PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u></u>	COMPLETED	
		155157	B. WING		05/25/2021	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹				
COLDEN	LIVING CENTER-	BICHMOND	1042 O	OND, IN 47374		
GOLDEN	I LIVING CENTER-	RICHMOND	KICI IIVI	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg						
		paredness Survey was	E 0000	The creation and submission of	of	
	•	idiana Department of Health		this Plan of Correction (POC)		
	in accordance with	42 CFR 483.73.		does not constitute an admiss		
				by this provider of any conclus	sion	
	Survey Date: 05/25	5/21		set forth in the statement of	_	
				deficiencies, or of any violation	n of	
	Facility Number: 0			regulation.		
	Provider Number:			This provider respectfully requ	ests	
	AIM Number: 100	266490		that this CMS-2567 Plan of		
	And the second	D 1 C 11		Correction be considered the	_	
		Preparedness survey, Golden		Letter of Credible Allegation of		
	_	mond was found not in		Compliance and requests a de	esk	
	-	nergency Preparedness Medicare and Medicaid		review in lieu of a post-survey		
	_	ders and Suppliers, 42 CFR		review on, or after June 24, 20)21.	
	483.73.	iers and Suppliers, 42 CFK				
	403.73.					
	The facility has 122	2 certified beds. At the time				
	of the survey, the co					
	Ouality Review con	mpleted on 05/27/21				
E 0037	403.748(d)(1), 416	6.54(d)(1), 418.113(d)(1),				
SS=F	441.184(d)(1), 482	2.15(d)(1), 483.475(d)(1),				
Bldg	483.73(d)(1), 484.	.102(d)(1), 485.625(d)(1),				
	485.68(d)(1), 485.	.727(d)(1), 485.920(d)(1),				
	486.360(d)(1), 49 ⁻	1.12(d)(1)				
	EP Training Progr	ram				
	§403.748(d)(1), §4	416.54(d)(1), §418.113(d)				
	(1), §441.184(d)(1					
		83.73(d)(1), §483.475(d)				
	(1), §484.102(d)(1					
	- ,,,,	485.727(d)(1), §485.920(d)				
	(1), §486.360(d)(1), §491.12(d)(1).				
	-	3403.748, ASCs at				
	§416.54, Hospitals	s at §482.15, ICF/IIDs at				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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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TITLE

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PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155157		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/25/2021	
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL NO CONTROLLED BY THE PROPERTY OF T		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	RE	(X5) COMPLETION
TAG	§483.475, HHAs a "Organizations" u §486.360, RHC/F (1) Training prog all of the following (i) Initial training in policies and proce existing staff, indi under arrangeme consistent with th (ii) Provide emerging at least ed (iii) Maintain docupreparedness training at least ed (iv) Demonstrate emergency proce (v) If the emerger and procedures at the [facility] must updated policies at The hospice must (i) Initial training in policies and proceed providing services consistent with the (ii) Demonstrate is emergency proceed (iii) Provide emergency proceed (iv) Periodically red emergency prepared employees (included with special empth the procedures red and others.	nder §485.727, OPOs at QHCs at §491.12:] ram. The [facility] must do g: n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. gency preparedness very 2 years. umentation of all emergency ning. staff knowledge of dures. ncy preparedness policies re significantly updated, conduct training on the and procedures. §418.113(d):] (1) Training. It do all of the following: n emergency preparedness edures to all new and employees, and individuals is under arrangement, eir expected roles. staff knowledge of dures. gency preparedness very 2 years. eview and rehearse its redness plan with hospice ding nonemployee staff), nasis placed on carrying out excessary to protect patients mentation of all emergency		TAG	DEFICIENCY)		DATE

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Event ID:

