

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
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: 02/18/14</p> <p>Facility Number: 012199 Provider Number: 155781 AIM Number: 200989880</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Morningcrest Nursing and Memory Care Center 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 with a partial basement was determined to be of Type II (000) construction and was fully sprinklered with the exception of the kitchen janitor's closet. The facility has</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
K010020 SS=B	<p>a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and hard wired smoke detectors in the resident rooms. The facility has a capacity of 32 and had a census of 10 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the kitchen janitor's closet.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/24/14.</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 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection of 1 of 1 exit stairwells. LSC 8.2.5.2 requires</p>	K010020	F-20 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The keypad that had	02/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010025 SS=C	<p>enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect any resident or staff using the southwest exit corridor.</p> <p>Findings include:</p> <p>Based on observation on 02/18/14 with the Maintenance Supervisor at 1:55 p.m., the west basement stairwell door had a pencil size hole through the door above the door handle.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the hole in the stairwell door.</p> <p>3.1-19(b)</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>been removed that caused the hole has been replaced. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. 3 What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. This area has been placed on the preventative maintenance program. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance measures will be put into place. A 3 month QA will be conducted to assure compliance. After 3 months and no issues identified the QA will be discontinued.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
	<p>Based on observation and interview, the facility failed to ensure the passage of sprinkler pipe through 1 of 1 smoke barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to 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 all residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/18/14 at 2:35 p.m., there were four sprinkler pipe penetrations through the smoke barrier in the attic that were sealed with expandable foam which is not an approved material for maintaining the smoke resistance of a smoke barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the sprinkler pipe penetrations had been sealed with expandable foam.</p>	K010025	F-25 1. Penetration areas have been repaired with a non expandable filler. 2. All residents have the potential to be affected by this deficient practice. 3. This area has been added to our Preventative Maintenance program. Maintenance will assess this area on a quarterly basis to assure continued compliance. 4. The Preventative Program is reviewed quarterly at our Quality Assurance meeting. If there have not been any issues identified after 3 months the QA will be discontinued.	02/21/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010029 SS=E	<p>3.1-19(b)</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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors serving hazardous areas such as a soiled linen room closed and latched to prevent the passage of smoke. This deficient practice could affect 5 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 02/18/14 at 1:30 p.m., the shower room door closer was disconnected. The shower room had three 44 gallon containers used for soiled linen. Based on interview at the</p>	K010029	F- 29 1. The part for the door closure has been order. It will be installed when the part arrives. 2. all residents have the potential to be affected by this deficient practice. Door closure to be installed. 3. All doors with Closures have will be assessed on a monthly basis to assure compliance. The Preventative Maintenance Program will be reviewed at our Quarterly QA meeting. We will monitor this area for 3 months, if after months we have not identified any issues the QA will be discontinued.	03/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
K010038 SS=E	<p>time of observation, the Administrator acknowledged the door closer was disconnected.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 5 exit doors which were equipped with delayed egress locks was provided with signage stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. LSC 7.2.1.6.1(d) requires on the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 10 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/18/14 at</p>	K010038	<p>F-38 1. The sign for the door exiting into the courtyard ahs been ordered. The sign will be installed when it arrives. 2. All residents have the potential to be affected by this deficient practice. Signage as required Will be installed to meet requirements. 3. This has been added to our Preventative Maintenance Program and will be assessed on a quarterly basis to assure continued compliance. 4. This area will be reviewed quarterly at our QA meeting. If no new issues have been identified after 3 months the QA will be discontinued. ADDENDUM 2. The 2 exterior gates from the courtyard have been corrected to swing away from the direction of egress by maintenance. 2. All residents have the potential to be affected by this deficient practice. 3. Exterior gates will be placed on our Preventative Maintenance Program and will be assessed on</p>	02/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
