STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 01 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/23-24/15 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Life Safety Code survey, Golden Living Center-Fountainview was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The original building 0102 consists of everything except the 300 wing Rehabilitation unit and was surveyed with Chapter 19, Existing Health Care Occupancies. The facility was surveyed as two separate buildings because of the construction dates of two sections of the building. Building 0102 built prior to March, 1 2003 was determined to be of Type V (111) construction and was fully	K 0000	Submission of this Response and Plan of Corrections is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. This facility is asking for a desk review for this survey.	

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

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 186 and had a census of 131 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility storage services which were not sprinklered. Quality Review completed 12/01/15 - DA			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier	K 0025	It is the intent of this facility to ensure that penetrations caused by the passage of wire and/or conduit are protected to maintain the smoke resistance of each	12/14/2015

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	walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 26 residents. Findings include: Based on observations with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 at 11:24 a.m., the smoke barrier wall near resident room 329 had two unsealed penetrations above the ceiling tile. One penetration was a one eight inch gap around conduit. Another one was a four inch by 10 inch missing section of drywall. Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged each aforementioned condition and provided the measurements.		smoke barrier. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The smoke barrier wall in the ACU medication room was repaired to seal the penetration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential of affecting staff on this unit. Smoke barrier walls were inspected during this survey process and any unprotected penetrations were sealed. No residents were affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will inspect any internal/contractor work completed in the areas of smoke barrier walls to assure that any penetrations are sealed. Any areas not found in compliance will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Inspection report of repairs completed in smoke barrier wall areas will be reviewed	

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	3.1-19(b)		with the Executive Director/Designee for compliance assurance. Any non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 delayed egress locks in the 200 Hall was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, states approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for	K 0038	It is the intent of this facility to ensure that the means of egress through delayed egress locks are readily accessible. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The exit door by resident room 229 was repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential to affect residents on this hallway of 200 Unit. Doors remain on monthly preventative maintenance checks are logged by the Director of Maintenance. The prior month inspection noted that	12/14/2015

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	more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 15 residents. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 at 10:28 a.m., the exit door by resident room 229 was equipped with a delayed egress lock and was provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. When the exit door was tested, the exit door failed to open within 15 seconds when pushed with the application of force. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		this egress lock was functional. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All doors with delayed egress locks will remain on the monthly preventative inspection reports. The door near resident room 229 will be tested 5x weekly for 2 weeks, 1x weekly for 2 weeks , then continue with monthly inspections if no further concerns are noted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Director of Maintenance will review all inspections for compliance. Any non-compliance will be reported to the Executive Director and repair secured. Non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0044 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 7 of 8 fire door	K 0044	It is the intent of this facility to	12/14/2015

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	sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 78 residents. Findings include: Based on record review with the Maintenance Technician #1 on 11/23/15 between 10:11 a.m. and 11:42 a.m., the site plans were reviewed and the smoke and fire barriers were identified. Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator between 11:50 a.m. and p.m., the following fire barriers were discovered: a) front entrance fire doors failed to latch when tested. b) fire doors near resident room 132 did not include positive latching hardware c) fire doors near resident room 121 did not include positive latching hardware d) fire doors near resident room 110 did		ensure that horizontal exits are in compliance. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The front entrance double fire doors at the hallway were adjusted to assure they latch when activated. A vendor has been contacted to install latches to fire doors located near resident rooms 132, 121, 110, 231, 219, and 208. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents in the areas of listed fire doors have the potential to be affected by this alleged deficient practice. Latches will be installed and doors will be inspected for proper closure during all fire drills. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** These doors will be inspected during fire drills monthly to ensure latches are fully operational.	

