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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/11/2012 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901 |
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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: 07/11/12</p> <p>Facility Number: 000258 Provider Number: 155367 AIM Number: 100289160</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Sycamore Village 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors,</p> | K0000 | | |

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>and battery operated smoke detectors in all resident rooms. The facility has a capacity of 110 and had a census of 103 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K0064 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 07/11/12 at 1:48</p> | K0064 | <p>A placard has been visibly placed near the K fire extinguisher by the kitchen door entrance.</p> <p>This deficient practice has the potential to affect any resident using the main dinning room</p> <p>All other fire extinguishers in the facility were audited for missing placards. There were no other findings.</p> <p>To ensure this deficient practice does not occur again, all staff will be in-serviced on identifying missing extinguisher placards and who to notify.</p> <p>To monitor for compliance the Maintenance Director or designee will audit every business day x6 months, then 3 times weekly x 3months, then 1 x monthly thereafter for missing fire extinguisher placards if no trends are identified. Results of audits will be monitored through QAA x6 months. QAA monitoring will d/c after 6 months if no trends are identified.</p> | 08/10/2012 | | | |

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| | <p>p.m. with the Maintenance Supervisor, there was a K-class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 07/11/12 at 1:50 p.m. with the Maintenance Supervisor, it was acknowledged the K-class portable fire extinguisher was not provided with a placard.</p> <p>3.1-19(b)</p> | | | | |

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| K0066 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is 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 is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container instead of on the ground for 1 of 1 areas where evidence of smoking was observed contrary to facility policy. This deficient practice could affect 4 residents observed in the main dining room as well as visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 07/11/12 at 1:15</p> | K0066 | <p>An ashtray and metal container of non-combustible material with a self closing cover have been placed in the area near the rear entrance where cigarette butts were found.</p> <p>This deficient practice has the potential to affect any residents, staff, or visitors using the main dinning room.</p> <p>All other entrances/exits were audited for discarded cigarette butts and smoking on the grounds. No other areas were identified to be out of compliance.</p> | 08/10/2012 |

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| | <p>p.m. with the Maintenance Supervisor, there were 12 cigarette butts strewn on the ground and not in a noncombustible container just outside the employee exit. Based on review of the smoking policy on 07/11/12 at 3:45 p.m. with the Maintenance Supervisor, the smoking policy indicated no residents or staff were allowed to smoke anywhere on the facility grounds. Based on interview on 07/11/12 at 1:22 p.m. with the Maintenance Supervisor it was acknowledged smoking was occurring outside the employee exit as evidenced by the extinguished cigarette butts thrown on to the ground.</p> <p>3.1-19(b)</p> | | <p>To ensure this deficient practice does not occur again, all staff members have been in- serviced on the facility and state smoking policy, and the proper way to dispose of used cigarettes.</p> <p>To monitor for compliance, Administrator or designee will audit every business day x6 months, then 3 times weekly x 3months, then 1 x monthly thereafter for smoking and improperly discarded cigarette butts. . Results of audits will be monitored through QAA x6 months. QAA monitoring will d/c after 6 months if no trends are identified.</p> | | |