

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155684	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614
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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: 02/09/16</p> <p>Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930</p> <p>At this Life Safety Code survey, Southfield Village, 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 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, spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 55 at the time of this survey.</p>	K 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. The submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. The Plan of Correction is being submitted to meet the requirements established by state and federal law.	

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 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review on 02/11/16 - 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 the penetrations caused by the passage of wire and/or conduit through 1 of 1 floor/ceiling smoke wall and 2 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. 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</p>	K 0025	<p>The smoke penetrations identified have been repaired utilizing a fire resistive chalk.</p> <p>To prevent this from reoccurring, the entire surface of all the smoke walls have been inspected for any additional openings and none were found.</p> <p>Systemically, following any work that is done by staff or a contractor that could compromise the structural integrity of the smoke barrier, the smoke barrier will immediately be inspected and repaired if necessary by the facility maintenance staff.</p>	03/10/2016			

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	<p>resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and at least 23 residents.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Director on 02/09/16 between 12:24 p.m. and 1:05 p.m., the following smoke wall penetrations were discovered:</p> <p>a) eight separate floor penetrations inside conduit in the Mechanical Phone room ranging from one and a quarter inch to three inch.</p> <p>b) the 200 Hall smoke barrier wall had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was one half inch around sprinkler pipe and a quarter inch around another sprinkler pipe.</p> <p>c) the 300 Hall smoke barrier wall had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a quarter inch around wires. Based on interview at the time of each observation, the Environmental Director acknowledged the aforementioned conditions and provided the measurements.</p> <p>3.1-19(b)</p>		<p>The Physical Plant and Safety Committee, a quality assurance group will verify that the above mentioned repairs were completed and the walls will be inspected after any future work that could create penetrations.</p>		

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and at least 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Director on 02/09/16 at 11:10 a.m., the fire doors separating Health Care and Assisted Living failed to close when released because the door caught on the floor and stayed open. When the door was assisted, the door failed to latch into the frame. Based on interview at the time of observation, the Environmental Director acknowledged the aforementioned condition and</p>	K 0044	<p>The current door, which is always kept in the closed position, to prevent resident elopement, is not repairable. This door will remain closed at all times to assure the integrity of the fire wall until the repair is made. Bids will be received for replacement doors by March 10, 2016. Manufacturing time is 4-6 weeks. The doors will be installed no later than May 10, 2016. The Physical Plant and Safety Committee, a quality assurance group will be responsible to assure the work is completed.</p>	03/10/2016			

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K 0050 SS=C Bldg. 01	<p>confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Southfield Village" forms with the Environmental Director on 02/09/16 at 10:01 a.m., four sequential third shift fire drills took place between 3:00 a.m. and 4:00 a.m. Three of four first shift drills were between 1:25 p.m. and 1:32 p.m. Based on interview at the time of record review, the Environmental Director acknowledged the aforementioned</p>	K 0050	<p>Fire drills will be conducted on each shift, quarterly at random times. Systemically, a revised fire drill schedule, that includes random times, has been completed for calendar year 2016. The Physical Plant and Safety Committee, a quality assurance group, will verify each month that drills are conducted in accordance with the scheduled dates and times.</p>	03/10/2016	

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K 0051 SS=E Bldg. 01	<p>condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Courtyard Dining Room and 1 of 1 smoke detector in the corridor outside resident room M118 was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the</p>	K 0051	<p>These two identified smoke detectors were moved 36 inches away from the ventilation system.</p> <p>An audit of the remainder of the building found one additional smoke detector that needed to be moved. That work was completed.</p> <p>Systemically, if for any reason a smoke detector needs to be moved in the future, the Maintenance staff will assure it is</p>	03/10/2016

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K 0062 SS=E Bldg. 01	<p>detectors. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with Environmental Director on 02/09/16 at 12:42 p.m. then again at 12:43 p.m., the Courtyard smoke detector was located twenty two inches away from an HVAC vent. Then again a 100 Hall smoke detector outside M118 was 27 inches away from an HVAC vent. Based on interview at the time of observation, the Environmental Director acknowledged each aforementioned condition and provided the measurements.</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> <p>Based on observation and interview, the facility failed to replace 2 of 2 corroded sprinkler heads in the exit discharge from 100 Hall. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the</p>	K 0062	<p>located at least 36 inches or greater from any type of mechanical ventilation.</p> <p>The Physical Plant and Safety Committee, a quality assurance group will monitor any future movement of smoke detectors to assure compliance.</p> <p>The two identified sprinkler heads have been replaced.</p> <p>An inspection of all other sprinkler heads found no others to be affected.</p> <p>Systemically, all internal and external sprinkler heads throughout the facility will be inspected annually</p>	03/10/2016