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		155157	B. W	ING		05/25	/2021
NAME OF F	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	ROVIDER OR SOTTEEL			1042 O			
GOLDEN	I LIVING CENTER-	RICHMOND		RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ΔTE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIL	DATE
	(vi) If the emerger	ncy preparedness policies					
	· ·	re significantly updated,					
		conduct training on the					
	updated policies a	and					
	procedures.						
	*IFor DDTFs at 8/	141.184(d):] (1) Training					
		TF must do all of the					
	following:	Tr must do an or the					
		n emergency preparedness					
		edures to all new and					
	1 '	viduals providing services					
	under arrangemei	nt, and volunteers,					
	consistent with the	eir expected roles.					
	1 ' '	ning, provide emergency					
	1 ' '	ning every 2 years.					
	1 ' '	staff knowledge of					
	emergency proce						
	l ' '	mentation of all emergency					
	preparedness trai	ning. cy preparedness policies					
	` <i>'</i>	re significantly updated,					
		onduct training on the					
	updated policies a	<u> </u>					
		ma procedures.					
	*[For PACE at §46	60.84(d):] (1) The PACE					
	-	do all of the following:					
	(i) Initial training ir	n emergency preparedness					
	policies and proce	edures to all new and					
	existing staff, indiv	viduals providing on-site					
		rangement, contractors,					
	1 -	volunteers, consistent with					
	their expected role						
		ency preparedness					
	training at least ev						
		staff knowledge of					
		dures, including informing					
		at to do, where to go, and n case of an emergency.					
		mentation of all training.					
	i (1 <i>v)</i> iviairitairi uocu	montation of all trailing.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED	
11.15 12.11		155157	B. W			05/25/	
				STREET	ADDRESS, CITY, STATE, ZIP CODE	1 2 7 2 37	
NAME OF F	PROVIDER OR SUPPLIER	8		1042 O			
GOLDEN	I LIVING CENTER-	RICHMOND			OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ncy preparedness policies		TAG	DEFICIENCY		DATE
	, ,	re significantly updated,					
	l '	onduct training on the					
	updated policies a	and procedures.					
	l -	s at §483.73(d):] (1) The LTC facility must do					
	all of the following						
		· n emergency preparedness					
	policies and proce	edures to all new and					
	•	viduals providing services					
	I -	nt, and volunteers,					
	consistent with the	eir expected role. ency preparedness					
	training at least ar	•					
	_	mentation of all emergency					
	preparedness trai						
	1 ' '	staff knowledge of					
	emergency proced	dures.					
		485.68(d):](1) Training.					
		do all of the following:					
		raining in emergency cies and procedures to all					
	1 ' '	staff, individuals providing					
	_	rangement, and volunteers,					
	consistent with the	eir expected roles.					
	' '	ency preparedness					
	training at least e						
	(iii) Maintain docu (iv) Demonstrate s	mentation of the training.					
	l ` '	dures. All new personnel					
		and assigned specific					
		garding the CORF's					
		vithin 2 weeks of their first					
	1	ning program must include					
		ocation and use of alarm					
	systems and signal equipment.	ais and illelighting					
		ncy preparedness policies					
	<u> </u>	• • •					

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Event ID:

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING		COMPL	
		155157	B. WII	NG		05/25/	/2021
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	-ROVIDER OR SUFFLIER			1042 O	AK DR		
GOLDEN	I LIVING CENTER-	RICHMOND		RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and procedures a	re significantly updated,					
		onduct training on the					
	updated policies a						
	<u>'</u>	·					
	*[For CAHs at §48	35.625(d):] (1) Training					
	_	H must do all of the					
	following:						
	(i) Initial training in	n emergency preparedness					
	policies and proce	edures, including prompt					
	reporting and exti	nguishing of fires,					
		nere necessary, evacuation					
	of patients, perso	nnel, and guests, fire					
prevention, and cooperation with firefighting							
		orities, to all new and					
	_	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
	, ,	ency preparedness					
	training at least ev						
	, ,	mentation of the training.					
		staff knowledge of					
	emergency proce						
	, ,	ncy preparedness policies					
		re significantly updated, nduct training on the					
	updated policies a	_					
	upuateu policies a	and procedures.					
	*IFor CMHCs at 8	485.920(d):] (1) Training.					
		provide initial training in					
		redness policies and					
		new and existing staff,					
	-	ing services under					
	-	volunteers, consistent with					
	their expected role						
		the training. The CMHC					
		staff knowledge of					
		dures. Thereafter, the					
	CMHC must provi						
	preparedness trai	ning at least every 2 years.					
		view and interview, the	E 00	37	It is the practice of this provide	er to	06/24/2021
	I		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		155157	B. W	B. WING		05/25/2021	
		<u>l</u>		STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1042 O			
COLDEN	I LIVING CENTER-	DICHMOND			OND, IN 47374		
GOLDEN	I LIVING CENTER-	-RICHWOND		KICHIVI	OND, IN 47374		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility failed to en	sure the emergency			ensure that federal participation	n	
	preparedness traini	ng and testing program			requirements for nursing home	es	
	includes a training	program. The LTC facility			participating in Medicare &/or		
	must do all of the f	following: (i) Initial training in			Medicaid programs are met in		
	emergency prepare	dness policies and procedures			accordance with federal and s	tate	
		ting staff, individuals providing			law.		
		ngement, and volunteers,			What corrective action(s) will be	e	
		ir expected roles; (ii) Provide			accomplished for those reside		
		dness training at least			found to have been affected b		
		ntain documentation of the			the deficient practice?	•	
	•	onstrate staff knowledge of			Training on the Emergency		
	emergency procedu	ares in accordance with 42			Preparedness Disaster Manua	ıl	
	CFR 483.73(d)(1).	This deficient practice could			(EPDM) is conducted for all ne		
	affect all residents				employees and no less freque		
		•			than annually thereafter. Evide	•	
	Findings include:				of the annual training and		
					subsequent testing will be reta	ined	
	Based on review of	f the Emergency Preparedness			per compliance.		
	Disaster Manual w	ith the Maintenance			How other residents having th	e	
	Supervisor (MS) or	n 05/25/21 at 10:40 a.m.,			potential to be affected by the	•	
	there was no docur	nentation to indicate facility			same deficient practice will be		
	staff were trained of	on the Emergency			identified and what corrective		
	Preparedness Disas	ster Manual over the past year.			action(s) will be taken?		
	Based on an intervi	iew with the Administrator, it			All residents in the facility have	_	
	was stated the facil	ity has not trained the staff			the potential to be affected by		
	and documented th	e training on the Emergency			same alleged deficient practice		
	Preparedness Disas	ster Manual and the facility			Training on the Emergency	٥.	
	does not have a tes	ting program. This was			Preparedness Disaster Manua	ıl	
	confirmed and revi	ewed with the Administrator			(EPDM) is conducted for all ne		
	during the exit con	ference.			employees and no less freque		
					than annually thereafter. Evide	-	
					of the annual training and	71100	
					subsequent testing will be reta	ined	
					per compliance.		
					What measures will be put into	1	
					place and what systemic	•	
					changes will be made to ensu	ro	
					that the deficient practice does	•	
					not recur?		
1	1		1				1

