STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING -- B. WING	02/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/05/19 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Emergency Preparedness survey, Golden Living Center-Richmond was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 122 certified beds. At the time of the survey, the census was 63. Quality Review completed on 02/12/19	E 0000		
E 0025 SS=F Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include:	E 0025	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice: Written agreements were obtained with a LTC facility and other provider (see E0025A & E0025B) 2. How other residents having the potential to be affected by this	03/07/2019

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

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	Based on review of the Emergency Preparedness Plan with the Maintenance Supervisor and the Administrator during record review from 10:15 a.m. to 3:00 p.m. on 02/05/19, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the Administrator agreed documentation of arrangements with other facilities was not available for review at the time of the survey.		same alleged deficient practice will be identified and what corrective action will be taken: The written agreements were obtained. 3. What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice will not recur The facility Administrator shall review annually that the written agreements are still in effect. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie. what quality assurance program will be put into place: The facility Administrator will present to the quality assurance committee the updated written agreements at QAPI. Written agreements will be placed in Emergency Preparedness Plan binders.	
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 483.90(a). Survey Date: 02/05/19	K 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or an agreement with the facts and conclusions set forth on the survey report.	

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	Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Life Safety Code survey, Golden Living Center-Richmond 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 was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 63 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled. Quality Review completed on 02/12/19		Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable Federal and State regulatory requirements.	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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	18.2, 19.2 Based on observation and interview, the facility failed to ensure 4 of 4 exit doors from staff office rooms were provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could staff on Administration hall. Findings include: Based on observations during a tour of the facility on 2/05/19 at 11:37 a.m., with the Maintenance Supervisor (MS) the following corridor doors were equipped with an independent dead bolt in addition to the door knob lock: a. Front reception office. b. Business office. c. Assistant DON's office. d. Administrator's office. Based on interview at the time of observations, with the MS it was acknowledged items a-d corridor doors had an independent dead bolt in addition to door knob lock. 3.1-19(b)	K 0200	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice: Dead bolts were removed from the following doors: A. Front reception office (see photo K0200A) B. Business Office (see photo K0200B) C. Assistant DON's Office (see photo K0200C) D. Administrator's Office (see photo K0200D) 2. How other residents having the potential to be affected by this same alleged deficient practice will be identified and what corrective actions will be taken: The facility recognizes that all residents who reside in the facility have the potential to be affected by this alleged deficient practice. The dead bolts were removed from the doors. 3. What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice will not recur: A facility audit was performed to ensure compliance with K-0200 . Since the facility Administrator and maintenance supervisor are the two facility staff members	03/07/2019

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			responsible for generating and approving maintenance requests to facility property. Both the Administrator and maintenance supervisor understand that doors can only have one locking mechanism. (see attachment K0200E) 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance program will be put in place: The Administrator will provide to the quality assurance committee during the monthly QAPI meeting that the is in compliance with K0200.	
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 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, the facility failed to meet the clear width requirement for 1 of 7 corridors was continuously maintained free of all obstructions to full use in case of emergency.	K 0211	1. What corrective action action will be accomplished for those residents found to have been affected by this alleged deficient	03/07/2019

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	This deficient practice could affect 19 residents, visitor and staff . Findings include: Based on observation on 02/05/19 during the tour between 12:29 p.m. to 3:00 p.m. with the Maintenance Supervisor (MS) the exit corridor next to laundry, there was a resident bed with mattresses in the corridor. Based on interview at the time of the observation and measurement with the MS and later with the Administrator, it was acknowledged the resident bed with mattersses stored in the corridor was an impediment in the means of egress. 3.1-19(b)		practice: The resident bed and mattress was immediately removed to a proper storage area. 2. How other residents having the potential to be affected by this same alleged deficient practice will be identified and what corrective action will be taken. The maintenance supervisor immediately removed the resident bed and mattress to an appropriate storage location. 3. What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice will not recur: The maintenance supervisor will conduct rounds to ensure means of egress are free of obstructions. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance program will be put into place: Administrator will present audit pertaining to K0211 to the quality assurance members monthly at QAPI to ensure compliance.	
K 0342 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Initiation Fire Alarm System - Initiation			

