

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 10/21/2014
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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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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: 10/21/14</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 and battery operated detectors in all</p>	K010000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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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K010025 SS=E	<p>resident sleeping rooms. The facility has a capacity of 110 and had a census of 96 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one shed used for facility storage which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 3 of 5 smoke barrier walls was protected to maintain the one half hour fire resistance rating of</p>	K010025	The facility has contracted a vendor to treat the 3 smoke barrier walls mentioned in this 2567 (the one inch thick sheet of insulating board on the North	11/20/2014

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	<p>the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 26 residents on Center hall as well as visitors and staff if smoke from a fire were to infiltrate the protective barrier wall.</p> <p>Findings include:</p> <p>Based on observations on 10/21/14 during the tour between 12:50 p.m. and 1:30 p.m. with the Maintenance Supervisor, the following smoke barrier walls on Center hall did not maintain a one half hour fire resistance rating:</p> <p>a. North smoke wall had a one inch thick sheet of insulating board on top of the smoke wall used to cover holes and no information was available to document its fire resistant rating.</p> <p>b. South smoke wall had two, two by four wood studs nailed together and mounted at the top of the smoke wall where the metal corrugated roof and wall meet to cover openings between the metal roof and wall.</p>		<p>smoke wall; the two, two by fours on the South smoke wall and the two by four wood stud on the Section 1 smoke wall) with a fire retardant and wood preservative that meets NFPA 255 standards which, in turn, should meet LSC Section 8.3.6.1 code (See attachment A). All residents have the potential to be affected by the deficient practice. Upon completion of the contracted work, the facility shall keep information on the work as well as the documentation of the fire retardant material used to treat the 3 smoke barriers listed in this 2567. This information will be kept in the maintenance office. This information will be reviewed at QAPI x 6 months to track any trends/changes. If any trends/changes identified then audits to be completed based on QAPI recommendations. If no trends/changes identified then will review on PRN basis.</p>	

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K010046 SS=F	<p>c. Section 1 smoke wall by the Nursing station had one, two by four wood stud to cover the openings where the corrugated metal roof meets the wall.</p> <p>Based on interview on 10/21/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier walls had unprotected openings which were not sealed with a fire rated material.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to provide documentation of a 30 second monthly functional test or a 90 minute annual functional test for 2 of 2 battery operated lights. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted monthly for 30 seconds on every required emergency lighting system and annually for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if emergency battery powered lights were not available.</p>	K010046	<p>The facility documented the monthly and annual tests for the battery back up emergency lights - which had been done, but had not been specifically documented..</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Facility will document time and date and duration of the monthly and annual test of the battery back up emergency lights on the generator. A log</p>	11/20/2014

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K010050 SS=F	<p>Findings include:</p> <p>Based on Fire Safety Record review on 10/21/14 at 4:13 p.m. with the Maintenance Supervisor the facility tested the battery back up emergency lights which one was located inside the generator and one outside attached to the building and a monthly thirty second test was not documented nor was an annual test for ninety minutes done. Based on interview on 10/21/14 at 4:15 p.m. with the Maintenance Supervisor it was acknowledged the battery back up emergency lights were checked monthly, but the documentation for the duration of the monthly and annual test was not documented.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct fire drills on</p>	K010050	<p>will be kept with this information in the maintenance office.</p> <p>These logs will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p> <p>Maintenance Director shall ensure that quarterly fire drills</p>	11/20/2014

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K010052 SS=C	<p>all shifts for 1 of 4 quarters for the past 12 months and did not vary the time when conducting drills on the same shift. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 10/21/14 at 3:15 p.m. with the Maintenance Supervisor, a fire drill report for the second and third shift of the first quarter of 2014 was not available for review. In addition, the third shift of the second, third and fourth quarter of 2014 were done at 12:00 a.m., 12:30 a.m. and 12:00 respectively. Based on interview on 10/21/14 at 3:17 p.m. with the Maintenance Supervisor, it was acknowledged the fire drill for the aforementioned shifts of the first quarter of 2014 had not been done and the third shift of the aforementioned quarters were not varied.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an</p>		<p>are performed on each shift and that the times of these drills will vary by 2 hours they are done</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Maintenance Director in-serviced on requirement that quarterly fire drills are to be performed on each shift and that the times of these drills will vary by 2 hours they are done. A log will be kept with this information in the maintenance office.</p> <p>Results of these monthly reviews will be submitted to QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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	<p>approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation, record review, and interview; the facility failed to ensure there was documentation for the testing of 66 of 66 battery operated smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors to be tested annually. NFPA 72, 7-3.3 requires single station detectors installed in other than one- and two family dwelling units shall be tested and maintained in accordance with Chapter 7. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Smoke Detector Log" with the Maintenance Supervisor during record review at 4:10 p.m. on 10/21/14, there was no documentation of maintenance for the battery operated smoke detectors in all the resident sleeping rooms for the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor stated the battery operated smoke detectors were checked, but did not document this or any other maintenance performed by the facility or outside agency and acknowledged</p>	K010052	<p>The facility checked and documented the monthly tests for the battery operated smoke detectors in the resident rooms..</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Facility will ensure that the battery operated smoke detectors are checked and documented monthly. A log will be kept with this information in the maintenance office.</p> <p>The log will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	11/20/2014			

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K010062 SS=F	<p>documentation was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observations on 10/21/14 at</p>	K010062	<p>The facility received the documentation from when the private fire hydrant had been inspected on 6/30/2014. All residents have the potential to be affected by the deficient practice. Facility will ensure that the private fire hydrant is checked and documented annually. A log will be kept with this information in the maintenance office. The log will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	11/20/2014