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	OF CORRECTION	IDENTIFICATION NUMBER: 155157	A. BUILDING B. WING	UNSTRUCTION	COMPLETED 05/25/2021		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374				
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
K 0000				Facility staff responsible for the EPDM training and subsequent testing will be inserviced on the alleged deficient practice and be educated in accordance with facility policy and professional standards of practice. How the corrective action(s) who be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the GLCR (OE037-20210525 Audit Tool. Progress will be monitored on business days for one (1) more weekly for four (4) weeks, and semi-monthly for four (4) monor until substantial compliance met. Documentation of all activities associated with this will be noted on said audit too The Executive Director (Administrator) and/or designed will review the audit tool(s) on business days during StandUple accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administration and/or designed will be responsible for monitoring this POC to ensure its successful completion.	nt lee will lith lith lith lith lith lith lith l		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
		155157	B. WI		 	05/25/2021	
		100101			_	00/20/	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
				1042 OAK DR			
GOLDEN	LIVING CENTER-	RICHMOND		RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 01							
	A Life Safety Code	Recertification and State	K 0	000	The creation and submission of	of	
	Licensure Survey was conducted by the Indiana				this Plan of Correction (POC)		
	Department of Heal	Ith in accordance with 42			does not constitute an admiss	ion	
	CFR 483.90(a).				by this provider of any conclus	sion	
	,				set forth in the statement of		
	Survey Date: 05/25	5/21			deficiencies, or of any violation	n of	
	,				regulation.		
	Facility Number: 0	000077			This provider respectfully requ	ests	
	Provider Number:				that this CMS-2567 Plan of		
	AIM Number: 100				Correction be considered the		
	111111111111111111111111111111111111111	200.50			Letter of Credible Allegation of	f	
	At this Life Safety (Code survey Golden Living			_		
	At this Life Safety Code survey, Golden Living Center-Richmond was found not in compliance				Compliance and requests a de	55K	
	with Requirements	-			review in lieu of a post-survey	١٥4	
	_	, 42 CFR Subpart 483.90(a),			review on, or after June 24, 20)21.	
		re and the 2012 edition of the					
	-	ction Association (NFPA)					
		ode (LSC), Chapter 19,					
	-	re Occupancies and 410 IAC					
	16.2.	te Occupancies and 410 IAC					
	10.2.						
	This one story facil	ity was determined to be of					
	_	ruction and fully sprinkled.					
		re alarm system with smoke					
	-	ridors, spaces open to the					
		ry operated smoke detectors					
		ing rooms. The facility has a					
		had a census of 56 at the					
	time of this visit.	had a census of 50 at the					
	unic of this visit.						
	All areas where resi	idents have customary access					
		all areas providing facility					
		kled. The facility has two					
	_	torage sheds which were not					
	sprinkled.	serage sheat which were not					
	sprinkied.						
	Quality Review con	mpleted on 05/27/21					
	Quality Review Con						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155157		A. BUILDING 01 B. WING		COMPLETED 05/25/2021		
	PROVIDER OR SUPPLIER I LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374				
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview the facility failed to maintain exit access routes free and clear of obstructions for 1 of 5 corridor exit access in accordance with the requirements of NFPA 101, 2012 edition, sections 19.2, 19.2.1, 7.1.10 and 7.1.10.1. This deficient practice could affect any resident, staff or visitor exiting through the Vacant hall. Findings include: Based on observation on 05/25/21 at 12:35 p.m. with the Maintenance Supervisor (MS) there was two resident beds stored in the corridor of the Vacant hall reducing the eight foot width of the corridor to 52 inches. Based on interview concurrent with the observation with the MS it was stated the beds were just there temporarily and would be removed. This was discussed with Administrator and MS during the exit conference. 3.1-19(b)	K 0232	It is the practice of this provide ensure that federal participation requirements for nursing home participating in Medicare &/or Medicaid programs are met in accordance with federal and slaw. What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? The vacant corridor was cleare immediately after LSC survey conference. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by same alleged deficient practice. The vacant corridor was cleare immediately after LSC survey conference. All aisles or corridin facility will be monitored to ensure regulatory compliance regarding areas serving as exiaccess.	es tate pe nts y ed exit e the e. ed exit lors		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155157	A. BUILDING B. WING	<u>01</u>	COMPLETED 05/25/2021
	ROVIDER OR SUPPLIEF		1042 O	ADDRESS, CITY, STATE, ZIP CODE IAK DR IOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All staff will be inserviced on the alleged deficient practice and be educated in accordance with facility policy and professional standards of care (see attached policies and/or related documents). How the corrective action(s) who be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the GLCR (OCK X232-20210525 Audit Tool. Progress will be monitored on business days for one (1) mor weekly for four (4) weeks, and semi-monthly for four (4) monitored until substantial compliance met. Documentation of all activities associated with this limits will be noted on said audit too. The Executive Director (Administrator) and/or designed will review the audit tool(s) on business days during StandUp accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designed will be	re s ne will th ed fill 096) ath, ths e is POC d. ee o, in