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	Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 Based on observation and interview the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2012 edition, sections 19.3.4, 9.6 and NFPA 72 - 2010 edition, sections 10.14.3 and 10.14.3.1. This deficient practice had the potential to affect approximately 20 of the 47 residents. Findings include: Based on observation on 02/05/19 during the tour between 11:30 a.m. to 3:00 p.m. with the Maintenance Supervisor (MS), the fire alarm pull station located in the corridor next to laundry was blocked by a set of employee lockers and hidden from view. When the MS was asked to locate a pull station for the laundry hall exit he searched for one beyond the set of smoke doors and was unaware one was five feet from the exit door. Based on interview with the MS concurrent with the observation it was acknowledged the pull station was blocked from view by employee lockers and the lockers needed to be moved. 3.1-19(b)	K 0342	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice: The lockers were immediately moved so that the fire alarm pull station is in sight. (seeK0342A) 2. How other residents having the potential to be affected by this same alleged deficient practice will be identified and what corrective action will be taken: The facility recognizes that all residents who reside in the facility have the potential to be affected by the alleged deficient practice. The fire alarm pull station was in sight and since remains. The maintenance supervisor will make rounds to ensure the fire	03/07/2019

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			alarm pull stations are visible and accessible. 3. What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice will not recur: The maintenance supervisor / and or other will make rounds to ensure fire alarm pull stations are visible and accessible. 4. How will corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance program will be put in place: The results of fire panel alarm rounds will be presented to the quality assurance committee during monthly QAPI meetings.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in			

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	clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 4.6.7.5 requires existing life safety features that do not meet the requirements for new buildings, but exceed the requirements for existing buildings shall not be further diminished. This deficient practice could affect 18 residents on ECU and 19 residents on TCU including visitors and staff. Findings include: Based on observations on 02/05/19 during the tour between 11:10 a.m. to 3:00 p.m. with the Maintenance Supervisor (MS), the following areas had sprinkler heads installed within six feet: a) 2 of 4 sprinkler heads in the TCU lounge measured five feet apart. b) 2 of 4 sprinkler heads in the ECU Nursing station measured five feet apart. Based on interview at the time of the observations, the MS acknowledged the distance of the sprinkler heads in items a and b were spaced less than six feet on center from each other.	K 0351	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice: On 2-21-19 service work to both the areas A) TCU lounge and B) ECU nurse station was completed. (see K0351 A) 2. How other residents having the potential to be affected by this same alleged deficient practice will be identified and what corrective actions will be taken: The facility recognizes that all residents who reside in the facility have the potential to be affected by this alleged deficient practice. Service work was completed on 2-21-19 to correct the situation. 3. What measures will be put into place or what systemic changes will be made to ensure the alleged deficient practice will not recur: A facility audit will be conducted to identify areas that may have similar installation.	03/07/2019

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	3.1-19(b)		4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie.e, what quality assurance program will be put into place: The results of the audit will be presented to the quality assurance committee during their monthly QAPI meeting.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors			

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	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 2 sets of double corridor doors would close completely and latch independently into their door frames. This deficient practice could affect residents, staff and visitors in the Therapy room. Findings include: Based on observations on 02/05/19 during a tour of the facility between 11:05 p.m. to 2:40 p.m. with the Maintenance Supervisor, there were two sets of double corridor doors leading into the Therapy room on Therapy hall which did not latch independently into their door frames. Based on interview this was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K 0363	1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice: On 2-19- 19 the two sets of double doors were professionally repaired. (see attachment K0363A & K0363 B,C,D,E) 2. How other residents having the potential to be affected by this same alleged deficient practice will be identified and what corrective action will be taken: The facility recognizes that all residents who reside in the facility have the potential to be affected by the alleged deficient practice. The repair was made on 2-19-19. 3. What measures will be put into place or what systemic changes	03/07/2019

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			will be made to ensure the alleged deficient practice will not recur: An audit was conducted facility wide to determine if other double corridors are in compliance with K0363. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance program will be put into place: Results of the audit will be presented to the quality assurance committee during their monthly QAPI meetings.	