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	not include positive latching hardware e) fire doors near resident room 231 did not include positive latching hardware f) fire doors near resident room 219 did not include positive latching hardware g) fire doors near resident room 208 did not include positive latching hardware Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned conditions and confirmed the set of doors were fire doors. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Director of Maintenance will review all inspections for compliance. Any non-compliance will be reported to the Executive Director and repair secured. Non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0051 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			

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	Based on observation and interview, the facility failed to ensure 1 of 2 smoke detectors in the corridor outside Therapy connected to the fire alarm system were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and at least 9 residents. Findings include: Based on observations with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 at 10:23 a.m., one smoke detector located in the corridor near Therapy was approximately 16 inches from an air vent. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)	K 0051	It is the intent of this facility to ensure that smoke detectors are properly separated from air supplies. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** A vendor has been contacted to relocate the smoke detector in the corridor near Therapy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents, staff and visitors in this area have the potential to be affected by this alleged deficient practice. Smoke detector will be relocated to assure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Vendor will inspect all smoke detectors in the facility to assure compliance. Any other detectors found in non compliance will also be corrected. **How the corrective action(s) will be monitored to ensure the deficient**	12/14/2015

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			practice will not recur, i.e., what quality assurance program will be put into place: Any relocation of smoke detectors in the facility will be completed by a qualified vendor. The Director of Maintenance will inspect any repairs for compliance and report findings to the Executive Director. Any areas of non compliance will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation, the facility failed to ensure 4 of 18 manual fire alarm boxes were mounted at the correct height. NFPA 72, 1999 Edition of the National Fire Alarm Code at 2-8.1 states each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 3 1/2 feet (42 inches) and not more than 4 1/2 feet (54 inches) above floor level. This deficient practice could affect	K 0052	It is the intent of this facility to ensure that manual fire alarm boxes are mounted at correct height. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Vendor was contacted to relocate the manual fire alarm pull stations by resident room 101, in the Main Dining room, outside the kitchen	12/14/2015

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	up to 71 residents as well as staff and visitors. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 from 12:53 p.m. to 2:35 p.m. the following was discovered: a) the manual fire alarm pull station by resident room 101 was mounted 67.75 inches from the floor. b) The manual fire alarm pull station in the Main Dining Room was mounted 69 inches from the floor. c) The manual fire alarm pull station outside the Kitchen was mounted 68 inches from the floor. The following was discovered on 11/24/15 at 10:57 a.m., d) The manual fire alarm pull station by resident room 201 was mounted 66 inches from the floor. Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned conditions. 3.1-19(b)		and by resident room 201. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents, staff and visitors located in these areas have the potential to be affected by this alleged deficient practice. Manual pull stations were relocated for compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee and vendor will measure all manual pull stations in the facility for proper placement. Any other areas found non compliant will be corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Manual pull stations will only be relocated by approved vendors. Any repairs/relocations will be inspected by the Director of Maintenance for compliance. Any non-compliance issues will be reported to the Executive Director and the QAPI committee for recommendation.	

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			Date systemic changes will be completed: 12/14/2015	
K 0053 SS=C Bldg. 01	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 98 of 98 single station smoke detectors would operate. This deficient practice affects all residents. Findings include: Based on record review on 11/23/15 at 11:35 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the monthly battery operated "Smoke Detector" documentation failed to include a battery replacement program for the ninety eight single station smoke detectors in resident rooms. Based on an interview with the Maintenance Director he acknowledged the aforementioned condition. 3.1-19(b)	K 0053	It is the intent of this facility to ensure that a battery replacement program is provided for single station smoke detectors. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident room battery operated smoke detectors have batteries changed semi-annually per facility preventative maintenance program. Documentation of battery changes will be added to the current semi-annual inspection report. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents have the potential to be affected by this alleged deficient practice when in resident rooms. Documentation will be modified to reflect dates that	12/14/2015

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			batteries are replaced in each battery operated smoke detector. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee will continue to follow facility preventative maintenance plan of changing batteries in single unit battery operated smoke detectors semi-annual and will add documentation to note dates batteries are replaced. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Maintenance will log these battery changes in the facility preventative maintenance program. System automatically notifies Executive Director when inspection dates are not in compliance. Executive Director will meet with Maintenance Director to assure batteries are replaced and report non-compliance concerns to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13,			