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K 0067 SS=C Bldg. 01	<p>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 only.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Director on 02/09/16 at 12:36 p.m., two sprinkler heads were corroded outside the 100 Hall exit discharge. Based on interview at the time of observation, the Environmental Director acknowledged the aforementioned condition.</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 interview and record review, the facility failed to ensure an undetermined number of dampers in the ductwork at smoke barriers and fire barriers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A to</p>	K 0067	<p>by a contract sprinkler service for corrosion, paint or physical damage.</p> <p>The Physical Plant and Safety Committee, a quality assurance group will verify the inspections occurred and are accurately documented.</p> <p>All of the facility's dampers have been fully exercised and all fusible links were replaced in February 2014. This was a prior deficiency cited and its correction verified by Indiana State Department of Health, Life Safety Inspector Dennis Austill. At that time, Mr. Austill identified 6</p>	03/10/2016	

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K 0130 SS=E Bldg. 01	<p>protect 55 of 55 residents. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include: Based on interview and record review with the Environmental Director on 02/09/16 at 1:34 p.m., the Environmental Director acknowledged the facility had dampers installed but failed to provide any documentation of damper inspection. 3.1-19(b)</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 1 fire barrier wall was maintained to ensure the fire resistance of the barrier.</p>	K 0130	<p>dampers that did not meet this requirement; the facility exercised and changed the fusible links on all 37 dampers though out the building. The current inspector was made aware of this and was told the date the dampers were the serviced was written on each individual unit. The Physical Plant and Safety Committee will be responsible to assure the dampers are exercised and the fusible links removed on or before February of 2018.</p> <p>The penetration in the fire wall has been repaired. The entire fire wall has been inspected for other penetrations and none exist. Systemically, following any work that is done by staff or a</p>	03/10/2016	

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	<p>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 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 20 residents.</p>		contractor that could compromise the structural integrity of the fire wall, the fire wall will immediately be inspected and repaired if necessary by the facility maintenance staff. The Physical Plant and Safety Committee, a quality assurance group will be responsible to assure the repair is completed.		

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K 0144 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on an observation with the Environmental Director on 02/09/16 at 1:14 p.m., a two and a half inch by four inch penetration in the fire wall separating Health Care and Assisted Living in the attic. Based on interview at the time of each observation, the Environmental Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the</p>	K 0144	The annunciator panel has been relocated to an active nurse's station. Since this is the only generator annunciator panel; this event cannot reoccur elsewhere in the facility. The Generator Weekly Inspection form will be up dated to include the transfer time. Historically, the transfer time is approximately one second. The generator was programmed in January 2014 to incorporate a 5 minute cool down period. Please see the up loaded documentation. The Physical Plant and Safety Committee, a quality assurance	03/10/2016			

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	<p>facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Director on 02/09/16 at 10:40 a.m., the generator annunciator panel is in the old nurse's station which is not manned constantly. Based on an interview at the time of observation, the Environmental Director 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 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Environmental Director on 02/09/16 at 10:40 a.m., the monthly testing forms failed to include the transfer time for twelve months of the last twelve months</p>		<p>group has verified the panel was relocated and the generator weekly inspection will include documenting the transfer time and cool down period.</p>	

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	<p>of testing. Based on interview at the time of record review, the Environmental Director acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Environmental Director on</p>			

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NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6450 MIAMI CIR SOUTH BEND, IN 46614			
(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>02/09/16 at 10:40 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Environmental Director acknowledged the aforementioned condition.</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 1 of 1 multiplug adapter and 3 of 3 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</p>	K 0147	The surge protectors identified have been removed. An environmental audit was conducted and found the same practice in other rooms. Those surge protectors were also removed. The Environmental Services Director will in service the staff to prevent reoccurrence. Additionally, room inspections will be conducted every six months to identify and correct any deficiencies. The Physical Plant and Safety Committee, a quality assurance group will verify the	03/10/2016			

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	<p>residents.</p> <p>Findings include:</p> <p>Based on observation with Environmental Director on 02/09/16 at 12:06 p.m. then again at 12:24 p.m., a surge protector was powering an oxygen concentrator in resident room M316. Also, a multiplug adapter was powering a paper shredder. Then again, a surge protector was powering another surge protector powering phone equipment in the Mechanical Phone room. Based on interview at the time of each observation, the Environmental Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		plan of correction is implemented.		