this plan of correction is not an admission by Golden LivingCenter-Indianapolis that the deficiencies alleged in the survey are accurate or that they depict the quality of care and	

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

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	Center-Indianapolis was found not in 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 basement was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors 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 115 and had a census of 62 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/25/21		service provided to the residents of our facility. This plan of correction is submitted solely because doing so is required by the state and federal law. Golden Living Centers – Indianapolis is respectfully requesting paper compliance.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 5 of 5 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents and visitors needing to exit the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/12/21 from 12:18 p.m. through 2:40 p.m., the following exit doors were marked as a facility exit, were magnetically locked and could not be opened without a facility furnished access card: A. the main entry / exit in the lobby area B. the A wing "short hall" emergency exit C. the kitchen entry / exit D. the rear entrance / exit E. the B wing "short hall" emergency exit Based on an interview at the times of the aforementioned observations, the Maintenance Director advised that the facility was part of a pilot program, and they removed the numbered keypads and replaced them with a card access	K 0222	1. What corrective actions will be accomplished for those residents found to have been affected by this alleged deficient practice: A delayed egress feature and 15 second delayed egress sticker will be added to all exterior doors to allow egress. An audit will be completed for all exterior doors to ensure 15 second egress feature functions properly and the 15 second delayed egress sticker is in place. 2. How will identify related safety features having the potential to be affected by the same deficient practice and what corrective actions will be taken. This deficient practice have the potential to be affected all residents, staff, and visitors. 3. How measures will be put into place or what systemic changes you will make to ensure that the deficiency does not recur Delayed egress function and delayed egress feature will be monitored using the Building engines system under door	09/05/2021

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	pad. This makes posting the door codes useless as there is no keypad to punch the door exit codes into. Furthermore, these doors were not set up with a 15 second delay egress doors either making it impossible for anyone without an access card to exit the facility once they are inside in case of an emergency. During the exit conference with the facility Administrator and the Maintenance Director at 2:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		checks which occur daily during regular maintenance hours by maintenance director, and/or designee. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place including time frames and person (s) responsible Maintenance Director, and/or designee will check the egress feature of each exit doors and monitor the documentation through Building Engines daily x6 weeks, and then weekly x6 months. All audit results will be addressed in monthly QAPI meetings. 5. A plan of correction completion date has been provided - September 5th, 2021. 6. Please see Exhibit A	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors			

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	are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 9 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 16 residents, 2 staff and 1 visitor on the A wing "short hall". Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/12/21 at 12:35 p.m., the set of barrier doors located near resident rooms #17 and #18 on the A wing "short hall" failed to fully close when tested on three separate occasions leaving a two-inch gap when closed to their fullest. Based on interview at the time of observation, the Maintenance Director acknowledged these barrier doors as failing to fully close adding that he tests the doors weekly and they were just tested and functioned properly, but he would adjust them and get them to fully close as soon as he could. 3.1-19(b)	K 0374	1. What corrective actions will be accomplished for those residents found to have been affected by this alleged deficient practice: The set of barrier doors located near the resident rooms #17 and #18 on A wing was adjusted fully closed and there as no two-inch gap after the adjustment. 2. How will identify related safety features having the potential to be affected by the same deficient practice and what corrective actions will be taken. This deficient practice has the potential to be affected all residents, staff, and visitors. 3. How measures will be put into place or what systemic changes you will make to ensure that the deficiency does not recur An audit was completed by the maintenance director to making sure all barrier doors in the building closing properly without any obstacle. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place	09/05/2021

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			including time frames and person (s) responsible Maintenance Director, and/or designee will check the proper closing of each barrier doors and monitor the documentation through Building Engines daily x6 weeks, and then weekly x6 months. All audit results will be addressed in monthly QAPI meetings. 5. A plan of correction completion date has been provided - September 5th, 2021. 6. Please see Exhibit B	
K 0511 SS=E 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 Based on observation and interview, the facility failed to ensure 3 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault	K 0511	1. What corrective actions will be accomplished for those residents found to have been affected by this alleged deficient practice: A. The GFCI within the six feet of A wing pantry sink was replaced immediately. B. The GFCI within the six feet of B wing pantry sink was replaced immediately. C. The GFCI within the six feet of the sink in B wing care area was	09/05/2021

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	circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations		replaced immediately. 2. How will identify related safety features having the potential to be affected by the same deficient practice and what corrective actions will be taken. This deficient practice have the potential to be affected all residents, staff members. 3. How measures will be put into place or what systemic changes you will make to ensure that the deficiency does not recur An audit was completed by maintenance director to making sure all GFCI in all resident rooms, basement, and all common areas are working properly. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place including time frames and person (s) responsible Maintenance Director, and/or designee will check/test GFCI and monitor the documentation through Building Engines 5X week for 4 weeks then monthly for 6 months. All audit results will be addressed in monthly QAPI meetings. 5. A plan of correction completion date has been provided -	