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN	155157	ATION NUMBER:	B. WING	01	05/25/2021
	100107				05/25/2021
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
001.05	LLIVING CENTED DICHMON	ID.	1042 O		
GOLDEN	I LIVING CENTER-RICHMON	טו	RICHM	OND, IN 47374	
(X4) ID	SUMMARY STATEMENT	OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BI		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR LSC IDENTI	FYING INFORMATION)	TAG	DEFICIENCY)	DATE
				responsible for monitoring this	
				POC to ensure its successful	
				completion.	
K 0321	NFPA 101				
SS=D	Hazardous Areas - Enclosur	re			
Bldg. 01	Hazardous Areas - Enclosur	re			
	Hazardous areas are protec	ted by a fire			
	barrier having 1-hour fire res	sistance rating			
	(with 3/4 hour fire rated door	•			
	automatic fire extinguishing	-			
	accordance with 8.7.1 or 19				
	approved automatic fire exti				
	option is used, the areas sha	•			
	from other spaces by smoke	_			
	partitions and doors in according coors shall be self-closing co				
	automatic-closing and permi				
	nonrated or field-applied pro				
	that do not exceed 48 inches	•			
	of the door.				
	Describe the floor and zone	locations of			
	hazardous areas that are de	eficient in			
	REMARKS.				
	19.3.2.1, 19.3.5.9				
		Automatic Sprinkler			
	Separation N/A	. 5			
	a. Boiler and Fuel-Fired Hea				
	b. Laundries (larger than 10				
	c. Repair, Maintenance, and d. Soiled Linen Rooms (exc				
	gallons)	eeding 04			
	e. Trash Collection Rooms				
	(exceeding 64 gallons)				
	f. Combustible Storage Roo	ms/Spaces			
	(over 50 square feet)	1			
	g. Laboratories (if classified	as Severe			
	Hazard - see K322)				
	Based on observation and inter	view, the facility	K 0321	It is the practice of this provide	er to 06/24/2021

