PRINTED:	08/25/2017
FORM AP	PROVED
OMB NO.	0938-0391

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

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 06/07/2017	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS			2860 C	ADDRESS, CITY, STATE, ZIP CODE HURCHMAN AVE IAPOLIS, IN 46203		
(X4) ID PREFIX TAG K 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
Bldg. 01	State Licensure the Indiana State accordance with Survey Date: 0 Facility Number Provider Number AIM Number: At this Life Safe Living Center-In in compliance w Participation in CFR Subpart 48 Fire and the 201 Fire Protection 1 Life Safety Cod Existing Health 410 IAC 16.2. This one story f was determined construction and facility has a fir smoke detectior corridors and in corridor. The face	r: 000063 er: 155138 100266210 ety Code survey, Golden ndianapolis was found not with Requirements for Medicare/Medicaid, 42 83.70(a), Life Safety from 2 edition of the National Association (NFPA) 101, e (LSC), Chapter 19, Care Occupancies and acility with a basement to be of Type III (200) d fully sprinklered. The e alarm system with n on all levels in the all areas open to the acility has battery	K 0000			
	-	detectors installed in all g rooms. The facility has			(X6) DATE	

TITLE

Any define cystatement 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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/07/2017
	PROVIDER OR SUPPLIE		2860	T ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE NAPOLIS, IN 46203	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLET DATE
		5 and had a census of 54			
	access were spr providing facili sprinklered.	residents have customary inklered and all areas ty services were completed on 06/08/17 -			
(0346 SS=C Bldg. 01	Fire Alarm - Out of Where required f services for more period, the autho be notified, and the evacuated or an be provided for a the shutdown unt been returned to 9.6.1.6 Based on record the facility faile written policy for residents indica followed in the system has to be four hours or m	re alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall be building shall be approved fire watch shall Il parties left unprotected by il the fire alarm system has service. I review and interview, d to provide a complete or 1 of 1 written fire the protection of ting procedures to be event the fire alarm e placed out of service for ore in a twenty four hour	K 0346	What corrective actions will accomplished for those residents found to have been affected by the deficient practice are as follows. Fire Alarm System Impairment procedure will be added to all Emergency Action Guides that outline the procedure if the fire	n it e
	9.6.1.6. This de	lance with LSC Section efficient practice could nts, staff and visitors.		alarm system is impaired, and include language to report to ISDH if the fire alarm system impaired for four hours in a 24 hour period.	is

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155138	A. BUILDING B. WING	01	COMPLETED 06/07/2017
		100100	OTDEET	ADDRESS, CITY, STATE, ZIP CODE	00/01/2011
NAME OF	PROVIDER OR SUPPLIE	ĒR		CHURCHMAN AVE	
GOLDEN	N LIVING CENTER	-INDIANAPOLIS		NAPOLIS, IN 46203	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Based on review	w of "Disaster Plan: Fire		How other residents having	
	Protection Syst	em Impairments"		potential to be affected by the	
	-	with the Maintenance		same deficient practice will	
				identified and what correctiv	e
	-	ng record review from :35 a.m. on 06/07/17, the		action will be taken is as follows:	
		ch policy did not			
		the fire alarm system in		All residents and staff have	
		policy and did not include		potential to be affected by the	
	· ·	he Indiana State		same deficient practice. : Fire	
				Alarm System Impairment procedure will be added to all	
	-	Health (ISDH) which is an		Emergency Action Guides that	
	-	g jurisdiction. Based on		outline the procedure if the fire	
		time of record review,		alarm system is impaired, and	l will
		e Director acknowledged		include language to report to	
	the written fire	watch policy for the		ISDH if the fire alarm system impaired for four hours in a 24	
	facility did not	include fire alarm system		hour period.	,
	impairment and	l did not include			
	notification of	he ISDH.			
	3.1-19(b)				
				What measures will be put in	nto
				place or what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not recur is as follows:	,
				Fire Alarm System Impairmen	it l
			procedure will be added to all		
				Emergency Action Guides that	ıt
				outline the procedure if the fire	
				alarm system is impaired, and	will
				include language to report to ISDH if the fire alarm system	
				impaired for four hours in a 24	
				hour period. Emergency Actio	
				Guides will be audited annual	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DAT	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	<u>01</u>	COM	PLETED
		155138	B. W	ING		06/0)7/2017
NAME OF I	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP C	ODE	
					HURCHMAN AVE		
GOLDEN	I LIVING CENTER	-INDIANAPOLIS		INDIAN	NAPOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE
					for proper contents by director and Maintenar Director.		
					How the corrective ac be monitored to ensu- deficient practice will i.e. what quality assur- program will be put in and by what date the changes will be comp as follows:	re the not recur rance ito place systemic	
					Emergency Action Gui audited annually for pro- contents by Executive and Maintenance Direc Annual Emergency Act audit will be submitted reviewed by the QA&A committee. Systemic c be completed by	oper director ctor. tion Guide to be	
					By what date the syst changes will be comp as follows: July 7th, 2	leted is	
0354 SS=C 3ldg. 01	extent and durati						