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	(7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect as many as 5 residents, 4 staff and 1 visitor. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/12/21 from 12:18 p.m. through 2:40 p.m., the following was noted: A. the A wing pantry had a sink located in it. There was a wall mounted GFCI electric outlet located there within six feet of the sink, but it failed when tested on three separate occasions. B. the B wing pantry had a sink located in it. There was a wall mounted GFCI electric outlet located there within six feet of the sink, but it failed when tested on three separate occasions. C. the B wing café area had sink located in it. There was a wall mounted GFCI electric outlet located there within six feet of the sink, but it failed when tested on three separate occasions. Based on an interview at the times of the aforementioned observations, the Maintenance Director advised that these GFCI outlets were probably installed when the facility was built, and they must have gone bad over time. He further added that he would have them replaced as soon as he could. During the exit conference with the facility Administrator and the Maintenance		September 5th, 2021. 6. Please see Exhibit C	

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	Director at 2:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 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 conduct quarterly fire drills for 1 of 4 quarters within the last twelve months. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the document entitled "Fire Drill Record - Golden Living Center Indianapolis facility #90" with the Maintenance Director on 08/12/21 at 10:47 a.m., there was no documentation for a second shift (2:00 p.m. to 10:00 p.m.) fire drill in the third quarter of 2020. Additionally, there was no documentation for a staff training document in Liew of the fire drill as would be accepted per the Centers for Medicare and Medicaid (CMS) waiver document. Based on	K 0712	1. What corrective actions will be accomplished for those residents found to have been affected by this alleged deficient practice: Maintenance director who is responsible for conducting fire drills on a timely manner was educated by Executive Director on 08/29/2021 that all fire drills should be held at varying times. 2. How will identify related safety features having the potential to be affected by the same deficient practice and what corrective actions will be taken. This deficient practice has the potential to be affected all residents, staff members. Fire	09/05/2021

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	an interview at the time of record review, the Maintenance Director noted that he had done two first shift drills that quarter and that was how the fire drill was missed. During the exit conference with the facility Administrator and the Maintenance Director at 2:55 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		drills will be held monthly at varying times by the maintenance director, ED, or designated staff to 'staff are familiar with procedures and are aware that drills are the part of established routine". 3. How measures will be put into place or what systemic changes you will make to ensure that the deficiency does not recur Monthly log will be kept by the maintenance director of fire drills with varying times noted. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place including time frames and person (s) responsible Maintenance Director, and/or designee will monitor QA and report any deficiency/findings in monthly QAPI meetings for 6 months and ongoing to ensure varying drills are completed. 5. A plan of correction completion date has been provided - September 5th, 2021. 6. Please see Exhibit D	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords			

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	Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 MDF room and 6 of 90 resident room flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 6 employees. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/12/21 from 12:18 p.m. through 2:40 p.m., the following	K 0920	1. What corrective actions will be accomplished for those residents found to have been affected by this alleged deficient practice: A. An extension cord in use in the laundry room powering a floor fan was removed immediately. B. A power strip was in use in the employee break room on top of the refrigerator was removed immediately. 2. How will identify related safety features having the potential to be affected by the same deficient practice and what corrective actions will be taken.	09/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 01 B. WING	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	was noted: A. an extension cord was found to be in use in the laundry room powering a floor fan. B. a power strip that was non U.L. rated was in use in the employee break room on top of the refrigerator. Based on interview at the time of each observation, the Maintenance Director acknowledged the items stating that staff knows better then to use those items. Both the extension cord and power strip were immediately removed from the area by the Maintenance Director as soon as they were pointed out fixing the noted deficiency. These items were discussed during the exit conference with the facility Administrator and the Maintenance Director at 2:55 p.m. 3.1-19(b)		This deficient practice have the potential to be affected all employees and few residents. 3. How measures will be put into place or what systemic changes you will make to ensure that the deficiency does not recur A thorough inspection of the facility has been completed with all surge protectors, power strips, and extension cords identified were removed and/or in compliance with K920 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place including time frames and person (s) responsible Maintenance Director, and/or designee will check 10 rooms at a time and employee break room, and laundry area to ensure there is no power strip, or an extension cord two times in a week for 2 months and then weekly for 6 months. . All audit results will be addressed in monthly QAPI meetings. 5. A plan of correction completion date has been provided - September 5th, 2021. Please see Exhibit: E	