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	01		
		155157	b. wind		05/25	5/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	CODE	
				DAK DR		
GOLDEN	I LIVING CENTER-	RICHMOND	RICH	MOND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		f 5 hazardous areas observed		ensure that federal pa	•	
	_	ms over 50 square feet,		requirements for nurs	•	
		frame and be provided with a		participating in Medica		
	-	This deficient practice		Medicaid programs ar		
		ts in the adjacent smoke		accordance with feder	ral and state	
	compartment as we	ll as staff on the vacant hall.		law.	-/-\;!! !	
	Findings in -11-			What corrective action		
	Findings include:			accomplished for thos		
	Rased on observativ	ons on 05/25/21 at 12:32 p.m.		found to have been at	•	
				the deficient practice?		
with the Maintenance Supervisor (MS), there were over 50 cardboard boxes stored in the PPE			Self-closing devices we on the two storage rooms.			
storage room on the Vacant hall and there was no			question, ensuring the			
	-	on the corridor door.		latch in their frames.	sy would	
	-	were 40 cardboard boxes and		How other residents h	avina the	
		er in the storage room next to		potential to be affecte	-	
	room # 12 and the c	corridor door was not		same deficient practic	-	
	equipped with a sel	f closing device. Based on		identified and what co		
	interview at the tim	e of observations with the MS		action(s) will be taken		
	it was stated he did	not even think about the two		All residents in the fac		
	storage areas as haz	ardous rooms and		the potential to be affe		
		should have been provided		same alleged deficien	-	
		vices. It was further		Self-closing devices w	•	
	~	rea was over 50 square feet.		on the two storage roo		
		with the Administrator and		question, ensuring the		
	MS during the exit	conterence.		latch in their frames. A	All storage	
	3 1 10/b)			areas in facility in exc		
	3.1-19(b)			(50) square feet will b	e monitored	
				to ensure regulatory of	ompliance.	
				What measures will be	=	
				place and what syster		
				changes will be made		
				that the deficient prac	tice does	
				not recur?		
				Related staff will be in		
				the alleged deficient p		
				will be educated in ac		
				with facility policy and		
				professional standard	s. All storage	
1	l		Ī	i e		1

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	OF CORRECTION	IDENTIFICATION NUMBER: 155157	A. BUILDING B. WING	01	COMPLETED 05/25/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR				
(X4) ID	SUMMARY ST	RICHMOND TATEMENT OF DEFICIENCIES	RICHM	OND, IN 47374 [(X5)		
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
K 0351	NFPA 101			areas in facility in excess of fif (50) square feet will be monitor to ensure regulatory compliant How the corrective action(s) who be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place? Progress toward the successful completion of this Plan of Correction (POC) will be monitored using the GLCR (00 K321-20210525 Audit Tool. Progress will be monitored on business days for one (1) more weekly for four (4) weeks, and semi-monthly for four (4) monitor or until substantial compliance met. Documentation of all activities associated with this find will be noted on said audit tool. The Executive Director (Administrator) and/or designed will review the audit tool(s) on business days during StandUp accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administration and/or designed will be responsible for monitoring this POC to ensure its successful completion.	ried ce. rill (;) (iii) (
SS=F Bldg. 01	Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, ar by construction typ	Installation nd hospitals where required					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		155157	B. WING		05/25/2021
NAME OF	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF	PROVIDER OR SUPPLIE	K	1042 0	DAK DR	
GOLDEN	N LIVING CENTER	-RICHMOND	RICHM	10ND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		approved automatic			
		in accordance with NFPA			
		the Installation of Sprinkler			
	Systems.	anatruation alternative			
		onstruction, alternative res are permitted to be			
	· ·	rinkler protection in specific			
		e or local regulations			
	prohibit sprinklers	_			
	1 .	nklers are not required in			
		patient sleeping rooms			
	where the area of	f the closet does not exceed			
		l sprinkler coverage covers			
		nt as required by NFPA 13,			
		allation of Sprinkler			
	Systems.	10050 10051			
		2, 19.3.5.3, 19.3.5.4,			
	1	19.3.5.10, 9.7, 9.7.1.1(1) ion and interview, the facility	K 0351	It is the practice of this provide	er to 06/24/2021
		of 1 complete automatic	K 0551	ensure that federal participation	
		as installed in accordance with		requirements for nursing home	l l
		, 2010 Edition, Standard for		participating in Medicare &/or	
		Sprinkler Systems, Section		Medicaid programs are met in	
	9.1.1.7, Support of	Non-System Components,		accordance with federal and s	tate
		piping or hangers shall not be		law.	
		n-system components. This		What corrective action(s) will	be
	_	could affect 12 residents, staff		accomplished for those reside	ents
	and visitors.			found to have been affected b	у
	E. 1 1 1			the deficient practice?	
	Findings include:			Low-voltage wires were remove	
	Based on observati	ion on 05/25/21 at 12:37 p.m.		and re-routed from the sprinkl	
		nce Supervisor (MS), above the		system piping/hangers shortly	
		Conference room there were		after the LSC survey exit conference.	
	_	e wires wrapped around a metal		How other residents having th	_
	_	sed on interview at the time of		potential to be affected by the	
	observation, the M			same deficient practice will be	
		ponents were attached to the		identified and what corrective	
		and was unaware of this		action(s) will be taken?	
	condition. This wa	as discussed with the		All residents in the facility hav	e