					06/07/2017	
X4) ID PREFIX	SUMMARY	-INDIANAPOLIS		ADDRESS, CITY, STATE, ZIP CODE		
REFIX				CHURCHMAN AVE JAPOLIS, IN 46203		
	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(2	K5)
TAG		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPI	LETION
	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DA	ΤЕ
	involved are insp	ected and risks are				
		mmendations are				
		nagement or designated				
		nd the fire department and				
		having jurisdiction have				
		here the sprinkler system is more than 10 hours in a				
		he building or portion of the				
		are evacuated or an				
		tch is provided until the				
		has been returned to				
	service.					
	18.3.5.1, 19.3.5.1	1, 9.7.5, 15.5.2 (NFPA 25)				
	Based on record	d review and interview,	erview, K 0354 What corrective actions will be	e 07/07	//201	
	the facility faile	ed to provide a complete		accomplished for those		
		for 1 of 1 written fire		residents found to have been		
		the protection of		affected by the deficient		
		-		practice are as follows:		
		ting procedures to be		Fire Drate stien Sustan		
		event the automatic		Fire Protection System Impairment procedure will be		
		n has to be placed		added to all Emergency Action		
	out-of-service f	or 10 hours or more in a		Guides that outline the procedu	ire	
	24-hour period	in accordance with LSC		if the sprinkler system is	-	
	Section 9.7.5. I	LSC 9.7.5 requires		impaired, and will include		
		rment procedures comply		language to report to ISDH if		
		Standard for the		system is impaired for four hour	rs	
	-	ting and Maintenance of		in a 24 hour period.		
	-					
		ire Protection Systems.				
		Edition, Section 15.5.2		How other residents having the		
	requires the fire	e department, insurance		potential to be affected by the		
	carrier, the alari	m company, the property		same deficient practice will be		
	owner or design	nated representative and		identified and what corrective		
	-	s having jurisdiction be		action will be taken is as		
		leficient practice could		follows:		
		nts, staff and visitors.				
	arreet an reside	nto, 5tarr and visitors.		All residents and staff have		
				potential to be affected by the		
	Findings includ	e:		same deficient practice. : Fire Protection System Impairment		

