

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 09/16/2014
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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: 09/16/14</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, spaces open to the corridors, and battery operated smoke detectors in</p>	K010000	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 the requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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K010029 SS=E	<p>all resident sleeping rooms. The facility has a capacity of 60 and had a census of 27 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three detached wooden storage sheds which were not sprinkled.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p> <p>The facility was found in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door</p>	K010029	K029 requires the corridor doors of hazardous areas be provided with self-closing devices.1. No	10/10/2014			

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	<p>to 2 of 11 hazardous areas, such as combustibile storage rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 10 residents who use the resident lounge at a time and any residents using the therapy room, located across the corridor from the clean utility room.</p> <p>Findings include:</p> <p>Based on observations on 09/16/14 during a tour of the Center Hall with the maintenance supervisor and administrator from 10:10 a.m. to 11:00 a.m., the Center Hall clean utility room and the respiratory therapy storage room, which measured between eighty and one hundred forty square feet and stored twenty shelves with paper, plastic and cardboard, each lacked a self closing device on the doors. The lack of self closing devices on the Center Hall clean utility room door and the respiratory therapy storage room door was verified by the maintenance supervisor and administrator at the time of observations and acknowledged by the administrator at the exit conference on 09/16/14 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p>residents were harmed. The door to the clean utility room was adjusted to allow for the proper function of the automatic closing device, and an automatic closing device was added to the Respiratory Therapy storage room.2. All residents utilizing the resident lounge and therapy area have the potential to be affected; thus, all other hazardous areas in the facility were reviewed with no additional concerns noted.3. The Maintenance Director has been educated on ensuring all hazardous areas are properly secured.4. All corridor doors will be reviewed as part of the facility preventative maintenance program and reviewed at least quarterly by the facility quality assurance committee. The plan of action will be adjusted accordingly, as warranted.5. The above corrective actions will be completed on or before October 10, 2014.</p>		

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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 sidewalk surface on 1 of 6 exit sidewalks was maintained to prevent elevation changes in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires that walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect 15 residents who use the dining room located near the employee exit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor and administrator on 09/16/14 at 12:10 p.m., the employee exit sidewalk had a four foot section of concrete sidewalk broken and separating with two inch areas of cracking on the sidewalk surface twelve feet from the exit door. Furthermore, the expansion joints had six areas along the expansion joints</p>	K010038	<p>K038 requires that exit access is arranged so that exits are readily accessible at all times.1. No residents were harmed. A contractor has been secured by the facility to replace the area of concrete outside the employee entrance.2. All residents utilizing the employee entrance in the event of an emergency have the potential to be affected; thus, all other means of egress surrounding the facility were checked by the facility Maintenance Director to ensure good repair, no additional concerns were noted.3. The Maintenance Director has been educated on ensuring that the concrete sidewalks surrounding the facility and used as a means of egress remain in good repair.4. The monitoring of all means of egress will be completed as part of the facility preventative maintenance program and reviewed at least quarterly by the facility quality assurance committee. The plan of action will be adjusted accordingly, as warranted.5. The above corrective measures will be completed on or before December 1, 2014. The facility respectfully requests that an extension be granted to allow time for the extensive work</p>	12/01/2014
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K010046 SS=A	<p>with missing concrete. The employee exit sidewalk surface broken and cracking was verified by the maintenance supervisor and administrator at the time of observation and acknowledged by the administrator at the exit conference on 09/16/14 at 12:55 p.m.</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 observation and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be</p>	K010046	<p>required by a contractor to replace the existing concrete due to the proximity to gas lines, oxygen storage and the emergency generator.</p> <p>K046 requires that emergency lighting of at least 1 1/2 hour duration is provided.1. No residents were affected. The lights in the medication room are powered by the emergency generator; therefore, the use of battery back-up lighting is not necessary. Thus, the battery back-up light has been removed from the medication room.2. No other battery back-up lighting is used within the facility.3. The Maintenance Director has been educated that should any battery back-up lighting be installed in the facility it is necessary to complete a monthly test log as well as an annual ninety minute test.4. The monitoring of monthly test logs and annual ninety minute testing of battery back-up lighting will be added to the facility preventative maintenance log and reviewed at</p>	09/22/2014	