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace corroded sprinklers in 6 of 9 exterior over hangs required to have sprinklers. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 78 residents. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator, the following corroded outdoor sprinkler heads were discovered on 11/23/15 between 12:09 p.m. and 3:09 p.m.: a) 8 of 8 sprinkler heads by the exit discharge near resident room 120 b) 5 of 7 sprinkler heads by the exit discharge near resident room 108 c) 10 of 10 sprinkler heads by the Ambulance entrance discharge. The following corroded outdoor sprinkler heads were discovered on 11/24/15	K 0062	It is the intent of this facility to ensure that exterior sprinklers are not corroded. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** A vendor has been contacted to inspect and replace the corroded sprinkler heads in exit overhangs near rooms 313, 323 and 333. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents in the areas of these exits have the potential to be affected by this alleged deficient practice. Vendor will replace the sprinklers and ensure the outside sprinklers are included in their regular sprinkler inspections. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance will review the regular scheduled sprinkler inspections with the vendor to assure that external as well as internal sprinklers are	12/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 01 B. WING	11/24/2015

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	between 10:28 a.m. and 10:52 a.m.: d) 8 of 8 sprinkler heads by the exit discharge near resident room 231 e) 8 of 8 sprinkler heads by the exit discharge near resident room 217 f) 4 of 8 sprinkler heads by the exit discharge near resident room 206 Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned conditions. 3.1-19(b)		inspected. Results of the inspections will be reviewed with the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0064 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 1 B Wing B Hall fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient	K 0064	It is the intent of this facility to ensure that portable fire extinguishers are properly charged and installed in location correctly. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The fire extinguisher near room 120 was replaced. The fire extinguisher in the Assisted Dining Room was relocated to the	12/14/2015

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	practice could affect up to 19 residents. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 12:30 p.m., the gauge on the portable fire extinguisher located near resident room 120 indicated the extinguisher was undercharged. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Assisted Dining Room portable fire extinguishers was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff only because the room is currently being remodeled.		proper height. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents in the areas near room 120 and in the Assisted Dining Room have the potential to be affected by this alleged deficient practice. The Maintenance Department was in-serviced on the monthly inspections of fire extinguishers and the proper height for mounting. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inspection was completed on all fire extinguishers in the facility to assure they were properly charged and mounted at the approved height range. The Director of Maintenance/Designee will inspect all fire extinguishers monthly and note on the attached inspection tags. Any fire extinguishers not properly charged or located will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be**	

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	Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 1:24 p.m., the Assisted Dining room fire extinguisher was 62.5 inches off the ground. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)		**put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires	K 0069	It is the intent of this facility to ensure that the kitchen range hood fire suppression system nozzles have devices in place to prevent the entrance of grease vapors into the nozzles. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Vendor was contacted in reference	12/14/2015

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	automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 2:28 p.m., all of the kitchen range hood fire suppression system nozzles were not provided with a blowoff cap or other suitable devices to prevent		to the nozzle caps for the kitchen range hood suppressions system nozzles. Vendor verified that the Range Guard nozzle is a metal cap and is in place on this unit. Nozzle is designed with a seal installed that dissipates in a fire and activates the nozzle. This style of nozzle does not have blow off caps. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice would directly affect staff only. The range hood continues on scheduled cleaning and inspection per protocol. The vendor (Allied Safety Services) advised that system does have nozzle caps in place and provided documentation to illustrate the type of caps used. The Director of Maintenance inspected the nozzles and verified the illustrated caps are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director or Maintenance/designee will inspect these nozzles after each scheduled inspections/cleanings to assure the proper nozzles are in place. Any	

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		findings of non-compliance will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non-compliance will be reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation, the facility failed to ensure exit egress for 1 of 17 exits was maintained to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.3 requires walking surfaces to be nominally level.	K 0072	It is the intent of this facility to ensure that exit egress are free of tripping hazards. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** A vendor has been contacted to repair the concrete section near room 120.	12/14/2015