	<p>2:30 p.m. with the Maintenance Supervisor, the exit door to the courtyard was equipped with a delayed egress lock but was not provided with signs indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 exterior gates from the courtyard swung in the direction of egress travel. LSC 7.2.1.4.3 states a door shall swing in the direction of egress travel. This deficient practice could affect up to 10 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/18/14 at 2:35 p.m. with the Maintenance Supervisor, both courtyard exit gates swung into the fenced in area instead of swinging in the direction of egress to the parking lots outside the gates. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>a quarterly basis to assure continued compliance. 4. This will be reviewed at our quarterly QA meeting. If no issues have been identified after 3 months the QA will be discontinued.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010046 SS=F	<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, observation and interview; the facility failed to ensure 16 of 16 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lighting" documentation with the Administrator at 1:00 p.m. on 02/18/14 and observation with the Maintenance Supervisor from 1:15 p.m. to 2:45 p.m., the following was noted:</p>	K010046	<p>F-46 1. The monthly Emergency Lighting functional testing for 30 seconds and 90 minute will be completed within the first week of the month with the completed required documentation. 2. All residents have the potential to be affected by this deficient practice. The functional testing of the battery operated lights will be completed monthly as required. 3. The Preventative Maintenance Program will be reviewed monthly at our monthly QA meeting and any issues identified will be reviewed with the maintenance supervisor and appropriate Corrective Action will be issued. 4. The Preventative Maintenance program is reviewed quarterly at our QA meeting any issues will be trended and monitored on an ongoing basis to assure continued compliance.</p>	03/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
	<p>a. The southwest exit battery operated emergency light and one of three courtyard exterior emergency lights were not functional when tested. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned battery operated emergency lights did not function when tested.</p> <p>b. Functional testing of the sixteen battery operated emergency lights in the facility was indicated by a check mark for each month on 2013. Based on interview at the time of record review, the Administrator acknowledged the battery operated emergency light documentation did not specify the duration of the monthly test or document the annual 90 minute test.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615		
(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	
K010050 SS=C	<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</p> <p>Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 3 of 4 third shift fire drills. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of fire drill report documentation with the Administrator on 02/18/14 at 12:45 p.m., three of four third shift fire drills were conducted between 1:00 a.m. and 2:00 a.m. Based on interview at the time of record review, the Administrator acknowledged the third shift fire drills were not held at unexpected times under varying conditions.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>F-50 1. Fire Drill will be held a varying times on the third shift. 2. All residents have the potential to be affected by this deficient practice. Fire drills will be scheduled at varying time son the third shift. 3. The maintenance supervisor shall complete a monthly schedule for the administrator. 4. The Fire Drill reports will be reviewed at our monthly QA. The monthly Fire Drill reports will be reviewed at the quarterly QA meeting if no issues are identified the QA will be discontinued after 3 months.</p>	02/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
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 a complete automatic sprinkler system was installed for 1 of 1 janitor's closets in the kitchen in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. This deficient practice could affect staff in the kitchen and residents, staff and/or visitors in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation on 02/18/14 with the Maintenance Supervisor at 2:05 p.m., the kitchen janitor's closet lacked sprinkler protection. Based on interview</p>	K010056	F-56 1. A bid to install a sprinkler protection in the kitchen janitors closet has been received and approved on 02/25/2014. Installation will begin when the equipment has been received. 2. All residents have the potential to be affected by this deficient practice. A Sprinkler protection system will installed when sprinkler heads have been completed. 3. The vendor who inspects our sprinkler system will now included this area in their quarterly inspections to assure functionality of system . 4. We will review Sprinkler system reports at our quarterly QA meeting. Any identified issues will be trended and will be corrected after the inspection has been completed. These report will then be reviewed at our next QA meeting to assure compliance occurred.	02/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
K010061 SS=F	<p>at the time of observation, the Maintenance Supervisor acknowledged the lack of sprinkler protection in the kitchen janitor's closet.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation, record review and interview; the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV) and 2 of 2 sprinkler backflow valves. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p>	K010061	F-61 1. Electronic supervision seals and locks shall be installed in the areas identified on the survey. . 2. All residents have the potential to be affected by this deficient practice, Ryan Fire Protection has been contacted and have scheduled the work to install the electronic supervision seals and locks. 3. This area will be placed on our Preventative Maintenance Program and will be assessed on a quarterly basis. 4. The Quarterly inspection reports will be reviewed by the Maintenance supervisor, If areas are identified on the report as non compliant the administrator will make the appropriate steps to correct the non compliant issues and contact the vendor for repairs. These reports will be reviewed at our quarterly QA meeting.	03/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615
---	--

(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
K010062 SS=C	<p>Based on review of sprinkler documentation dated 12/19/13 with the Administrator on 02/18/14, electronic supervision, seals or locks were not provided on the OS&Y valves on the sprinkler backflow control device. Based on observation with the Maintenance Supervisor from 1:15 p.m. to 2:15 p.m., the two OS & Y valves on the sprinkler backflow control device in the basement sprinkler riser room and the Post Indicator Valve (PIV) outside the facility lacked electronic supervision. Based on interview at the time of observation, the Maintenance Director acknowledged the sprinkler OS & Y valves on the sprinkler backflow control device and the PIV lacked electronic supervision.</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, NFPA 25, 9.7.5</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
