

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
--------------------	--	---------------	---	----------------------

K 0000  Bldg. 01	<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: 09/21/15</p> <p>Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730</p> <p>At this Life Safety Code survey, Signature Healthcare of South Bend 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), and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 73 at the time of this</p>	K 0000	<p>Signature HealthCARE of South Bend requests that this planof correction be considered its credible allegation of compliance for thedeficiencies cited. However, preparationand/or execution of this plan of correction does not constitute admission oragreement by the facility to the truth of the facts alleged or conclusions setforth in the statement of deficiencies. This plan of correction is submitted tomeet requirements established by state and federal law.</p> <p>Signature HealthCARE of South Bend alleges date ofcompliance to be October 16, 2015.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0025 SS=D Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was fully sprinklered and one wooden storage shed which was not sprinklered.</p> <p>Quality Review completed 09/23/15 - DA</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 1 of 1 ceiling smoke barriers were maintained to provide a one 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 staff and at least 3 residents near the Activity Lounge area.</p>	K 0025	<p>It is the intent of the facility to maintain fire and smokebarriers in accordance with regulation.</p> <p>Q1: What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice; A1: No specific resident was identified to be acutely affected.</p> <p>Q2: How other residents having the potential to be affectedby the same deficient practice will be identified</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>Findings include:</p> <p>Based on observations with the Plant Operations Director and Administrator on 09/21/15 at 12:35 p.m., the electrical room in S Hall had a one inch gap in the ceiling around electrical wires. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged and provided the measurements for the unsealed penetration.</p> <p>3.1-19(b)</p>		<p>and what corrective action(s) will be taken;</p> <p>A2: Three residents with rooms near the Activity Lounge area have the potential to be effected. The Maintenance Director filled the gap with appropriate fire-rated caulk.</p> <p>Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>A3: Facility will be inspected for any further areas where fire/smoke barrier walls have been penetrated and will ensure that the area is appropriately corrected. The Maintenance Director, or designee, will also inspect behind any facility contractor and ensure that any fire/smoke wall penetration is appropriately corrected. The Maintenance Director, or designee, will conduct a facility inspection/audit of fire/smoke walls to ensure compliance monthly for three months and quarterly thereafter.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>A4: Maintenance Director, or designee, will keep record of audits and observations. These audits and observations will be reviewed monthly in the facility Safety Meeting for three months and quarterly thereafter. The results will also be reviewed monthly in QAPI</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0062 SS=C Bldg. 01	<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>1. Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrants were 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 record review with the Plant Operations Director and Administrator on</p>	K 0062	<p>until the QAPI Committeedetermines that substantial compliance has been reached.</p> <p>Q5: By what date the systemic changes will be completed. A5: October 16, 2015.</p> <p>It is the intent of the facility to ensure automaticsprinkler systems are maintained, inspected, and tested as required byregulation.</p> <p>Q1: What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice; A1: (1) No specific resident was identified to be acutely affected.(2) No specific resident was identified to be acutely affected. (3) No residentwas identified to be acutely affected.</p> <p>Q2: How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective action(s)will be taken; A2: (1) All residents have the potential to be affected. Thehydrant was immediately called for inspection and was inspected on 9/29/2015.(2) One resident had the potential to be affected. The</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>09/21/15 at 11:15 a.m., one private fire hydrant was last inspected on 8/30/13. Based on interview at the time of record review, the Plant Operations Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in resident room 210 was maintained. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Director and Administrator on 09/21/15 at 11:34 a.m., resident room 210 had one sprinkler head missing an escutcheon. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged for aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to replace 4 of 4 corroded sprinkler heads outside in the Front Entrance. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be</p>		<p>Maintenance Director replaced an escutcheon on the affected sprinkler head. (3) Residents who use the front entrance have the potential to be affected. The contractor that services sprinkler heads for the facility was immediately contacted to facilitate replacement of the sprinkler heads. The needed materials have been ordered, and sprinkler heads will be replaced as soon as they are delivered.</p> <p>Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A3: (1) Maintenance Director will ensure that the hydrant is scheduled routinely for annual inspection. (2) &amp; (3) Maintenance Director, or designee, will conduct an audit of facility sprinkler heads monthly for three months and quarterly thereafter.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A4: (1) (2) &amp; (3) Maintenance Director will ensure that annual hydrant inspection is added to the ongoing preventative maintenance schedule. The Maintenance Director, or designee, will keep documentation of monthly and quarterly audits. These results will be reviewed in monthly Safety Meeting. The results will also be reviewed by the QAPI Committee</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0066 SS=B Bldg. 01	<p>inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director and Administrator on 09/21/15 at 12:51 p.m., all four sprinkler heads outside protecting under a canopy were corroded. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read</p>		<p>monthly for three months and quarterly thereafter until the QAPICommittee determines that substantial compliance has been achieved.</p> <p>Q5: By what date the systemic changes will be completed. A5: October 16, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observations and interview with the Plant Operations Director and Administrator on 09/21/15 at 1:07 p.m., the Plant Operations Director and Administrator acknowledged there were at least 30 cigarette butts on the ground in the designated staff smoke area. Based on interview at the time observation, the Plant Operations Director and Administrator acknowledged the aforementioned conditions.</p>	K 0066	<p>It is the intent of the facility to maintain designated smoking areas in accordance with regulation.</p> <p>Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A1: No specific resident was identified to be affected.</p> <p>Q2: 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;</p> <p>A2: No residents have the potential to be affected. Signature HealthCARE of South Bend allows smoking in designated areas for staff only. Smoking area was cleaned and cleared of any loose cigarette butts.