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	155187	A. BUILDING 01 B. WING	11/24/2015

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	This deficient practice could affect at least 9 residents. Findings include: Based on observation on 11/23/15 at 12:09 p.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the exit discharge near resident room 120 had a two inch raised concrete section causing a trip hazard. Based on interview at the time observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice has the potential of affecting residents using this exit egress. The raised concrete section was repaired/ replaced. The maintenance department was educated on the importance of maintaining a safe egress. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will inspect all exit egress paths weekly to ensure pathways are clear of obstructions. Any concerns of non-compliance will be reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of monthly inspections will be reported to the Executive Director/designee. Any findings of non-compliance will be corrected and reported to the QAPI committee for review and further	

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			recommendations. **Date systemic changes will be completed:** 12/14/2015	
K 0075 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 100 Hall and 1 of 2 100 Hall shower room. This deficient practice could affect staff and at least 30 residents. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 11:58 a.m. then again at 12:21 p.m., two adjacent 32 gallon containers of biohazardous soiled linen	K 0075	It is the intent of this facility to ensure that soiled linen or trash receptacles do not exceed a capacity of 32 gallons within a 64 square foot area not protected as a hazardous area. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The two 32 gallon containers were relocated from the 100 Hall corridor to the soiled utility room. The door on the 100 Hall shower room was repaired to latch. **How other residents having the potential to be affected by the**	12/14/2015

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	and biohazardous trash were discovered in the 100 Hall corridor outside resident room 134. Then again two adjacent 32 gallon containers of biohazardous soiled linens and biohazardous trash were stored in the 100 Hall shower room. When the shower room corridor door was tested, the door self closed but failed to positively latch into the frame. Based on an interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned conditions. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken:** Residents on this unit have the potential to be affected by this alleged deficient practice. Housekeeping/laundry and nursing staff were educated on returning linen and trash containers to designated storage areas when not in use. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff, supervisors and Guardian Angels were educated to observe units for proper storage of linen and trash containers when not in use. Any noted non compliance is to be corrected immediately and reported to the Executive Director/Director of Nursing Services/ or designee. Unit will be audited 2x daily/ 5x per week for 4 weeks for unattended containers observed in non designated areas. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Audit results will be reported to the	

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	155187	A. BUILDING 01 B. WING	11/24/2015

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			Executive Director/designee. Pattern of non compliance will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include:	K 0076	It is the intent of this facility to ensure that oxygen cylinders are properly chained or supported in a stand or cart. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Oxygen vendor was contacted and delivered supporting cart for oxygen cylinder. **How other residents having the potential to be affected by the same deficient practice will be**	12/14/2015

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	Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 12:18 p.m., the 100 Hall oxygen transfer room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		**identified and what corrective action(s) will be taken:** Residents were not affected by this alleged deficient practice. Vendor was educated on supplying facility with a support stand or cart for each cylinder supplied. Nursing staff was educated on necessity of securing all oxygen cylinders when in storage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/designee will monitor oxygen storage rooms 5x /week for oxygen cylinder storage compliance for 4 weeks. Results of the audits will be presented to the Director of Nursing Services/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of the audit summary will be presented to the QAPI committee for review and further recommendations. **Date systemic changes will be completed:** 12/14/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure the penetration in 5 of 8 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is	K 0130	It is the intent of this facility to ensure that penetrations to fire walls are sealed for fire resistance. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The fire barrier wall near resident room 301 was repaired to seal the penetration. The penetration around the sprinkler pipe and inside conduit near room 122 was sealed. The penetration near room 209 was repaired and sealed. The penetrations near room 220 were sealed. The penetrations near room 225 were sealed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential of affecting any	12/14/2015

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	155187	A. BUILDING 01 B. WING	11/24/2015

