

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLIN RD FORT WAYNE, IN 46815
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/17/12</p> <p>Facility Number: 000282 Provider Number: 155755 AIM Number: 100287520</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Years Homestead was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined</p>	K0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Plan of Correction is prepared and submitted because of requirements under State law. This provider respectfully requests that the Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after October 16, 2012.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	<p>to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 106 and a census of 102 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to smoke detector coverage, and found not in compliance with state law in regard to sprinkler coverage.</p> <p>All areas where residents have customary access were sprinklered. Areas providing facility services which were not sprinklered were the dumb waiter and an unsprinklered detached garage used for the storage of mowing equipment and a golf cart.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/27/12.</p> <p>The facility was found not in compliance with the</p>			

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	aforementioned regulatory requirements as evidenced by the following:			

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K0040 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 exit doors from the Chapel/Activity room had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors in the means of egress from nursing homes shall be no less than 41.5 inches. This deficient practice could affect residents evacuated through the Chapel/Activity room exterior exit doors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Maintenance Technician # 1 on 09/17/12 at 1:40 p.m., the single exterior emergency exit door from the Chapel/Activity room had a clear width of thirty six inches. The double exterior emergency exit doors measured thirty six</p>	K0040	<p>Golden Years Homestead's exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. Golden Years Homestead's Statement:Golden Years Homestead reviewed this finding with our Architect (Dan Ware at Interdesign). He has indicated in the attached e-mail (attachment 1) that our facility meet all building codes involving means of egress in the activity/chapel area. Under section 7.2 (NFPA life Saffety) there has been a misinterpretation of section 18.2.3.5 which states that the minimum clear width for doors in the means of egress from sleeping rooms, diagnostic and treatment areas, such as x-ray ,surgery, or physical therapy; and nursery rooms shall be as follows: (1) Hospitals and nursing homes- 41.5 in(2) Psychiatric hospitals and limited care facilities- 32in. Which does not apply to the Chapel/Activity</p>	10/16/2012	

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	<p>inches of clear width between the door frame and the locked stationary center bar. The stationary bar is locked into the door frame and can be removed when unlocked with a key. Based on an interview with the Maintenance Supervisor and Maintenance Technician # 1 at the time of observation, only Maintenance staff and the Chaplain have a key. Measurements were taken and confirmed by the Maintenance Supervisor and Maintenance Technician # 1.</p> <p>3.1-19(b)</p>		<p>room area. Golden Years Homesead Inc. appeals this citation and respectfully requests it be removed from our survey. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident is affected by this misinterpreted finding. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents are affected by this misinterpreted finding. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? No changes are warranted as this finding was misinterpreted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? This finding is not consistent with all other (State and Local) Inspections and was part of the initial construction which was approved by State and Local building requirements and regulations.</p>		

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of smoke compartments in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Supervisor and Maintenance Technician # 1 on 09/17/12 at 11:50 a.m., the</p>	K0048	<p>Golden Years Homestead has a written plan for the protection of all patients and for their evacuation in the event of an emergency. Golden Years Homestead's statement: Golden Years Homestead reviewed our Disaster Plan and believe we meet the requirement under (6) Evacuation of smoke compartment. Under (in the event of an emergency, employee shall evacuate:) Affected apartment and nearest apartment. Affected neighborhood. <u>-(This is out of the smoke compartment into another smoke department or to the out of doors).</u> If a complete evacuation is necessary, all residents should be moved to safety through the nearest exit. To account for all residents and staff, all neighborhoods should meet in the parking lot of their neighborhoods. <u>(This also is evacuating from a smoke compartment).</u> The Surveyor cited us by saying that our plan does not show Evacuation from one smoke compartment to another smoke department location. We find no where that is required. We changed it in our Disaster Plan to meet what we perceive as the personal preferences of the surveyor. Golden Years</p>	10/16/2012

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	"Disaster Plan" did not address evacuation of smoke compartments. This was confirmed by the Maintenance Supervisor and Maintenance Technician # 1 at the time of record review. 3.1-19(b)		Homestead respectfully requests this finding be removed from our survey. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? No resident is affected by the alleged finding. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No resident or residents is affected by the alleged finding. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? We changed our Disaster Plan to meet what we perceive as the personal preference of the surveyor. (Attachment 2 & Attachment 3). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Our Disaster Plan was updated, it is reviewed at minimum annually and as the need arises, this information is reviewed and taught during every new hire orientation class and annually for all staff which has always been our procedure. Effectiveness is monitored through monthly		

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			and annual drills by Campus Engineer, Administrator and/or designee. Findings are submitted quarterly to the Quality Assurance Committee on an on-going basis.	