Event ID: YL5H21 Facility ID: 000063

If continuation sheet Page 5 of 15

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155138	A. BUILDING <u>01</u> B. WING		COMPLETED 06/07/2017
	PROVIDER OR SUPPLIE		2860 0	ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE NAPOLIS, IN 46203	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLET
	Protection Syst documentation Supervisor duri 8:45 a.m. to 10 written fire wat sprinkler syster include notifica Department of authority havin interview at the the Maintenanc acknowledged written fire wat	w of "Disaster Plan: Fire em Impairments" with the Maintenance ng record review from 35 a.m. on 06/07/17, the ch policy for automatic n impairment did not tion of the Indiana State Health (ISDH) which is an g jurisdiction. Based on time of record review, e Supervisor the aforementioned ch policy for automatic n impairment did not tion of the ISDH.		procedure will be added to all Emergency Action Guides that outline the procedure if the sprinkler system is impaired, a will include language to report ISDH if system is impaired for four hours in a 24 hour period. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur is as follows: Fire Protection System Impairment procedure will be added to all Emergency Action Guides that outline the proced if the sprinkler system is impaired, and will include	to
				language to report to ISDH if system is impaired for four hou in a 24 hour period. Emergence Action Guides will be audited annually for proper contents b Executive director and Maintenance Director. How the corrective action wil be monitored to ensure the deficient practice will not rece i.e. what quality assurance program will be put into plac and by what date the system changes will be completed is as follows:	y II ur ic

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIP	LE CONSTRUCTION		OMB NO. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		. ,	IPLETED
	or conduction	155138	B. WING	G <u>01</u>	_)7/2017
			STR	EET ADDRESS, CITY, STATE, ZIP C	ODF	
NAME OF I	PROVIDER OR SUPPLIE	R		60 CHURCHMAN AVE	ODE	
GOLDEN	ILIVING CENTER	-INDIANAPOLIS		DIANAPOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		DECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	IX PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC	G DEFICIENCY)		DATE
				Emergency Action Gui		
				audited annually for pr	•	
				contents by Executive and Maintenance Direct		
				Annual Emergency Ac		
				audit will be submitted		
				reviewed by the QA&A		
				committee. Systemic c	hanges will	
				be completed by.		
				By what date the sys	temic	
				changes will be comp		
				as follows: July 7th, 2	017	
K 0711	NFPA 101					
SS=C	Evacuation and F					
Bldg. 01	Evacuation and F					
		plan for the protection of or their evacuation in the				
	event of an emer					
		eriodically instructed and				
	kept informed wit	h their duties under the				
		of the plan is readily				
		ephone operator or with				
		n addresses the basic				
		d of staff per 18/19.7.2.1.2 all of the fire safety plan				
	components per					
		18.7.1.3, 18.7.2.1.2,				
		3, 19.7.1.1 through 19.7.1.3,				
	19.7.2.1.2, 19.7.2					
	Based on record	l review, observation and	K 0711	What corrective action		07/07/201
	interview; the fa	acility failed to provide a		accomplished for tho		
	written plan tha	t addressed all		residents found to ha		
	components in	1 of 1 written fire plans.		affected by the deficie practice are as follow		
	_	quires a written health			5.	
		fire safety plan that shall		The "Fire Plan" will be	updated in	
		Survey prair that Shall		the "specific assignme		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/07/2017
	PROVIDER OR SUPPLIE		2860 C	ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE JAPOLIS, IN 46203	-
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E (X5) COMPLETION DATE
	provide for the (1) Use of alarr (2) Transmission department (3) Emergency department (4) Response to (5) Isolation of (6) Evacuation (7) Evacuation (8) Preparation evacuation (9) Extinguishr Section 19.2.3.4 aisle or corrido inches in clear means of egress rooms. Project width shall be p equipment prov wheeled equipr similar emergen written fire safe program for the equipment is lin i. Equipment in ii. Medical emergen use iii. Patient lift a	following: ns on of alarm to fire phone call to fire o alarms fire of immediate area of smoke compartment of floors and building for nent of fire 4(4) states any required r shall not be less than 48 width where serving as s from patient sleeping ions into the required permitted for wheeled vided the relocation of nent during a fire or ney is addressed in the ety plan and training e facility. The wheeled mited to: use and carts in use ergency equipment not in and transport equipment practice could affect all and visitors.		to include moving of medical equipment not in use to the nearest unoccupied room. Language will include crash patient lifts, treatment carts, carts, transport equipment at any other obstruction in the hallway. How other residents having potential to be affected by a same deficient practice will identified and what correct action will be taken is as follows: All residents have the potent be affected by this deficient practice. The "Fire Plan" will updated in the "specific assignments" section to inclu- moving of medical equipmer in use to the nearest unoccu room. Language will include crash carts, patient lifts, trea carts, med carts, transport equipment and any other obstruction in the hallway. What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur is a follows: Emergency action guides will be audited by the maintenance director and	carts, med nd g the the be ive iial to be ude nt not pied tment into