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K010070 SS=E	<p>3:30 p.m. with the Maintenance Supervisor, there was one fire hydrant located adjacent to the Front entrance. Based on review of Fire Systems report on 10/21/14 at 3:33 p.m. with the Maintenance Supervisor, the facility lacked documentation of annual inspection for the private fire hydrant. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant inspection was not available for review and the facility was unaware the fire hydrant needed to be serviced annually.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters in non resident rooms. This deficient practice could affect 22 residents adjacent to the Admissions Marketing office on Administrative hall as well as visitors and staff.</p>	K010070	The portable space heater was unplugged and removed from the premises. Admissions and marketing director was inserviced that portable space heaters are not permitted on the property.	11/20/2014			

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	<p>Findings include:</p> <p>Based on observation on 10/21/14 at 2:45 p.m. with the Maintenance Supervisor, a portable space heater which was plugged in for use and was located in the Admissions Marketing office on the Administrative hall. Based on interview on 10/21/14 concurrent with the observation, it was acknowledged by the Maintenance Supervisor and the Admissions Marketing Director (AMD) the space heater was being used, however, the AMD was unaware they were not allowed in the facility. The facility did not have a portable space heater policy for review to indicate they could not be used in non resident rooms unless the heating elements of the portable heater did not exceed 212 degree F.</p> <p>3.1-19(b)</p>		<p>The maintenance director performed a facility audit (including offices, resident rooms, storage areas as well as common areas) to ensure that there were no additional portable space heaters in use at the facility. This audit determined that there were none.</p> <p>Facility staff were inserviced that the facility does not allow portable space heaters on the premises. Maintenance director will perform a monthly walk-through at the facility to ensure that no portable space heaters are located on the property. Maintenance director will record this walk-through on a monthly log to be kept in the maintenance director's office.</p> <p>The log will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 6 residents observed in the Main dining room adjacent to the Kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 10/21/14 at 2:18 p.m. with the Maintenance Supervisor, there was a metal rolling fire door protecting the openings from the kitchen to the Main dining room which had an attached inspection tag indicating the last inspection was 7/8/13. Based on interview on 10/21/14 at 3:37 p.m. with the Maintenance Supervisor and</p>	K010130	<p>The facility had the metal rolling fire door inspected and documented the results.</p> <p>All residents located in the dining room have the potential to be affected by the deficient practice.</p> <p>Facility will ensure that the metal rolling fire door is checked and documented annually. A log will be kept with this information in the maintenance office.</p> <p>The log will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	11/20/2014			

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K010144 SS=F	<p>Inspection vendor there was no additional documentation of an annual inspection or test to check for proper operation and full closure since 7/8/13.</p> <p>3.1-19(b)</p> <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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature</p>	K010144	<p>The facility documented the monthly load test for the generator - which had been done, but had not been documented properly. Amperage is now recorded to verify at 30 percent of the EPS nameplate rating.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Facility will document time and date/time and duration of the monthly test of the emergency generator. A log will be kept with this information in the maintenance office.</p>	11/20/2014

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	<p>conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 10/21/14 at 3:44 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating and no other method was used to document monthly load for the past twelve months. Based on interview on 10/21/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly and was aware it had to be documented at 30 percent but, could not verify the percentage and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p>		<p>These logs will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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 10/21/2014
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	<p>2. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 12 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of Generator Log records on 10/21/14 at 3:46 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load was not documented. Based on interview on 10/21/14 at 3:47 p.m. with the Maintenance Supervisor it was</p>			
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K010147 SS=E	<p>acknowledged the information on time of load transfer had not been recorded for the past twelve months and the Maintenance Supervisor was unaware it needed to documented.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords observed and 1 of 14 surge protectors observed were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 22 residents on 300 hall and 20 residents on 200 hall as well as visitors.</p> <p>Findings include:</p> <p>Based on observation on 10/21/14 at 2:47 p.m., with the Maintenance Supervisor,</p>	K010147	<p>The extension cord was removed from the Admissions and Marketing office. Admissions and marketing director was inserviced that the use of extension cords was not permitted. The extension cord was removed from room #222 and refrigerator was plugged directly into wall outlet.</p> <p>The maintenance director performed a facility audit (including offices, resident rooms, storage areas as well as common areas) to ensure that there were no additional extension cords in use at the</p>	11/20/2014	

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	<p>an extension cord was plugged into a power source which then extended to power a portable heater located in the Admissions Marketing office on Administrative hall. Furthermore, a surge protector was used to provide power to a medium sized refrigerator/freezer at the head of the residents bed in room # 222 instead of directly plugging the unit into a wall outlet. Based on interview on 10/21/14 at 2:48 p.m. it was acknowledged by the Maintenance Supervisor, an extension cord was used to provide power to the aforementioned heating appliance which was not allowed and the surge protector should not be used to power the refrigerator/freezer unit.</p> <p>3.1-19(b)</p>		<p>facility. This audit determined that there were none.</p> <p>Facility staff were inserviced that the facility does not allow extension cords on the premises. Maintenance director will perform a monthly walk-through at the facility to ensure that no extension cords are in use on the property. Maintenance director will record this walk-through on a monthly log to be kept in the maintenance director's office.</p> <p>The log will be reviewed at QAPI x 6 months to track any trends. If any trends identified then audits to be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>		