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K0056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 dumb waiters in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician # 1 on 09/17/12 at 12:40 p.m., as viewed in the attic, a sprinkler pipe extends out above the dumb</p>	K0056	<p>Golden Years Homestead has an automatic sprinkler system. This system is maintained in accordance with NFPA 25. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents have the potential to be affected by the alleged deficient practice. What measures will be</p>	10/16/2012			

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	<p>waiter shaft and a hole has been cut out of the drywall at the top of the dumb waiter shaft directly below the extended sprinkler pipe but the pipe did not extend down and into the dumb waiter shaft. At the time of observation, Maintenance Technician # 1 confirmed the dumb waiter shaft lacked sprinkler coverage.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Shambaugh and Sons assessed the identified issue and ordered parts. The sprinkler head will be installed once the parts have arrived and due to time involved in receiving parts (out of our control) will be completed no later than 10-31-2012. Please note: This standard was missed by all past inspections by: (State and Local Inspectors) and was part of the initial building construction. The sprinkler head will be installed in the dumb waiter chase and will need no further measures to ensure that the alleged deficient practice will recur. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Golden Years Homestead will continue its regularly scheduled preventative maintenance programs with fire system contracted vendors per regulations. Any negative findings will be addressed immediately and reported to the Quarterly Quality Assurance Committee meetings. This is an on-going procedure so will be monitored per protocol by Campus Engineer, Administrator and/or</p>		

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			designee. Findings are on file and can be reviewed as needed.	

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K0062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 2 sprinkler heads was unobstructed in the Community D Magnolia Manor nurses' station. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 14 residents in Community D Magnolia Manor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Maintenance Technician # 1 on 09/17/12 at 1:16 p.m., the spray pattern of one of two sprinkler heads in the Community D</p>	K0062	<p>Golden Years Homestead has the required sprinkler systems continuously maintained in reliable operating condition and are inspected and tested periodically. Please note this finding was missed by all State and Local Inspectors for the past three years and was part of the initial building construction we received approval for. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents were affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Shambaugh and Sons inspected the sprinkler head, ordered parts that may require extended time to receive and will extend the head down past</p>	10/16/2012

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	Magnolia Manor nurses' station was obstructed by a ceiling light fixture mounted two and one half inches from the sprinkler head. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		the light fixture. Work will be completed no later than 10-31-2012. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Golden Years Homestead will continue its regularly scheduled preventative maintenance programs with fire system contracted vendors per regulations. Any negative findings will be addressed immediately and reported to the Quarterly Quality Assurance Committee meetings. This is an on-going procedure so will be monitored per protocol by Campus Engineer, Administrator and/or designee. Findings are on file and can be reviewed as needed. Repair will resolve the finding.		

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect 25 residents in Community C.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/17/12 at 2:00 p.m., the oxygen transfilling/storage room contained several large containers of liquid oxygen and the mechanical vent could not be</p>	K0143	<p>Golden Years Homestead's transferring of oxygen is separated from any portion of a facility wherein patients are housed, examined or treated by a separation of a fire barrier of 1-hour fire-resistive construction and in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring and is an area posted with signs indicating transferring is occurring and that smoking is not permitted. Please note: This standard was missed by all state and local inspectors for the past three years and was part of the initial building construction. Golden Years Homestead respectfully requests to reduce the scope</p>	10/16/2012

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	<p>heard. When asked if the mechanical ventilation was running the Maintenance Supervisor turned a vari-speed knob to the run position and then the mechanical vent could be heard. At this time the Maintenance Supervisor acknowledged the mechanical ventilation was controlled by a switch</p> <p>3.1-19(b)</p>		<p>and severity because the switch only would allow for the reduction of speed of the fan but not allow for it to be turned off and residents are not near the location of the oxygen storage area. The oxygen storage room is in the hallway across from the "A" laundry room and that area is classified commercial building construction and has a fire barrier door and a smoke barrier door between it and the resident living areas. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents were affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The ventilation fan for the oxygen storage room was removed from the vari-speed switch and is controlled by only the main breaker controlling the on-off operation of the ventilation fan. The</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLIN RD FORT WAYNE, IN 46815
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			vira-switch was removed and the opening covered. This is complete.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be putinto place?The vira-switch was removed and opening covered so alleged finding is no longer in operation. It was permanently removed.	

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K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupant.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Generac Generator Weekly Report" with the Maintenance Supervisor and Maintenance Technician # 1 on 09/17/12 at 11:30 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly</p>	K0144	<p>Golden Years Homestead's generators are inspected weekly and exercised under load for 30 minutes per month. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No other residents were affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Golden Years Homestead has added the transfer time to the monthly inspection sheet and will record the transfer time when we complete the monthly power test on the generator (Attachment 4). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Generator test logs will be reviewed monthly for proper</p>	10/16/2012			

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	<p>load test record did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>		<p>completion and compliance. Findings will be reported at Quarterly Quality Assurance meetings by Campus Engineer, Administrator and/or designee x 6 months.</p>	