

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 10/30/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/21/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/30/15</p> <p>Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730</p> <p>At this PSR survey, Signature Healthcare of South Bend was found in substantial 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</p>	K 0000	Signature HealthCARE of South Bend requests that this plan of correction be considered its credible allegation of compliance for the deficiencies cited. However, preparation and/or execution of this plan of correction does not constitute admission or agreement by the facility to the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is submitted to meet requirements established by state and federal law. Signature HealthCARE of South Bend respectfully requests that this Plan of Correction and any supporting documentation be accepted. We allege date of compliance to be November 2, 2015.	
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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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K 0130 SS=B Bldg. 01	<p>rooms. The facility has a capacity of 157 and had a census of 77 at the time of this 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 on 11/09/15 - DA</p> <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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p>	K 0130	<p>It is the intent of the facility to ensure fire barrierwalls are maintained to ensure the fire resistance of the barrier.</p> <p>Q1: What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice; A1: No residents were directly affected.</p> <p>Q2: How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken; A2: Three residents with rooms near the Activity Loungearea have the potential to be effected. The</p>	11/02/2015

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	<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 19 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Service Manager on 10/30/15 at 9:38 a.m., the Activity Lounge fire barrier wall had a one and a half inch unsealed penetration around wires. Based on interview at the time of observation, the Environmental Service Manager acknowledged the aforementioned condition and provided the measurement.</p>		<p>Maintenance Director repaired the wall penetration immediately.</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: The fire barrier wall was repaired immediately. 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; and 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>-</p> <p>Q5: By what date the systemic</p>	

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	This deficiency was cited on 09/21/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		changes will be completed. A5: November 2, 2015		