

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/09/13</p> <p>Facility Number: 000510 Provider Number: 155507 AIM Number: 100285440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sycamore Springs Rehabilitation Centre 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in</p>	K010000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending August 9, 2013.</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>all resident sleeping rooms. The facility has a capacity of 60 and had a census of 33 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the ten foot by ten foot area in the Center Hall near the smoke barrier doors. All areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 64 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any 16 resident who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor on 08/09/13 at 11:50 a.m., an eight inch square area of drywall missing above the hot water heaters in the master closet room ceiling was by filled with a bed sheet. Furthermore, there were seven water pipe penetrations in the ceiling with between a one quarter inch and one half inch gap around the pipes with no fire</p>	K010025	K025 requires that smoke barriers be constructed to provide at least a one half hour fire resistance rating. The eight inch square area above the hot water heaters in the master closet was repaired with the addition of drywall over the opening. The four inch square area on the north wall near the floor/wall juncture was repaired with the addition of drywall over the opening. The penetrations of the seven water pipes in the ceiling were filled with fire rated caulking. The facility Maintenance Director completed an audit in the facility to ensure there were no other smoke barrier penetrations in need of repair. The facility Maintenance Director will monitor monthly and will add to the monthly preventative maintenance log that all areas of the facility are inspected to ensure there are no smoke barrier penetrations in need of repair. The necessary repairs were completed on	08/16/2013	

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	<p>stopping material used to fill the gaps, and a four inch by four inch square area of drywall missing on the north wall near the floor wall juncture. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 08/09/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>		August 16, 2013.		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon</p>	K010038	<p>K038 requires that exit access be arranged so that exits are readily accessible at all times. Elwood Fire Protection has been contacted to repair the delayed egress lock located on the North Hall exit door. The facility Maintenance Director audited all other exit doors utilizing a delayed egress lock to ensure proper function; no further concerns were noted. Weekly, the facility Maintenance Director will monitor to ensure that the delayed egress locks are functioning appropriately. This will be added to the weekly preventative maintenance schedule. The necessary repairs will be completed on or before September 8, 2013.</p>	09/08/2013			

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	<p>application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>This deficient practice could affect 6 residents who would use the therapy room at one time.</p> <p>Findings include:</p> <p>Based on observation on 08/09/13 at 12:40 p.m. with the administrator and maintenance supervisor, the North Hall exit door was provided with a delayed egress lock and had a sign reading PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.</p>						

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	<p>Furthermore, when the doors were pushed on three separate attempts, the irreversible process to release the lock was not initiated. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 08/09/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>			

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 corridors was completely sprinkled. This deficient practice could affect 21 residents who use the Center Hall near the nurses' station.</p> <p>Findings include:</p> <p>Based on observation on 08/09/13 at 11:10 a.m. with the administrator and maintenance supervisor, the Center Hall near the nurses' station had two bulkheads which extended one and one half foot down from the ceiling. Furthermore, a sidewall sprinkler was located at the southeast end of the bulkhead wall with a light fixture within six inches of the sprinkler, which obstructed the sprinkler from providing full coverage in the ten foot by ten foot area near the smoke</p>	K010056	<p>K056 requires if there is an automatic sprinkler system, it is installed to provide complete coverage for all portions of the building. Elwood Fire Protection has been contacted to relocate the sprinkler head located in the Center hall near the Nurses' Station. An audit was completed on all sprinkler heads to ensure appropriate spacing. Following completion of the audit and relocation of the sprinkler head, no further inspection needs to occur. The necessary repairs will be completed on or before September 8, 2013.</p>	09/08/2013			

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	<p>barrier doors. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 08109 at 1:40 p.m.</p> <p>3.1-19(b)</p>			

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K010144 SS=F	<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 ensure a written record of weekly inspections for 1 of 1 generators was maintained for the past year. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K010144	<p>K144 requires that generators are inspected weekly and exercised under load for 30 minutes per month. The generator and battery electrolyte level were inspected with no concerns noted. The inspection was documented in the preventative maintenance log. The Maintenance Director will conduct weekly inspections of the generator and will document the findings. Additionally, the storage battery test results will be documented weekly. Documentation of each will be recorded in the weekly preventative maintenance log. The necessary corrections were made on August 16, 2013.</p>	08/16/2013

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	<p>Based on record review with the administrator and maintenance supervisor on 08/09/13 at 9:35 a.m., there was no record of weekly inspections including storage battery tests for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated the monthly load tests were conducted but the weekly inspections were not conducted. This was verified by the maintenance supervisor and administrator at the time of interview and acknowledged by the administrator at the exit conference on 08/09/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>			

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 3 alcohol based hand rub dispensers was not installed over an ignition source such as an electrical outlet. This deficient practice could affect 21 ambulatory residents in the facility who use the Center Hall near the nurses' station.</p> <p>Findings include:</p> <p>Based on observation on 08/09/13 at 10:55 a.m. with the administrator and maintenance supervisor, a 7.6 ounce alcohol hand sanitizer dispenser was installed directly above an electrical outlet at the Center Hall nurses' station near the smoke barrier doors. This was verified by the administrator and maintenance</p>	K010211	<p>K211 requires where alcohol based hand rub dispensers are installed in a corridor: The corridor is at least 6 feet wide, the maximum individual fluid dispenser capacity shall by 1.2 liters, the dispensers have a minimum spacing of 4 feet from each other, not more than 10 gallons are used in a single smoke compartment outside a storage cabinet, dispensers are not installed over or adjacent to an ignition source, if the floor is carpeted the building is fully sprinklered. The alcohol based hand sanitizer dispenser was removed and relocated to an area that meets requirements. An audit was completed to ensure proper placement of all other alcohol based hand sanitizer dispensers within the facility; no concerns</p>	08/09/2013			

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	supervisor at the time of observation and acknowledged by the administrator at the exit conference on 08/09/13 at 1:40 p.m. 3.1-19(b)		were noted.Following the audit and relocation of the dispenser, no further inspections need to occur.The necessary corrections were completed on August 9, 2013.		