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K010062 SS=F	<p>kept by the owner for inspection by the authority having jurisdiction. This deficient practice affects the nursing staff who work at the center nurses' station.</p> <p>Findings include:</p> <p>Based on observation on 09/16/14 at 10:40 a.m. with the maintenance supervisor and administrator, the facility had one battery backup light in the medication room at the center nurses' station. Based on an interview with the maintenance supervisor on 09/16/14 at 10:50 a.m., the facility does not have a monthly test log for the battery backup light and does not conduct an annual ninety minute test on the battery backup light. The lack of a monthly test log and an annual ninety minute test for the one battery backup emergency light in the medication room was verified by the maintenance supervisor and administer at the time of observation and acknowledged by the administrator at the exit conference on 09/16/14 at 12:55 p.m.</p> <p>3.1-19(b)</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,</p>		<p>least quarterly by the quality assurance committee. The plan of action will be adjusted accordingly, as warranted.5. The above corrective measures will be completed on or before September 22, 2014.</p>				

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	<p>NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Sprinkler System Test Reports on 09/16/14 at 9:45 a.m. with the maintenance supervisor, the last internal pipe inspection for the sprinkler system was conducted on 06/09/2009 through 06/10/2009, which was a period exceeding five years.</p> <p>Based on an interview with the maintenance supervisor on 09/16/14 at</p>	K010062	<p>K062 requires the automatic sprinkler systems to be continuously maintained in reliable operating condition and inspected and tested periodically.1. No residents were harmed. The internal pipe inspection for the sprinkler system has been scheduled to be completed by Elwood Fire Protection.2. All residents have the potential to be affected; thus, the facility Maintenance Director will continue to complete required maintenance and ensure required maintenance is scheduled with appropriate contractors.3. The facility Maintenance Director has been educated on the required maintenance for the automatic sprinkler system.4. The required maintenance of the automatic sprinkler system will be monitored as part of the facility preventative maintenance program and reviewed at least quarterly by the facility quality assurance committee. The action plan will be adjusted accordingly, as warranted.5. The above corrective measures will be completed on or before October 10, 2014.</p>	10/10/2014			

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K010144 SS=F	<p>10:20 a.m., the maintenance supervisor contacted the sprinkler system inspection company on a telephone interview and indicated there has not been an internal pipe inspection conducted since 06/09/2009 and there is not an internal pipe inspection scheduled to be conducted. The lack of a current five year internal pipe inspection was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/16/14 at 12:55 p.m.</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>Based on record review and interview, the facility failed to exercise the generator for 8 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. 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. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving</p>	K010144	<p>K 144 requires that generators be inspected weekly and exercised under load for 30 minutes per month.1. No residents were harmed. The generator has been exercised under load with no concerns noted.2. All residents have the potential to be affected; thus, the facility Maintenance Director will continue to exercise the generator under load for 30 minutes each month.3. The facility Maintenance Director was educated on ensuring the generator is exercised under load for 30 minutes each month.4. The generator test logs will be</p>	09/22/2014			

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	<p>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 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.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Emergency Generator-Monthly Test Log on 09/16/14 with the maintenance supervisor at 9:30 a.m., the test log did not list a monthly load test conducted on the emergency generator for the months of January, February, March, April, May, June, July, and August 2014. Based on an interview with the maintenance supervisor on 09/16/14 at 9:40 a.m., there were no records available for review to indicate a monthly load test was conducted between January and August of the year 2014.</p>		<p>reviewed as part of the facility preventative maintenance program and will be reviewed at least quarterly by the facility quality assurance committee. The plan of action will be adjusted accordingly, as warranted.5. The above corrective measures will be completed on or before September 22, 2014.</p>				

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	The lack of monthly load testing for the above listed months was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/16/14 at 12:55 p.m. 3.1-19(b)				