	<p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 02/18/14 at 1:20 p.m. with the Maintenance Supervisor, there were no pendant sprinklers in the spare sprinkler cabinet. There were pendant sprinkler heads observed during the tour throughout the facility. The lack of spare pendant sprinklers was acknowledged by the</p>	K010062	F64 1. The facility has contacted Ryan Fire Protection and they have issued spare supply of pendants. 2. All residents have the potential to be affected by this deficient practice. The pendants are available as per the requirement. 3. The maintenance supervisor will complete a monthly visual check to assure we have the appropriate supplies necessary to meet this requirement. Maintenance will report to the administrator at our monthly QA meeting . We will review for any trends if no issues are identified after 3 months the QA will be discontinued.	03/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010064 SS=B	<p>Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to inspect 1 of 1 portable K-class fire extinguishers in the kitchen each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice was not in a resident care area but could affect any number of staff in the event of an emergency.</p>	K010064	<p>F-64 1. The Fire extinguisher was on checked on 2/19/14. 2. All residents have the potential to be affected by this deficient practice. The Dietary manager will assign a staff member to complete the monthly check and document compliance. 3. The Dietary Supervisor shall have the ultimate responsibility to assure compliance. 4. The Dietary Supervisor will report at our monthly QA any trends of non compliance. The QA will review the reports at our quarterly meeting if no issues have been identified after 3 months the QA will be discontinued.</p>	02/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010067 SS=E	<p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 02/18/14 at 2:00 p.m., the monthly inspection tag on the K-class fire extinguisher located in the kitchen lacked documentation of a monthly inspection for the months of September, December of 2013 and January of 2014. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 17 rooms were not using the corridor as a portion of a return air system/plenum for the heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect at least 10</p>	K010067	F-67 1. Work has begun on installing air returns in the 4 areas identified on the survey. 2. All residents have the potential to be affected by this deficient practice.,	02/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010069 SS=B	<p>residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 1:15 p.m. to 2:45 p.m. on 02/18/14, the Administrators office, the Activities office, the Director of Nursing office and the Dietary/Social Services office were using the egress corridors as a return air system. Based on interview at the time of observations with the Maintenance Supervisor, it was confirmed the return air was exhausted into the corridor for the aforementioned adjoining rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified</p>	K010069	F-69 1. A copy of the reports for the time frame missing have been received. . 2. All residents have the potential to be affected by this deficient practice. All inspection reports will now be retained in the administrator's office. 3. All inspection reports will be reviewed by the administrator and retained in that office. 4. Inspections reports will be	02/27/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
	<p>company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Administrator at 12:55 p.m. on 02/18/14, documentation of the most recent semiannual kitchen exhaust system inspection was dated 12/20/13. The previous available documented semiannual kitchen exhaust system inspection was dated 12/11/12, a period greater than six months. Based on interview at the time of record review,</p>		<p>reviewed at our quarterly QA meeting.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615		
(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	
K010076 SS=E	<p>the Administrator acknowledged no other kitchen exhaust system inspection documentation was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 6 of 12 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect resident, staff or visitor in the courtyard.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010076	F-76 1. Oxygen tanks were placed into the appropriate containers. 2. All residents have the potential to be affected by this deficient practice; an in service was completed with the nursing staff and instructions were provided on the proper storage process for oxygen 3. A weekly assessment of the storage area will be completed by central supply. 4. We will review the findings of the assessment at our monthly clinical QA meeting. If no issues are identified after 3 months the QA will be discontinued.	02/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
K010147 SS=D	<p>Maintenance Supervisor on 02/18/14 at 2:30 p.m., there were four oxygen E-cylinders and two oxygen B-cylinders standing in the oxygen cabinet located outside on the courtyard patio without support. The Maintenance Supervisor agreed at the time of observation, the cylinders should have been in the racks which were provided.</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 Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would not directly affect residents but could</p>	K010147	F-147 1. The refrigerator that were identified to be connected on surge protectors have been plugged into direct current. 2. No residents would be affected by this practice but could affect staff. 3. Refrigerators have been placed on the Preventative Maintenance program and will be assessed monthly. Any non compliance will be identified and issues corrected to assure continued compliance. 4. This area will be reviewed in our quarterly QA meeting. If no issues have been identified the QA will be discontinued after 3 months.	02/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155781		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2014	
NAME OF PROVIDER OR SUPPLIER MORNINGCREST NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 915 S 27 ST SOUTH BEND, IN 46615			
(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			
	<p>affect staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor from 1:15 p.m. to 2:45 p.m. during a tour of the facility on 02/18/14, the following was noted:</p> <p>a. A refrigerator was plugged into a power strip in the Medication room.</p> <p>b. A refrigerator was plugged into a power strip in the basement employee break room.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>						