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/25/2021
PROVIDER OR SUPPLIER		1042 0	ADDRESS, CITY, STATE, ZIP CODE DAK DR MOND, IN 47374	•
I LIVING CENTER- SUMMARY S (EACH DEFICIEN	RICHMOND TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			y the ice. oved der by ep octed once. oto ure es ed on e and ce all ers will ur, e? sful f 00096) on onth, od

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	OF CORRECTION	IDENTIFICATION NUMBER: 155157	A. BUILDING B. WING	<u>01</u>	COMPLETED 05/25/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET A 1042 O	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-F	RICHMOND		OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COM	(X5) MPLETION DATE
K 0372 SS=E	NFPA 101 Subdivision of Buil	ding Spaces - Smoke		or until substantial compliance met. Documentation of all activities associated with this F will be noted on said audit tool The Executive Director (Administrator) and/or designe will review the audit tool(s) on business days during StandUp accordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrational and/or designee will be responsible for monitoring this POC to ensure its successful completion.	POC ee o, in ne ttor)	
Bldg. 01	Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers should be barrier at an attract and required in ducted HVAC system in system is compartments adjuit 19.3.7.3, 8.6.7.1(1) Describe any medicipation of the barriers and the barriers in system in REMAR	ding Spaces - Smoke on all be constructed to a ance rating per 8.5. all be permitted to ium wall. Smoke dampers duct penetrations in fully ems where an approved installed for smoke acent to the smoke barrier.) hanical smoke control	K 0372	It is the practice of this provide	er to 06/	24/2021
	failed to ensure 1 of had a minimum of a and the penetrations wire and/or conduit	6 smoke barriers observed 1/2 hour fire resistive rating caused by the passage of the smoke barrier walls was n the smoke resistance of	10372	ensure that federal participation requirements for nursing home participating in Medicare &/or Medicaid programs are met in accordance with federal and significant for the process of the	on es	∠ T/ ∠U∠ 1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE	SURVEY LETED	
ANDILAN	OI CORRECTION	155157	B. WING	<u>01</u>		5/2021
		100107	-			11 LUL I
NAME OF F	PROVIDER OR SUPPLIER	8		T ADDRESS, CITY, STATE, ZIP	CODE	
COLDEA		PICHMOND		OAK DR IMOND, IN 47374		
	I LIVING CENTER-			IIVIOIND, IIN 41314		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	I SHOULD BE E APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE
		LSC Section 19.3.7.5		law.	(-)iII b -	
	1 -	riers to be constructed in C Section 8.5 and shall have a		What corrective action		
		re resistive rating. This		accomplished for tho		
		ould affect 12 residents,		found to have been a	•	
	visitors and staff.	said affect 12 residents,		the deficient practice		
	, ishors and stail.			The affected smoke to penetration with a on		
	Findings include:			around the sprinkler	• .	
				sealed to ensure com	•	
	Based on observation	on on 05/25/21 at 1:04 p.m.		How other residents	-	
		ce Supervisor (MS), above the		potential to be affected	•	
	ceiling tiles of the s	mokewall next to resident		same deficient practi	=	
	room # 30, there wa	as a five inch diameter		identified and what co		
	sprinkler pipe penet	trating the smokewall and the		action(s) will be taken		
	one inch gap around	d the pipe was not sealed.		All residents in the fa		
		after physical observation by		the potential to be aff	-	
		d the contractors had recently		same alleged deficie	-	
		er pipe and neglected to seal		The affected smoke b		
		ling was reviewed with the		penetration with a on		
	Administrator and N	MS at the exit conference.		around the sprinkler		
				sealed to ensure con		
	3.1-19(b)			smoke barrier walls v	vere verified	
				to ensure regulatory	compliance	
				(six (6) total).		
				What measures will b	be put into	
				place and what syste		
				changes will be made	e to ensure	
				that the deficient prac	ctice does	
				not recur?		
				Related staff will be in		
				the alleged deficient	•	
				will be educated in a		
				with facility policy and		
				professional standard		
				barrier walls were ve		
				ensure regulatory co	mpiiance (six	
				(6) total).	-4:- ·- (-) · · · '!!	
				How the corrective as		
				be monitored to ensu	ire trie	
	l			1		1