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 54 residents. Findings include: Based on an observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 between 11:37 a.m. and 11:05 a.m., the following fire wall penetrations were discovered: a) one half inch hole by resident room 301 b) one eighth inch penetration around sprinkler pipe and one half inch gap inside conduit by resident room 122 c) one ten inch by twenty six inch piece of drywall cut out by resident room 209 d) four penetrations ranging from one half inch to two and half inch by resident room 220 e) one eighth inch penetration inside conduit and two separate one half inch penetrations in drywall by resident room 225. Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged each		resident on this unit. Fire walls were inspected during this survey process and any unprotected penetrations were sealed. No residents were affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will inspect any internal/contractor work completed in the areas of fire walls to assure that any penetrations are sealed. Any areas not found in compliance will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Inspection report of repairs completed in fire wall areas will be reviewed with the Executive Director/Designee for compliance assurance. Any non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 01 B. WING	11/24/2015

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	aforementioned condition and provided the measurements. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 98 of 98 single station smoke detectors would operate. This deficient practice affects all residents. Findings include: Based on record review on 11/23/15 at 11:35 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the monthly battery operated "Smoke Detector" documentation failed to include a battery replacement program for the ninety eight single station smoke detectors in resident rooms. Based on an interview with the Maintenance Director he acknowledged the aforementioned condition. 3.1-19(b)			
K 0143 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:			

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	155187	A. BUILDING 01 B. WING	11/24/2015

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	(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure an outlet in 1 of 1 100 Hall sprinklered oxygen storage/transfer location was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 12:18 p.m., the oxygen transferring room with at least two large	K 0143	It is the intent of this facility to ensure that outlets in the oxygen storage/transfer rooms are at least 5 feet from the floor. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The outlet was relocated to meet compliance requirements. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this alleged deficient practice. The outlet was relocated to meet compliance requirements. **What measures will be put into**	12/14/2015

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	liquid oxygen cylinders had one electrical switch on the wall 51.5 inches above the floor. Based on an interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition and provided the measurement. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 100 Hall liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 12:18 a.m., the 100 Hall oxygen storage/transfer room was provided with a mechanically operated fan/vent but was not working. The fans were checked with a piece of paper. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition.		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance department was in-serviced on the electrical requirements of oxygen transfer/storage rooms in relation to the outlet. An inspection of all oxygen transfer/storage rooms was completed with no other findings of non-compliance. Any electrical repair/maintenance work completed in the oxygen transfer/storage rooms will be inspected by the Director of Maintenance/designee for compliance. Any findings of non-compliance will be corrected and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non-compliance following future repairs/construction will be reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	

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	3.1-19(b)			
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Emergency Generator monthly testing log	K 0144	It is the intent of this facility to ensure that the generator monthly load test includes a cool down period. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The current generator test log has been modified to allow for documentation of the cool down period after the monthly 30 minute load test. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this alleged deficient practice. Monthly generator load tests will include documentation of the cool down period following the load test. The Maintenance department was instructed on the proper documentation required with this	12/14/2015

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	155187	A. BUILDING 01 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	on 11/24/15 at 10:27 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. During interview at the time of record review, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		test. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will monitor monthly generator load tests to ensure that the log includes the cool down period time following the load test. The completed report will be reviewed with the Executive Director monthly x 4 months to assure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of the monthly audit will be reported Executive Director. Any non-compliance noted will be reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 9 of 9 flexible	K 0147	It is the intent of this facility to	12/14/2015

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	cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and at least 4 residents. Findings include: Based on observation with Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 between 2:37 p.m. to 3:05 p.m. the following was discovered: a) a surge protector was powering two separate surge protectors powering the phone system in the Boiler Room b) a surge protector powering a microwave, a coffee pot, and a refrigerator in the Maintenance Room c) a surge protector powering a microwave and a coffee pot in the Staff Lounge d) a surge protector powering two separate surge protectors powering computer equipment in the Business Office The following was discovered on 11/24/15 at 10:43 a.m.: e) a surge protector powering a		ensure that electrical junction boxes are in safe operating condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The electrical junction box near room 329 had a cover installed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this alleged deficient practice. An inspection of the facility was conducted with the surveyor to identify any other areas of electrical non-compliance. No other areas were noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee will inspect any electrical repairs/ installations to ensure that junction boxes are finished to code and compliance. Any areas found to be non-compliant will be corrected by the contractor and results reported to the Executive Director for review. **How the corrective action(s) will be**	