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 08/25/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOD MEDICADE & MEDICAID SEDVI

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 06/07/2017
	PROVIDER OR SUPPLIE	R	STREET 2860 C	ADDRESS, CITY, STATE, ZIP CO HURCHMAN AVE JAPOLIS, IN 46203	-
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE COMPLETION
TAG	Based on review "Fire Plan" docu Maintenance Su review from 8:4 06/07/17, the w not address the equipment durin emergency. Th the aforementio plan stated spect the event of fire housekeeping st hallways by mo laundry receptate etc. to the neare (shower, resider specifically add medical equipm lift and transport interview at the the Maintenance acknowledged th did not address wheeled equipm similar emerger observations wi Supervisor durin from 10:35 a.m 06/07/17, crash corridor by the and the B Wing	aff to "help clear the ving all linen carts, cles, housekeeping carts, st unoccupied room nt room, etc.,) but did not ress the relocation of ent not in use and patient t equipment. Based on time of record review, e Supervisor he written fire safety plan the relocation of all nent during a fire or acy. Based on th the Maintenance ing a tour of the facility to 12:40 p.m. on carts were noted in the A Wing nurse's station nurse's station. Hoyer in the corridor outside	TAG	 DEFICIENCY) ensure the proper language present. How the corrective active active be monitored to ensure deficient practice will rise. what quality assurate program will be put intra and by what date the signal changes will be completed by what date the signal changes will be audited by maintenance director and ensure the proper language present. Results of annual emerge action guide audit will be submitted to QA&A for risystemic changes will be completed by July 7th, 20 By what date the systechanges will be completed by July 7th, 20 	ion will the the not recur ance o place ystemic teted is action y the ad ally to lage is gency e eview. be 2017 mic eted is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YL5H21 Facility ID: 000063

If continuation sheet Page 9 of 15

PRINTED: 08/25/2017 FORM APPROVED OMD NO 0039 0301

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	r í	LDING	ONSTRUCTION <u>01</u>	СОМ	te survey pleted)7/2017
	PROVIDER OR SUPPLIE			2860 C	ADDRESS, CITY, STATE, ZIP COE CHURCHMAN AVE NAPOLIS, IN 46203	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	alarm signal and fire conditions. Fi unexpected times at least quarterly familiar with proof drills are part of e Responsibility for drills is assigned who are qualified Where drills are of PM and 6:00 AM may be used inst 18.7.1.4 through 19.7.1.7 Based on record the facility faile of the fire alarm drills conducted 9:00 p.m. for 1 19.7.1.4 states for occupancies shat transmission of simulation of en When drills are p.m. (2100 hou hours), a coded permitted to be alarms. This de	the fire alarm signal and mergency fire conditions. conducted between 9:00 rs) and 6:00 a.m. (0600 announcement shall be used instead of audible efficient practice could nts, staff and visitors in	К 07	712	What corrective actions accomplished for those residents found to have affected by the deficient practice are as follows: Fire alarms will be activa monthly basis in conjunc the monthly fire drill. If a is planned, the alarm will activated within the same period and documented is same section as the mor drills in chronological ord How other residents hav potential to be affected same deficient practice identified and what corr action will be taken is a	t ted on a tion with silent drill be 24 hour n the athly fire er. ving the by the will be rective	07/07/201