</p> <p>Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>A3: Maintenance Director, or</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0075 SS=D Bldg. 01	3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater		designee, will inspect the designated staff smoking area three times per week for four weeks, weekly for four weeks, and monthly thereafter. The Maintenance Director, or designee, will conduct education with all employees who smoke in regard to safe smoking practices on facility grounds. Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A4: Maintenance Director, or designee, will keep record of audits and observations. These audits and observations will be reviewed monthly in the facility Safety Meeting for three months and quarterly thereafter. The results will also be reviewed monthly in QAPI until the QAPI Committee determines that substantial compliance has been reached. Q5: By what date the systemic changes will be completed. A5: October 16, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 of resident room areas. This deficient practice could affect staff and 1 resident in room 224.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director and Administrator on 09/21/15 at 11:50 a.m., two adjacent 30 gallon containers of biohazardous soiled linens and biohazardous trash were discovered in resident room 224. Based on an interview at the time of observation, the Plant Operations Director and Administrator acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0075	<p>It is the intent of the facility to ensure that hazardous material is contained in accordance with regulation.</p> <p>Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1: No specific resident was identified to be acutely affected.</p> <p>Q2: 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; A2: One resident had the potential to be affected. This second hazardous receptacle was removed from the room, leaving one 30 gallon receptacle in the space.</p> <p>Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A3: Resident and biohazard rooms were inspected to ensure proper storage of biohazard waste. Education will be conducted by the Staff Development Coordinator for all nursing staff regarding the restriction on the volume of waste receptacles allowed in resident rooms. Maintenance Director, or designee, will conduct periodic room checks for residents on contact precautions to ensure compliance with the biohazard</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 4 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of</p>	K 0130	<p>waste volume restrictions.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>A4: Maintenance Director, or designee, will keep record of audits and observations. These audits and observations will be reviewed monthly in QAPI until the QAPI Committee determines that substantial compliance has been reached.</p> <p>Q5: By what date the systemic changes will be completed.</p> <p>A5: October 16, 2015.</p> <p>It is the intent of the facility to maintain fire and smoke barriers in accordance with regulation.</p> <p>Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A1: No specific resident was identified to be acutely affected.</p> <p>Q2: 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;</p> <p>A2: All residents had the potential to be affected. Thenoted drywall has been repaired.</p> <p>Q3: What measures will be put into place or what systemic changes will</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect at least 10 residents in 2 of 11 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Director and Administrator on 09/21/15 at 2:25 p.m., the Activity Lounge fire barrier wall had a four inch diameter circle of one piece of drywall cut out. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged the aforementioned</p>		<p>be made to ensure that the deficient practice does not recur;</p> <p>A3: Facility will be inspected for any further areas where fire/smoke barrier walls have been penetrated and will ensure that the area is appropriately corrected. The Maintenance Director, or designee, will also inspect behind any facility contractor and ensure that any fire/smoke wall penetration is appropriately corrected. The Maintenance Director, or designee, will conduct a facility inspection/audit of fire/smoke walls to ensure compliance monthly for three months and quarterly thereafter.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>A4: Maintenance Director, or designee, will keep record of audits and observations. These audits and observations will be reviewed monthly in the facility Safety Meeting for three months and quarterly thereafter. The results will also be reviewed monthly in QAPI until the QAPI Committee determines that substantial compliance has been reached.</p> <p>Q5: By what date the systemic changes will be completed.</p> <p>A5: October 16, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
K 0147 SS=D Bldg. 01	<p>condition and provided the measurement.</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 6 of 6 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with Plant Operations Director and Administrator on 09/21/15 between 12:11 p.m. to 1:49 p.m. the following was discovered:</p> <p>a) A surge protector was powering another surge protector powering computer components in the Business Office.</p> <p>b) An extension cord was powering a refrigerator in resident room 101.</p>	K 0147	<p>It is the intent of the facility to maintain electricalwiring and equipment in accordance with regulation.</p> <p>Q1: What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice;</p> <p>A1: (1) No specific resident was identified to be affected. (2)No specific resident was identified to be affected.</p> <p>Q2: How other residents having the potential to be affectedby the same deficient practice will be identified and what corrective action(s)will be taken;</p> <p>A2: (1) One resident had the potential to be affected. Surgeprotector was removed from (a) the Business Office computer (b) resident room101 (c) the Therapy Office and (d) the MDS office. (2) No residents had thepotential to be affected. The outlet was immediately covered.</p> <p>Q3: What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur;</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>c) A surge protector was powering another surge protector in the Therapy Office.</p> <p>d) A surge protector was powering a coffee pot in the MDS office. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Therapy office. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only. Findings include: Based on observation with the Plant Operations Director and Administrator on 09/21/15 at 1:45 p.m., an electric receptacle in the Therapy office was uncovered. Based on interview at the time of observation, the Plant Operations Director and Administrator acknowledged the aforementioned condition.</p>		<p>A3: (1) Facility will be inspected for any further improper use of surge protectors. The Maintenance Director, or designee, will conduct a facility audit to ensure compliance monthly for three months and quarterly thereafter. (2) Maintenance Director, or designee, will conduct a facility audit of outlets to ensure that this was an isolated incident.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>A4: Maintenance Director, or designee, will keep record of audits and observations. These audits and observations will be reviewed monthly in the facility Safety Meeting for three months and quarterly thereafter. The results will also be reviewed monthly in QAPI until the QAPI Committee determines that substantial compliance has been reached.</p> <p>Q5: By what date the systemic changes will be completed.</p> <p>A5: October 16, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/21/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(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	
	3.1-19(b)				