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 05/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND			1042 O	ADDRESS, CITY, STATE, ZIP CODE AK DR OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice will not recur i.e., what quality assurance program will be put into place? Progress toward the successful completion of the full-facility sweep relative to this Plan of Correction (POC) will be documented using the GLCR (0096) K372-20210525 Audit Tool. Completion will be documented. The Executive Director (Administrator) and/ordesignee will be responsible for monitoring this POC to ensure successful completion.	e Lal
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided n 18.5.1.1, 19.5.1.1,	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life. 9.1.1, 9.1.2			
	failed to ensure 1 of observed was protec 70, National Electric Edition, Article 406 (Cover Plates), requ shall be installed so opening and seat ag	an and interview, the facility I electrical receptacles sted accordance with NFPA cal Code. NFPA 70, 2011 .6, Receptacle Faceplates ires receptacle faceplates as to completely cover the ainst the mounting surface. ce could affect all 10 and staff.	K 0511	It is the practice of this provide ensure that federal participation requirements for nursing home participating in Medicare &/or Medicaid programs are met in accordance with federal and solaw. What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? The affected junction box local in the attic with the wires exposite.	tate pe nts y ted
	Based on observation	n on 05/25/21 at 12:49 p.m.		(no plate cover) was covered	

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	of correction identification number: 155157	A. BUILDING 01 B. WING	COMPLETED 05/25/2021			
	PROVIDER OR SUPPLIER I LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE			
	with the Maintenance Supervisor (MS), one electrical junction box with wires exposed was missing a plate cover above the ceiling tiles next to the Conference room. Based on interview at the time of observation, the MS confirmed the receptacle cover plate was missing and said he would take care of this right away. This was discussed with the Administrator and the MS during the exit conference. 3.1-19(b)	ensure compliance. How other residents having potential to be affected by a same deficient practice will identified and what corrects action(s) will be taken? All residents in the facility if the potential to be affected same alleged deficient practice in the attic with the wires expensive compliance. All junction boxes in the attic were veri ensure regulatory compliant What measures will be put place and what systemic changes will be made to enthat the deficient practice of not recur? Related staff will be inservithe alleged deficient practice will be educated in accorda with facility policy and professional standards. All junction boxes in the attic werified to ensure regulator compliance. How the corrective action(she monitored to ensure the deficient practice will not refice, what quality assurance program will be put into plate progress toward the succeed completion of the full-facility sweep relative to this Plan Correction (POC) will be documented using the GLC (0096) K511-20210525 Au	the be ve			

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
AND PLAN	155157	B. WING	01	05/25/2021
	133137			03/23/2021
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVING CENTER-RICHMOND		OAK DR IOND, IN 47374	
			T	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
mo	REGULATION ON ESC IDENTITATION IN CRIMINATION)	1710	Tool. Completion will be	DATE
			documented. The Executive	
			Director (Administrator) and/o	r
			designee will be responsible f	or
			monitoring this POC to ensure	e its
			successful completion.	
K 0741	 NFPA 101			
SS=E	Smoking Regulations			
Bldg. 01	Smoking Regulations			
	Smoking regulations shall be adopted and			
	shall include not less than the following			
	provisions:			
	(1) Smoking shall be prohibited in any room,			
	ward, or compartment where flammable			
	liquids, combustible gases, or oxygen is used or stored and in any other hazardous			
	location, and such area shall be posted with			
	signs that read NO SMOKING or shall be			
	posted with the international symbol for no			
	smoking.			
	(2) In health care occupancies where			
	smoking is prohibited and signs are			
	prominently placed at all major entrances,			
	secondary signs with language that prohibits smoking shall not be required.			
	(3) Smoking by patients classified as not			
	responsible shall be prohibited.			
	(4) The requirement of 18.7.4(3) shall not			
	apply where the patient is under direct			
	supervision.			
	(5) Ashtrays of noncombustible material and			
	safe design shall be provided in all areas			
	where smoking is permitted.			
	(6) Metal containers with self-closing cover devices into which ashtrays can be emptied			
	shall be readily available to all areas where			
	smoking is permitted.			
	18.7.4, 19.7.4			
	Based on record review, observation and	K 0741	It is the practice of this provide	er to 06/24/2021

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MUL' A. BUIL B. WINC	DING	o1	(X3) DATE S COMPLI 05/25/2	ETED
	PROVIDER OR SUPPLIER			1042 OA	DDRESS, CITY, STATE, ZIP CODE IK DR DND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	butts can be disposed disposal of paper gowhere evidence of sideficient practice coresidents and staff vilocations. Findings include: Based on review of policy on 05/25/21 among the MS on 05/25/21 area for residents; Ewith the appropriate lid where cigarette of, however, paper gamong the trash. Bawith the observation see that paper goods can with the cigarette constant of the management of the managemen	ry failed to ensure a strainer into which cigarette d of was not combined with gods in 1 of 2 outdoor areas moking occurred. This studd affect any number of who use the outside smoking at 10:42 a.m. with the visor (MS), resident and staff d on the premises at the s. Based on observation with at 1:20 p.m., the smoking CU courtyard, was provided a metal can with a self closing butts were properly disposed goods were also observed ased on interview concurrent in the MS was discouraged to so were thrown in the metal the butts. This was discussed tor and MS during the exit			ensure that federal participation requirements for nursing home participating in Medicare &/or Medicaid programs are met in accordance with federal and staw. What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice? Non-combustible disposal container for cigarette butts was labeled and an additional container for the disposal of all other paper goods was provide and labeled as such. All staff inserviced on this protocol as it relates to the disposal of cigare butts and other paper goods. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility have the potential to be affected by same alleged deficient practice. Non-combustible disposal container for cigarette butts was labeled and an additional container for the disposal of all other paper goods was provide and labeled as such. Staff inserviced on this protocol as it relates to the disposal of cigare butts and other paper goods. Smoking areas will be monitored to ensure compliance. What measures will be put into place and what systemic	ate e e nts c e e t e e t e t e t e e t e e e e e	