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	155187	A. BUILDING 01 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	refrigerator in Therapy Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged each aforementioned condition. 3.1-19(b)		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any non-compliance will be reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/23-24/15 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Life Safety Code survey, Golden Living Center-Fountainview was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.70(a) Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The 300 wing, Rehabilitation unit consisted	K 0000	Submission of this Response and Plan of Corrections is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that	

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	of 14 additional beds and was surveyed with Chapter 18, New Health Care Occupancies. The facility was surveyed as two separate buildings because of the construction dates of two sections of the building. Building 0202 built in 2005 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 186 and had a census of 131 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has three detached buildings providing facility storage services which were not sprinklered. Quality Review completed 12/01/15 - DA		mandate submission of a plan of correction with ten (10) days of the survey as a condition of participation in the Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. This facility is asking for a desk review for this survey.	
K 0017 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 ACU	K 0017	It is the intent of this facility to	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

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	Assisted Living Dining room were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and at least 20 residents. Findings include: Based on an observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 12:14 p.m., the Assisted Living Dining room in ACU had no door on the door frame. The room was not viewable from the nurse's station. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the Assisted Living Dining Room was not protected by an electrically supervised automatic smoke		ensure that non-hazardous areas open to the corridor are protected with an electronic smoke detection system. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Vendor has been contacted to install an electronically supervised automatic smoke detector in the ACU assisted dining room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents in the area of the ACU assisted dining room have the potential to be affected by this alleged deficient practice. An electronically supervised automatic smoke detector will be installed in the ACU assisted dining room. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An inspection of the facility was completed with the survey and no other areas of non compliance were noted. Any future plans to include removal of a door into the corridor area will be inspected by the	

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	detection system. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		Director of Maintenance/ designee to ensure the area is properly protected by an electronically supervised smoke detector. The Executive Director and/or Corporate Supervisor will be advised of any proposed changes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0018 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 98 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 2 residents. Findings include:	K 0018	It is the intent of this facility to ensure that resident room doors latch when closed. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:**	12/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 02 B. WING	11/24/2015

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	Based on observation and interview on 11/05/15 at 2:20 p.m., the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the corridor door to resident room 301 was not latching into the door frame when tested. 3.1-19(b)		The door latch for room 301 was adjusted and corrected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential to affect 2 residents in room 301. The Director of Maintenance/ designee will monitor that door for 301 latches 5x weekly for 3 weeks then monthly, ongoing, to ensure door stays in adjustment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Audit tool will be reviewed weekly by the Executive Director for compliance. All other doors in the facility remain on checks coinciding with monthly fire drills. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be**	

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			completed: 12/14/15	
K 0025 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 1:57 p.m., there was a half inch ceiling penetration in the ACU medication room. Based on interview at the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged and	K 0025	It is the intent of this facility to ensure that penetrations caused by the passage of wire and/or conduit are protected to maintain the smoke resistance of each smoke barrier. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The smoke barrier wall in the ACU medication room was repaired to seal the penetration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential of affecting staff on this unit. Smoke barrier walls were inspected during this survey process and any unprotected penetrations were sealed. No residents were affected. **What**	12/14/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided the measurements for the unsealed penetration. 3.1-19(b)		**measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will inspect any internal/contractor work completed in the areas of smoke barrier walls to assure that any penetrations are sealed. Any areas not found in compliance will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Inspection report of repairs completed in smoke barrier wall areas will be reviewed with the Executive Director/Designee for compliance assurance. Any non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0029 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 doors	K 0029	It is the intent of this facility to ensure that any storage rooms over	12/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	serving hazardous areas near resident room 302 such as combustible storage room over 50 square feet in size, had a self closer that would positively latch into the frame. This deficient practice could affect staff and 4 residents. Findings include: Based on observations with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 at 1:29 p.m., resident room 302 was being used as storage and the door lacked a self closing device. The room contained seven mattress, a large cardboard box containing carpet squares and other storage. Based on interview during the time of observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		50 square feet that store hazardous materials have a self closure on the door that positively latches. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** All hazardous materials in room 302 were removed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice has the potential to affect residents and staff in immediate area of room 302. All hazardous materials have been removed from this room. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Department has been in-serviced on the regulation requiring an automatic closure on the door of any storage room storing hazardous materials. The Maintenance Director/designee will observe rooms on routine preventative rounds for any hazardous materials stored in non-designated storage rooms and correct immediately. Any findings of	

