STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155686	A. BUILDING 01 B. WING	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-KNOX	300 E CULVER RD KNOX, IN 46534

(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: 11/10/15 Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260 At this Life Safety Code survey, Golden Living Center-Knox was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms were provided with battery powered smoke detectors. The facility has the capacity for 57 and had a census of 51 at the time	K 0000		

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

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

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	of this survey. All areas where residents have customary access were sprinklered. One detached storage shed was unsprinklered. Quality Review completed on 11/16/15 - DA			
K 0025 SS=F 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 3 smoke barrier 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	K 0025	1. The ceiling tile was repaired by Maintenance Director on 11-16-2015 after receipt of fire stop material. 2. The facility houses two additional smoke barrier walls and both were inspectied during the Life Safety Survey on 11-10-2015 with no identified concerns. 3. All three smoke barrier walls will be inspected monthly by Maintenance Director or Designee for any concerns and will continue indefinitely. 4. Smoke barrier inspection reports will be reviewed monthly in QAPI.	12/10/2015

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	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 staff and 43 out of 51 residents. Findings include: Based on observations with Maintenance Director on 11/10/15 at 12:01 p.m. the smoke barrier wall near resident room 28 had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a 1/4" around wires. Based on interview at the time of observation, The Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of	K 0027	1. Safe Care contacted for a quote to	12/20/2015

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	smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect at least staff, visitors, at least 33 residents. Findings include: Based on observation with the Maintenance Director on 11/10/15 during the tour from 10:05 a.m. to 12:14 p.m., the Maintenance Director confirmed the service corridor set of doors was part of a smoke barrier. The smoke barrier did not extend from exterior wall to exterior wall. Based on record review, the site plans showed the smoke barrier path was different from what the Maintenance Director indicated. Based on interview with the Maintenance Director, he acknowledged the smoke barrier set of doors were not installed in the smoke barrier. 3.1-19(b)		construct the smoke barrier set of doors and was subsequently provided on 11-25-2015. Quote approved by Facilities Engineer Consultant. Letter of Intent received from Safe Care Contractor for project start date of 12-18-2015. An extension is requested for this identified concern as is a larger construction project requiring an outside contractor. 2. All staff in-service initiated on 11-24-2015 regarding Smoke Barrier door requirement and Fire/Evacuation policy and Procedure. 3. Life Safety Survey indicated there were no additional smoke barrier set of door deficiencies. 4. Smoke Barrier set of doors projected to start by Safe Care on 12-18-2015 and completed by 12-20-2015.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing			

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	system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 "Biohazard" rooms, a hazardous area, would latch into the frame. This deficient practice could affect staff and up to 33 residents. Findings include: Based on observation on 11/10/15 at 10:41 p.m., the corridor door for the " Biohazard" room containing a fuel-fired water heater near resident room 24 self closed but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0029	1. Biohazard room door repaired by Maintenance Director on 11-16-2015. 2. Life Safety Survey indicated the other room door housing a fuel-fired water heater was closing properly with no identified deficiency. 3. Maintenance Director or Designee will inspect both room doors that house the fuel-fired water heater one time monthly. 4. Outcome of above inspections will be review monthly in QAPI.	12/10/2015
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 1 of 1 multiplugs	K 0147	1. Multi-plug in Laundry room was	12/10/2015

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	and 1 of 1 flexible 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 only. Findings include: Based on observation with Maintenance Director on 11/10//15 at 11:08 a.m. then again at 11:24 a.m., a multiplug was powering two soap dispensers in the Laundry room. Then again a surge protector was powering two separate coffee pots and a microwave. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		removed and a receptacle installed on 11-11-2015. The surge protector in the staff break room was removed and coffee pot and microwave relocated to locations with appropriate receptacles. 2. Maintenance Director completed inspection of all resident rooms and staff service areas on 11-11-2015 with no deficiencies identified. All staff in-serviced regarding use of surge protector use. 3. Maintenance Director or Designee will inspect resident rooms and staff services areas for surge protectors and proper receptacles one time weekly for fours weeks. Resident room inspections will continue via Department Head Guardian Angel room inspections monthly. Service area inspections will be completed monthly by Maintenance Director/Designee. 4. Outcome of weekly and monthly inspection will be reviewed monthly in QAPI.	