

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2015
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NAME OF PROVIDER OR SUPPLIER SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
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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: 08/24/15</p> <p>Facility Number: 001201 Provider Number: 155506 AIM Number: 100380860</p> <p>At this Life Safety Code survey, Sanctuary at Holy Cross-Indiana 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. The original facility was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in areas open to the corridors and in resident sleeping rooms.</p>	K 0000		

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 0018 SS=D Bldg. 01	<p>The facility has a capacity of 168 and had a census of 120 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the garage used for maintenance storage.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 112 resident room corridor doors closed and latched into their door frames. This deficient practice could affect 4 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/24/15 at 11:03 a.m. and again at 11:22 a.m., the the corridor doors to resident</p>	K 0018	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: K- 18, the doors closing was immediately corrected with no adverse effect for the 4 residents involved. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: an audit was conducted of all resident doors with no other</p>	09/04/2015

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K 0029 SS=D Bldg. 01	<p>rooms 3E and 12E failed to latch when tested. This was acknowledged by the Administrator and Environmental Director at the time of each observation.</p> <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 the corridor door to 1 of 1 laundry and 1 of 1 Basement Storage, both hazardous areas, were provided with self closers and would latch into their frames. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p>	K 0029	<p>deficiencies noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Checking of door closures added to monthly preventive maintenance rounds. How will the corrective action be monitored Environmental Director will report to Mission Driven Quality Improvement Committee monthly times 6 then committee will determine the need for further reporting.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: K- 29, the doors have new self-closure devices installed. No residents were identified as affected by this practice. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: no resident</p>	09/04/2015

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K 0147 SS=D Bldg. 01	<p>Based on observation with the Environmental Director and Administrator on 08/24/15 at 2:31 p.m. and again at 3:40 p.m., the Basement Storage area contained eight mattresses, fourteen large cardboard boxes, two hazardous chemical storage cabinets, and other miscellaneous storage. When tested, the Basement Storage door failed to positive latch when tested. Furthermore, the door to the laundry room, containing fuel fired dryers, failed to positive latch when tested. Based on interview at the time of each observation, the Environmental Director and Administrator acknowledged the aforementioned conditions.</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>Based on observation and interview, the facility failed to ensure 2 of 2 multiplugs and 5 of 5 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</p>	K 0147	<p>affected. What measures will be put into place to what systemic changes will be made to ensure that the deficient practice does recur: Checking of door closure added to monthly preventive maintenance rounds for function. How will the corrective action be monitored Environmental Director will report to Mission Driven Quality Improvement Committee monthly times 6 then committee will determine the need for further reporting.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: K-147, Multiplug in W16 and E 16 were removed and items relocated for use of fixed wired outlets, surge protectors were removed immediately, and fixed wired outlets were added to the IT closet with no adverse effect for</p>	09/04/2015

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K 0000 Bldg. 02	<p>not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 4 residents.</p> <p>Findings include:</p> <p>Based on observation with Environmental Director and Administrator on 08/24/15 between 11:17 a.m. to 2:57 p.m. the following was discovered:</p> <p>a) a multiplug was powering a TV, photo frame, and a DVD player in resident room 16E</p> <p>b) a surge protector was powering a coffee pot and a refrigerator in the Director of Nursing office</p> <p>c) a surge protector was powering a refrigerator in the Staff Education room</p> <p>d) a multiplug was powering a TV and antenna in resident room 16W</p> <p>e) a surge protector powering two other surge protectors powering electrical equipment in the Sanctuary IT Room</p> <p>Based on interview at the time of observations, the Environmental Director and Administrator acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>the 4 residents involved or to staff. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: an audit was conducted of the building for power surge and multiplug, if noted they were removed immediately and fixed wiring used to power high current draw. What measures will be put into place to what systemic changes will be made to ensure that the deficient practice does not recur: Checking building for surge protectors and multiplugs has been added to monthly preventive maintenance rounds. How will the corrective action be monitored Environmental Director will report to Mission Driven Quality Improvement Committee monthly times 6 then committee will determine the need for further reporting.</p>	

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