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155138	A. BUILDING B. WING	01	 06/07/2017
	PROVIDER OR SUPPLIE		2860 0	TADDRESS, CITY, STATE, ZIP CO CHURCHMAN AVE	DE
GOLDEI	N LIVING CENTER	-INDIANAPOLIS	INDIA	NAPOLIS, IN 46203	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETE
				follows:	
	Fire Drill" docu Maintenance Su review from 8:4 06/07/17, docum shift fire drill co 2:30 p.m. indica conducted after p.m. and did no fire alarm syste fire alarm signa	w of "Report of Monthly imentation with the ipervisor during record 45 a.m. to 10:35 a.m. on mentation for the first onducted on 03/08/17 at ated the drill was 6:00 a.m. but before 9:00 t include activation of the m and transmission of the 1. The aforementioned entation stated the drill		All residents have the po be affected by the same practice. Fire alarms will activated on a monthly b conjunction with the mon drill. If a silent drill is plan alarm will be activated w same 24 hour period and documented in the same as the monthly fire drills chronological order.	e deficient I be pasis in nthly fire nned, the vithin the d e section
	"silent drill" in the fire alarm as aforementioned stated "no sim" Central Monito fire alarm notifi	d silent drill" and stated response to "who sounded nd when." In addition, the fire drill documentation in response to "Did the ring Company receive the cation?" Based on		What measures will be place or what systemic changes will be made t ensure that the deficier practice does not recur follows:	io nt
	the Maintenanc facility operates a.m. to 6:00 p.m a.m.) and ackno for the aforeme conducted after	time of record review, e Supervisor stated the s two shifts per day (6:00 n. and 6:00 p.m. to 6:00 owledged documentation ntioned first shift fire drill 6:00 a.m. but before 9:00 lude activation of the fire	Maintenance director and Executive Director will review all fire drills and alarm activations each month to ensure alarms have been activated monthly in accordance with life safety code standards.		eview all vations larms nthly in
	-	nd transmission of the fire		How the corrective acti be monitored to ensure deficient practice will n i.e. what quality assura program will be put inte and by what date the sy changes will be comple	e the not recur nnce o place ystemic

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	AULTIPLE C	ONSTRUCTION		MB NO. 0938-0391 E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	î î	BUILDING	01	· ,	LETED
		155138	В. V	VING		06/07	7/2017
NAMEOE	PROVIDER OR SUPPLIE	D		STREET	ADDRESS, CITY, STATE, ZIP CODE		
					CHURCHMAN AVE		
GOLDEN	N LIVING CENTER	-INDIANAPOLIS		INDIAN	NAPOLIS, IN 46203		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE PRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	as follows:		DATE
					Maintenance director and		
					Executive Director will revie		
					fire drills and alarm activati each month to ensure alarr		
					have been activated month	-	
					accordance with life safety	-	
					standards. Results of the re		
					will be documented in QA8		
					verify and document that th alarms were activated and		
					drills have taken place prop		
					The systematic changes w		
					place by July 7th, 2017		
					By what date the systemic changes will be complete		
					as follows: July 7th, 2017	u 15	
K 0923	NFPA 101						
SS=E	-	Cylinder and Container					
Bldg. 01	Storag						
		Cylinder and Container					
	Storage	equal to 3,000 cubic feet					
		s are designed, constructed,					
	•	accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000						
		s are outdoors in an					
		in an enclosed interior limited- combustible					
		n door (or gates outdoors)					
		red. Oxidizing gases are not					
		nables, and are separated					
		es by 20 feet (5 feet if					
		nclosed in a cabinet of					
		construction having a					1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 06/07/2017	
	PROVIDER OR SUPPLIE N LIVING CENTER			2860 C	ADDRESS, CITY, STATE, ZIP CODE CHURCHMAN AVE NAPOLIS, IN 46203		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	e RIATE	(X5) COMPLETIC DATE
	minimum 1/2 hr. Less than or equ In a single smoke cylinders availab patient care area of less than or eco not required to be Cylinders must b as specified in 11 A precautionary s on each door or g room, where the as a minimum "C GAS(ES) STORE SMOKING." Storage is planne order of which the supplier. Empty from full cylinders cylinders with inte threshold pressu established. Em avoid confusion. open are protecte 11.3.1, 11.3.2, 1 99) Based on obser facility failed to nonflammable g properly secure oxygen storage NFPA 99, Heal 2012 Edition, S storage for nonf or greater than 3 cubic feet) shall and 5.1.3.3.2(7) req	fire protection rating. al to 300 cubic feet e compartment, individual le for immediate use in s with an aggregate volume jual to 300 cubic feet are e stored in an enclosure. e handled with precautions l.6.2. sign readable from 5 feet is gate of a cylinder storage sign includes the wording AUTION: OXIDIZING ED WITHIN NO ed so cylinders are used in ey are received from the cylinders are segregated s. When facility employs egral pressure gauge, a re considered empty is pty cylinders are marked to Cylinders stored in the	К 0		What corrective actions will accomplished for those residents found to have be affected by the deficient practice are as follows: A support chain was added to oxygen room to secure oxyg cylinders properly. How other residents having potential to be affected by the same deficient practice will identified and what correct	I be en to the en	07/07/20