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	155187	A. BUILDING 02 B. WING	11/24/2015

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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			non-compliance will be reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0053 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barriers or horizontal exit doors in the corridor.) Such detectors are electronically interconnected to the fire alarm system. 18.3.4.5.3 Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 98 of 98 single station smoke detectors would operate. This deficient practice affects all residents. Findings include: Based on record review on 11/23/15 at	K 0053	It is the intent of this facility to ensure that a battery replacement program is provided for single station smoke detectors. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident room battery operated smoke detectors have batteries changed semi-annually per facility	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

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GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	11:35 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the monthly battery operated "Smoke Detector" documentation failed to include a battery replacement program for the ninety eight single station smoke detectors in resident rooms. Based on an interview with the Maintenance Director he acknowledged the aforementioned condition. 3.1-19(b)		preventative maintenance program. Documentation of battery changes will be added to the current semi-annual inspection report. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents have the potential to be affected by this alleged deficient practice when in resident rooms. Documentation will be modified to reflect dates that batteries are replaced in each battery operated smoke detector. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee will continue to follow facility preventative maintenance plan of changing batteries in single unit battery operated smoke detectors semi-annual and will add documentation to note dates batteries are replaced. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Maintenance will log these battery changes in the facility preventative maintenance program. System automatically notifies Executive Director when inspection dates are not in	

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			compliance. Executive Director will meet with Maintenance Director to assure batteries are replaced and report non-compliance concerns to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0062 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace corroded sprinklers in 3 of 9 exterior over hangs required to have sprinklers. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 53 residents. Findings include: Based on observation with the	K 0062	It is the intent of this facility to ensure that exterior sprinklers are not corroded. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** A vendor has been contacted to inspect and replace the corroded sprinkler heads in exit overhangs near rooms 313, 323 and 333. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents in the areas of these exits have the potential to be affected by this alleged deficient practice.	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	Maintenance Tech #1, Maintenance Director, and the Administrator on 11/23/15 between 1:53 p.m. and 2:11 p.m., the following corroded outdoor sprinkler heads were discovered: a) 6 of 6 sprinkler heads by the exit discharge near resident room 313 b) 6 of 6 sprinkler heads by exit discharge near resident room 323 c) 7 of 7 sprinkler heads by exit discharge near resident room 333 Based on interview at the time of each observation, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned conditions. 3.1-19(b)		Vendor will replace the sprinklers and ensure the outside sprinklers are included in their regular sprinkler inspections. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance will review the regular scheduled sprinkler inspections with the vendor to assure that external as well as internal sprinklers are inspected. Results of the inspections will be reviewed with the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0104 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility failed to ensure at least 2 dampers	K 0104	It is the intent of this facility to	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	in the ductwork at smoke barriers and fire barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to protect 88 of 88 residents. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 at 11:24 a.m. then again at 11:31 a.m., a damper was observed in the smoke barrier by resident room 329 above the drop ceiling. Then again a damper was observed in the smoke barrier by resident room 311 above the drop ceiling. Based on interview at the time of record review, the Maintenance		ensure dampers in the ductwork at smoke barriers are inspected and provide necessary maintenance as required per regulation. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Vendor has been contacted to inspect and maintain the dampers located near room 329 and near room 311. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents in this building have the potential to be affected by this alleged deficient practice. Facility vendor has been contacted to inspect and maintain the dampers located near room 329 and near room 311. Vendor will inspect all dampers located at smoke barriers to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance will put into the Preventative Maintenance program scheduled inspections/maintenance of	

