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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	05/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/18/21 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Golden Living Center - Bloomington was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 153 certified beds. At the time of the survey, the census was 111. Quality Review completed on 05/24/21	E 0000	The submission of this Plan of Correction does not indicate an admission by Golden Living of Bloomington (the “Facility”) that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living—Bloomington. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is submitted as a matter of statute only. We are respectfully requesting paper compliance for this survey (survey event ID 7UC221). We are requesting a desk review with paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000	The submission of this Plan of Correction does not indicate an	

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

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

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	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/18/21 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Golden Living Center-Bloomington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 111 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/24/21		admission by Golden Living of Bloomington (the “Facility”) that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living—Bloomington. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is submitted as a matter of statute only. We are respectfully requesting paper compliance for this survey (survey event ID 7UC221). We are requesting a desk review with paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means			

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	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to ensure 1 of 8 corridor means of egress were continuously maintained free of obstructions. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 05/18/21 during a tour of the facility from 12:30 p.m. to 2:00 p.m. with the Administrator and Director of Maintenance, the following was noted: a. An unwheeled contact isolation cart was stored in Station One hall corridor by resident room 9. b. An unwheeled contact isolation cart was stored in Station One hall corridor by resident room 10. Based on an interview at the time of observations, the Director of Maintenance acknowledged the	K 0211	**F 211=E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It shall be the policy of Golden Living Bloomington to make sure all means of egress will remain free of obstructions. The un-wheeled isolation carts were removed and replaced for resident room 9 and resident room 10 with wheeled carts. See Exhibit A **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 have the potential to be affected by the alleged deficient practice. All isolation carts in the hallway were inspected to make sure they were wheeled. No other issues were noted. The “Mean of Egress Policy” (exhibit B) was reviewed and no changes were noted. Maintenance staff, Housekeeping staff, and nursing staff were educated on the “Means of Egress Policy”.	06/17/2021

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	above mentioned items in the corridor were unwheeled. These findings were reviewed with the Administrator at the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or Designee will utilize the Life Safety Survey (exhibit C) to monitor compliance. The audit will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months, and Quarterly for 2 quarters. The audit results will be submitted through the QAPI committee to determine if compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that			

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	requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by			

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	an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect approximately 16 residents, staff and visitors if needing to exit the facility in an emergency. Findings include: Based on observations with the Administrator and Director of Maintenance during a tour of the facility at 12:25 p.m. on 05/18/21, the south exit door by the dining room and kitchen was	K 0222	**F 222=E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It shall be the policy of Golden Living Bloomington to maintain door codes at all exit doors. The door at the south end of the dining room/kitchen now has a posted code so it can be accessed and exited if needed. See Exhibit D **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;**	06/17/2021

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	magnetically locked and could be opened by entering a four-digit code, but the code to the door was not posted at the exit. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned exit was indeed marked as an exit and could only be opened by entering a four-digit code, but the code was not posted at the door. This finding was discussed with the Administrator at the exit conference. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. Exit doors were inspected for posted exit codes and no other issues were noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and his assistant were educated on the need for the codes to be posted by exit doors. The "Life Safety Audit Tool" (exhibit C) will be used to monitor compliance. The audit will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months, and quarterly for 2 quarters. The results will be submitted to the QAPI committee to determine if compliance has been achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of**	

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			correction date; **6/17/2021**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			
	1.) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 05/18/21 at 9:45 a.m., the last fire alarm report dated 01/07/21 by the facility's fire alarm vendor was the annual inspection. The report indicated "3 smoke detectors were not replaced since last inspection and need replaced." Based on interview at the time of record review, the Director of Maintenance confirmed the issue but was unable to show documentation showing repairs have been made or were scheduled to be	K 0345	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It shall be the policy of Golden Living Bloomington to review all inspection reports and correct deficiencies in a timely manner. The three (3) defective smoke detectors reported in the 1/7/21 report were replaced with functioning detectors. See Exhibit E. **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 have the potential to	06/17/2021

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	repaired. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 2.) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g., duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the Director of Maintenance on 05/18/21 at 9:40 a.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Director of Maintenance agreed that visual semi-annually inspections of the fire-alarm system were not completed on a semi-annual basis. This finding was reviewed with the Administrator		be affected by the alleged deficient practice. The Three (3) defective smoke detectors were replaced with functioning detectors. The report was reviewed for other noted faulty fire equipment during the 1/7/21 inspection. No other problems were noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and assistant were educated on the importance of monitoring all inspection reports for recommendations. The Maintenance Director or designee will monitor all inspection reports on the “Inspections Recommendations Log” (Exhibit F) and correct the deficiencies in a timely manner. A log of inspection recommendations will be maintained and monitored for timely corrections. This log will be completed and presented to the Quality Assurance meeting Monthly for 12 months. The QAPI committee will then determine if compliance has been achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined**	

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	at the exit conference. 3.1-19(b)		**that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure 2 of 2 sprinkler heads in the shower room covered with dust/lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It shall be the policy of Golden	06/17/2021