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155157	B. WING		05/25/2021
	ROVIDER OR SUPPLIE		1042 O	ADDRESS, CITY, STATE, ZIP CODE AK DR OND, IN 47374	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				changes will be made to ensure that the deficient practice does not recur? Staff will be inserviced on the alleged deficient practice and be educated in accordance wifacility policy and professional standards. Smoke area(s) will monitored to ensure regulator compliance. How the corrective action(s) who be monitored to ensure the deficient practice will not recurred. In the interpretation of this Plan of Correction (POC) will be monitored using the GLCR (Or K741-20210525 Audit Tool. Progress will be monitored on business days for one (1) mor weekly for four (4) weeks, and semi-monthly for four (4) monor until substantial compliance met. Documentation of all activities associated with this will be noted on said audit too The Executive Director (Administrator) and/or designed will review the audit tool(s) on business days during StandUplaccordance with the proposed schedule AND monthly during QAPI Committee meetings. The Executive Director (Administrator) and/or designed will be responsible for monitoring this POC to ensure its successful completion.	will th be y will r, ? ul 096) nth, I ths e is POC I. ee p, in I ne eator)

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/25/2021
GOLDEN	PROVIDER OR SUPPLIER	RICHMOND	1042 C RICHM	ADDRESS, CITY, STATE, ZIP CODE DAK DR MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in according another is in according to any gas from one prohibited in paties to liquid oxygen oxygen conditions under a transfilling to liquid portable containers and the same chanically we dition, 11.5.2.2 (NFPA 98 assed on observation was mechanically we dition, 11.5.2.3.1 (transfilling rooms to this deficient practivisitors or staff. Findings include: Based on observation with the Maintenant Oxygen storage room oxygen transfilling exhaust fan which a on an interview at the MS was asked to tepiece of paper to obwould indicate the of Moments later with acknowledged by the vent recently and it	1.5.2.3.1 (NFPA 99). d oxygen containers or to s under 50 psi comply with 1.5.2.3.2 (NFPA 99). on and interview, the facility 1 oxygen transfilling rooms entilated. NFPA 99 2012	K 0927	It is the practice of this providensure that federal participat requirements for nursing hon participating in Medicare &/o Medicaid programs are met i accordance with federal and law. What corrective action(s) will accomplished for those reside found to have been affected the deficient practice? Non-functioning exhaust fan oxygen storage room was replaced shortly after LSC suexit conference. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents in the facility has the potential to be affected by same alleged deficient practice.	ion nes r n state be lents by in the lervey he e e e e y the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155157	B. WING		05/25/2021
			CTDE	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER	•	OAK DR	
COLDEN	I LIVING CENTER	PICHMOND		MOND, IN 47374	
		-RIGHMOND	RICI		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	ATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	finding was reviewed with the		Non-functioning exhaust fan	in the
	Administrator MS	at the exit conference.		oxygen storage room was	
				replaced shortly after LSC su	-
	3.1-19(b)			exit conference. Oxygen stor	•
				room will be monitored to en	sure
				compliance.	,
				What measures will be put in	το
				place and what systemic	
				changes will be made to ens	
				that the deficient practice do	es
				not recur?	
				Oxygen storage room will be	
				monitored to ensure regulato	ry
				compliance.	.,,
				How the corrective action(s)	WIII
				be monitored to ensure the	
				deficient practice will not reci	ur,
				i.e., what quality assurance	
				program will be put into place	
				Progress toward the success	ful
				completion of this Plan of	
				Correction (POC) will be	
				documented using the GLCF	
				(0096) K927-20210525 Audit	
				Tool. Replacement of exhaus	
				will be documented. The Exe	
				Director (Administrator) and/o	
				designee will be responsible	
				monitoring this POC to ensur	e its
				successful completion.	

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