

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2015
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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(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
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K 000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/20/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/02/15</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>At this PSR survey, Ironwood Health and Rehabilitation Center 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of the rear entrance canopy. The facility has a fire alarm system with smoke detection the corridors, areas open to the corridors,</p>	K 000		
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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 130 SS=C Bldg. 01	<p>and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 183 with a census of 105 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the rear entrance canopy. All areas providing facility services were sprinklered except for a detached laundry building, maintenance shed and a storage shed.</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 11 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 130	<p>K 130</p> <p>The penetrations sealed with fire chalk and expandable foam in 400 hall attic near resident room 412 has been removed and replaced with FP200 FR Expanding Foam tested in accordance with ASTM E814 UL1479 to provide an effective insulating barrier, maintaining the integrity of the wall and preventing the spread of fire from one compartment to another.</p> <p>The Maintenance Director and Assistant have been in-serviced that identified exposed penetrations in the attic are to be logged on the routine maintenance rounding logs monthly and repaired immediately with the approved ASTM E814, UL1479 rated expanding foam to</p>	06/12/2015

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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 residents in 2 of 13 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during the tour with the Maintenance Director on 06/02/15 at 4:19 p.m., penetrations sealed with fire chalk and expandable foam in 400 Hall attic near resident room 412 was discovered. Based on interview at the time of observations, the Maintenance Supervisor provided documentation for the fire chalk and expandable foam used. The can of expandable foam certifications included an asterisk saying</p>		<p>ensure that continued compliance is maintained.</p> <p>The Maintenance Director and/or Assistant will log any identified concerns during routine rounds monthly and will follow up immediately to ensure compliance is maintained. The Administrator/Designee will review completed logs monthly to ensure any needed follow up has been completed and the approved ASTM E814, UL 1479 rated expanding foam was used.</p> <p>The rounding logs completed by the Maintenance Director and/or Assistant that will be reviewed by the Administrator/Designee, will be further reviewed at the regularly scheduled Quality Assurance committee meeting (QA) for a period of 3 months, then quarterly thereafter, to ensure compliance is maintained by using the ASTM E814, UL1479 rated expanding foam. The QA Committee will make recommendations for needed changes and/or follow up.</p>	

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	"Not to be used as a fire stop in commercial construction."				