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD				(X3) DATE SURVEY COMPLETED	
		155138	B. WING			06/07/	2017	
NAME OF	PROVIDER OR SUPPLIE	ER			DRESS, CITY, STATE, ZIP CODE			
GOLDE	N LIVING CENTER	-INDIANAPOLIS			RCHMAN AVE POLIS, IN 46203			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	П)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		FIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETI DATE	
	fastenings to se	cure all cylinders from		a	ction will be taken is as			
	falling, whether	r connected, unconnected,		fo	ollows:			
	full or empty.	This deficient practice			Il residents have potential to b			
	could affect 20	staff and visitors in the			ffected by the same deficient	50		
	vicinity of the c	oxygen storage and			ractice. A support chain was			
	transfilling room			a	dded to the oxygen room to ecure oxygen cylinders prope	rly.		
	Findings includ							
	Based on obser			Vhat measures will be put int	to			
	Maintenance Su		-	lace or what systemic hanges will be made to				
	the facility from			nsure that the deficient				
	on 06/07/17, th			ractice does not recur is as				
	oxygen cylinde		fo	ollows:				
	and transfilling							
	room were not			n audit will be added to the	c			
		proper cylinder stand, cart			daily interior rounds" section o uilding engines to check the	or		
	or rack. Eight l			roper securing and storage of	all			
	-	ved stored in the room.			ompressed gas cylinders on a			
		view at the time of the		d	aily basis.			
		ne Maintenance Supervisor						
		three of eight 'E' type						
	-		.	low the corrective action will				
	oxygen cylinde			e monitored to ensure the				
	oxygen storage			eficient practice will not rec	ur			
	were not proper			e. what quality assurance				
	a proper cylind	a proper cylinder stand, cart or rack.			rogram will be put into place			
					nd by what date the systemi			
	3.1-19(b)				hanges will be completed is s follows:			
				Δ	n audit will be added to the			
					daily interior rounds" section o	of		
					uilding engines to check the			
				р	roper securing and storage of			
					ompressed gas cylinders on a	a		
	1			Ы	aily basis. Results of daily			

				PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155138		(X2) MULTIPLE CC A. BUILDING B. WING	<u>v</u>		
		2860 C	HURCHMAN AVE		
(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) interior rounds will be reported the QA&A for review. Systemi changes will be completed by 7th, 2017	DATE d to c	
			By what date the systemic changes will be completed is as follows: July 7th, 2017	5	
	MEDICARE & MEDIC T OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIEF LIVING CENTER- SUMMARY S (EACH DEFICIEN	DF CORRECTION IDENTIFICATION NUMBER: 155138 ROVIDER OR SUPPLIER LIVING CENTER-INDIANAPOLIS	Image: Medicare & Medicard Services T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 155138 B. WING STREET / 2860 C LIVING CENTER-INDIANAPOLIS ID SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	MEDICARE & MEDICAID SERVICES T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING 01 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIVING CENTER-INDIANAPOLIS STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS will be reported the QA&A for review. Systemic changes will be completed by 7th, 2017 By what date the systemic changes will be completed is	

5H21 Facility ID: 000063