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	sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry room. Findings include: Based on observation with the Administrator and Director of Maintenance during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 05/18/21, the two sprinkler heads located in Station Two shower room were covered with dust/lint. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned automatic sprinkler was loaded with dust/lint. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		Living Bloomington to ensure all spinklers are cleaned according to the regulatory requirement. The two noted sprinklers in the station 2 shower room were immediately cleaned. See exhibit G **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 have the potential to be affected by the alleged deficient practice. Sprinkler heads have been inspected and no other issues were noted. The Policy “Sprinkler System” (exhibit H) was reviewed with no changes were made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and Assistant were educated on the policy “Sprinkler System” (see exhibit H) The “Life Safety Survey 2021 Audit Tool” (exhibit C) will be completed weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months and quarterly for 2 quarters. . The results will be submitted to the Quality Assurance Committee for review to determine if compliance has	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observations and interview, the facility failed to ensure 1 of 1 basement boiler room ceiling was constructed to provide at least a one half hour fire resistance rating. LSC Section 8.5.2.1	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/17/2021

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	requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect approximately 10 residents and 4 staff. Findings include: Based on observation with the Director of Maintenance during a tour of the facility on 05/18/21 at 1:15 p.m., there was a pipe measuring approximately two and one-half inches in diameter in the basement boiler room ceiling that had approximately one-half inch of annular space around about 20 cables running up into the pipe extending up into the floor area above. The above mentioned penetration was acknowledged by the Director of Maintenance at the time of observation. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**practice;** It is the policy of Golden Living Bloomington to ensure all smoke barriers meet the regulatory requirements. The noted annular space was sealed with fire caulk (see exhibit I). This will ensure one continuous fire wall without any open penetrations. See Exhibit J. **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 have the potential to be affected by the alleged deficient practice. All fire walls have been inspected throughout the facility for any open penetrations and no other problems were noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and Assistant were educated on unsealed penetrations in fire walls and fire caulk. The Maintenance Director or designee will utilize the “Life Safety Survey Audit Tool” (exhibit C) to monitor all fire walls monthly for 3 months and then Quarterly for 3 Quarters. All results will be submitted to the	

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			Quality Assurance Committee to determine if compliance has been achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, National Electric Code, 2011 edition states energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Golden Living Bloomington to secure all electrical panels and to be only	06/17/2021

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	contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations during tour of the facility with the Administrator and Director of Maintenance on 05/18/21 at 1:47 p.m., an electrical panel located by room 119 & 135 in Station Two Hall corridor were each not locked, secured or in a secured room. Based on interview at the time of the observation, the Director of Maintenance agreed that the aforementioned electrical panels located in Station Two Hall corridor were not secured from non-authorized personnel. These findings were reviewed with the Administrator at the exit conference. 3.1-19(b)		accessible by authorized personnel. The panels in question have been secured so that only authorized personnel can access them. See exhibit K **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 have the potential to be affected by this alleged deficient practice. All electrical panels were inspected and no other problems were noted. Staff will be educated on the policy “Electrical Safety” (see exhibit L) to ensure all electrical panels remain locked unless being utilized by authorized personnel. The policy “Electrical Safety” (exhibit L) was reviewed and no changes were made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and Assistant were educated on the policy “Electrical Safety” (see exhibit L). and maintaining secured electrical Panels. The Maintenance Director or Designee will utilize the “Life Safety Survey 2021 Audit Tool” (see exhibit C) to	

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			monitor the electrical panels weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months, and quarterly for 2 quarters. The audits will be submitted to the Quality Assurance Committee for determination of compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE			

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	meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Golden Living Bloomington that power strips will not be used as a source of fixed wiring. The power strip noted was immediately 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;** All residents have the potential to be affected. A building wide search was conducted with no other issues noted. The policy “Electrical Safety” (see exhibit L) was reviewed and no changes were made. Staff will be educated on the proper use of power strips.	06/17/2021

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	grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 15 residents and staff. Findings include: Based on observation with the Administrator and Director of Maintenance during a tour of the facility on 05/18/21 at 12:15 p.m., the following was noted: a mini refrigerator, microwave oven and a coffee pot were plugged into a power strip in the Unit Manager's office in the Alzheimer's Care unit. Based on interview at the time of the observation, the Director of Maintenance acknowledged the items plugged into the power strip as a substitute for fixed wiring at the aforementioned location. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director and Assistant were educated on the “Electrical Safety” policy (see exhibit L). The “Life Safety Survey 2021 Audit Tool” (see exhibit C) will be utilized to monitor for the inappropriate use of power strips. The audit will be conducted weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months, and quarterly for 2 quarters. The audits will be submitted to the Quality Assurance Committee for determination of compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 01	Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.			

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	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 2 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any resident, staff, or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations on 05/18/21 during the tour of the facility at 12:03 p.m. with the Administrator and Director of Maintenance, there was a seven foot long wooden countertop and three cardboard boxes within 5 feet of the stored oxygen tanks in the oxygen transfilling room in Station One corridor across from the nurse's station. Based on interview at the time of observation, the Director of Maintenance acknowledged that combustible materials were stored within five feet of stationary liquid oxygen containers and stated that he would have the countertop and cardboard boxes removed. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0923	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Golden Living Bloomington that oxygen is stored within the regulatory requirements. The countertop and box were immediately removed from the oxygen storage room. See exhibit M. **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 have the potential to be affected by alleged deficient practice. The facility has two oxygen storage areas. The second area was inspected and found to have no issues. The Maintenance department, Nursing department, and Housekeeping department will be educated on the policy of Oxygen Safety (see exhibit N). This policy was reviewed and no changes were made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	06/17/2021

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			The “Life Safety Survey 2021 Audit Tool” (exhibit C) will be used to monitor the proper use of oxygen storage areas weekly for 4 weeks, bi-monthly for 2 months, monthly for 3 months, and quarterly for 2 quarters. The results of the audit will be submitted to the Quality Assurance Committee for review of compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **6/17/2021**	