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	Tech #1, Maintenance Director, and the Administrator was unaware of any dampers in the facility. 3.1-19(b)		dampers located near smoke barriers. Next inspection will be scheduled within 4 years. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any findings of non compliance will be corrected and results submitted to the QAPI committee for review and recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0130 SS=C Bldg. 02	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 98 of 98 single station smoke detectors would operate. This deficient practice affects all residents. Findings include: Based on record review on 11/23/15 at 11:35 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the monthly battery operated "Smoke Detector" documentation failed to include a battery	K 0130	It is the intent of this facility to ensure that penetrations to fire walls are sealed for fire resistance. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The fire barrier wall near resident room 301 was repaired to seal the penetration. The penetration around the sprinkler pipe and inside conduit near room 122 was sealed.	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	replacement program for the ninety eight single station smoke detectors in resident rooms. Based on an interview with the Maintenance Director he acknowledged the aforementioned condition. 3.1-19(b)		The penetration near room 209 was repaired and sealed. The penetrations near room 220 were sealed. The penetrations near room 225 were sealed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential of affecting any resident on this unit. Fire walls were inspected during this survey process and any unprotected penetrations were sealed. No residents were affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will inspect any internal/contractor work completed in the areas of fire walls to assure that any penetrations are sealed. Any areas not found in compliance will be corrected immediately and reported to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient**	

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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			practice will not recur, i.e., what quality assurance program will be put into place: Inspection report of repairs completed in fire wall areas will be reviewed with the Executive Director/Designee for compliance assurance. Any non-compliance concerns will be reported to the QAPI committee for recommendation. **Date systemic changes will be completed:** 12/14/2015	
K 0144 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to	K 0144	It is the intent of this facility to ensure that the generator monthly load test includes a cool down period. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The current generator test log has been modified to allow for documentation of the cool down period after the monthly 30 minute load test.	12/14/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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	shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Emergency Generator monthly testing log on 11/24/15 at 10:27 a.m. with the Maintenance Tech #1, Maintenance Director, and the Administrator, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. During interview at the time of record review, the Maintenance Tech #1, Maintenance Director, and the Administrator acknowledged the aforementioned condition. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this alleged deficient practice. Monthly generator load tests will include documentation of the cool down period following the load test. The Maintenance department was instructed on the proper documentation required with this test. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Maintenance/designee will monitor monthly generator load tests to ensure that the log includes the cool down period time following the load test. The completed report will be reviewed with the Executive Director monthly x 4 months to assure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Results of the monthly audit will be reported Executive Director. Any non-compliance noted will be	

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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			reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	
K 0147 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes by the Smoke Barrier near resident room 329 observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff. Findings include: Based on observation with the Maintenance Tech #1, Maintenance Director, and the Administrator on 11/24/15 at 11:24 a.m., a electrical junction box with numerous wire connections jutting out of the box without a cover was above the ceiling tile	K 0147	It is the intent of this facility to ensure that electrical junction boxes are in safe operating condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The electrical junction box near room 329 had a cover installed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this alleged deficient practice. An inspection of the facility was conducted with the surveyor to identify any other areas of electrical non-compliance. No other areas were noted. **What measures will be put into**	12/14/2015

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	155187	A. BUILDING 02 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	near the smoke barrier by resident room 329. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** Director of Maintenance/designee will inspect any electrical repairs/ installations to ensure that junction boxes are finished to code and compliance. Any areas found to be non-compliant will be corrected by the contractor and results reported to the Executive Director for review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any non-compliance will be reported to the QAPI committee for further recommendations. **Date systemic changes will be completed:** 12/14/2015	