

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2013
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NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617
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K010000	<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: 04/22/13</p> <p>Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist, & Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Cardinal Nursing and Rehabilitation Center 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,</p>	K010000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p>	
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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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	<p>Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility with a basement was determined to be of Type II (111) construction with a one story addition determined to be of Type V (111) construction and both were fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 144 with a census of 104 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/30/13.</p>				

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	The facility was not found in compliance with the aforementioned regulatory requirements.			

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K010018 SS=E	<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.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 75 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 12 residents in the north hall.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., resident room door 103 would not latch in its frame.</p> <p>Based on interview at the time of observation on 04/22/13 at 9:15</p>	K010018	<p>It is the policy of this facility that resident room doors are provided with a means suitable for keeping the door closed. It is the policy of this facility that there are no impediments to opening storage room doors in the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Appropriate repairs were made to ensure that resident room 103 door latches properly into its frame. Basement exit corridor door has no impediment to opening the door. 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: The alleged deficient practices had the potential to affect 12 residents</p>	05/20/2013			

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	<p>a.m., the Maintenance Director acknowledged resident room 103 door would not latch in its frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 basement exit corridors had no impediments to opening a door into the exit corridor. This deficient practice had the potential to affect the staff utilizing the basement area.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., a resident bed presented an impediment to opening a storage room door in the basement. Based on interview at the time of observation on 04/22/13 at 1:30 p.m., the Maintenance Director acknowledged the door was blocked with a stored resident bed.</p>		<p>in the north hall and the staff utilizing the basement area. The resident bed was immediately removed and no longer creates an impediment to opening the storage room door in the basement. The Maintenance Director and/or designee inspected all resident room doors and verified that all resident room doors latch properly into their respective frames. The Maintenance Director and/or designee inspected all storage areas to validate that there are no impediments to the opening of storage rooms throughout the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states all resident room doors must latch properly into its respective frame and that at no time shall there be impediments to the opening of storage room doors. Housekeepers and/or maintenance personnel will check daily that resident room doors latch properly into their respective door frames and that there are no impediments to the opening of storage rooms throughout the</p>		

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	3.1-19(b)		facility. Any issues noted during daily checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Resident Door Inspections" weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 98% each is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.		

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K010020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 stairwell enclosures maintained the one hour fire resistance rating. This deficient practice had the potential to affect residents on the first floor north hall.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the Alzheimer stairwell penetrations were sealed with expandable foam around the sprinkler head. The expandable foam did not maintain the one hour fire rating for the stairway. Based on interview at the time of observation on 04/22/13 at 9:22 a.m., the Maintenance Director acknowledged, the foam did not</p>	K010020	<p>It is the policy of this facility that stairwell enclosures maintain a minimum one hour fire resistance rating. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. Appropriate repairs were made to ensure the Alzheimer stairwell penetrations are properly sealed with expandable foam around the sprinkler head with an appropriate foam which maintains a one hour fire rating for the stairwell. 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: The alleged deficient practice had the potential to affect residents on the first floor north hall. Appropriate repairs were made to ensure the Alzheimer stairwell penetrations are properly sealed with expandable foam around the sprinkler head with an appropriate foam which maintains a one hour fire rating for the stairwell. The Maintenance Director and/or designee</p>	05/20/2013			

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	maintain the required fire rating. 3.1-19(b)		inspected all stairwells throughout the facility and verified that there were no sprinkler heads which did not have an appropriate foam which maintains a one hour fire rating for the respective stairwells. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states that stairwell enclosures must maintain a minimum one hour fire resistance rating and that any penetrations must be appropriately sealed with an acceptable product which maintains a one hour fire rating. Immediately following any stairwell construction, installation, or stairwell repair work which has the potential to cause structural penetrations or otherwise compromise a one hour fire resistance rating, the Director of Maintenance/designee shall physically inspect said construction site, installation or repair work and shall ensure that any potential or actual structural penetrations are appropriately sealed with an acceptable product which maintains a one hour fire rating. Any issues noted during such inspection will be immediately reported to the		

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			ED/Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Post Construction Repair Inspection" following any applicable stairwell construction, installation or stairwell repair project(s) weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.		

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K010025 SS=E	<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 openings through 1 of 10 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice had the potential to affect 12 residents on north hall, staff and</p>	K010025	<p>It is the policy of this facility that openings through barriers are protected to maintain the smoke resistance of each smoke barrier. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. Gaps around the cable, electrical, and telephone wires in the north hall smoke barrier wall adjacent to the nursing station have been properly sealed. 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: The alleged deficient practice had the potential to affect 12 residents on the first floor north hall. Gaps around the cable, electrical, and telephone wires in the north hall smoke barrier wall adjacent to the nursing station have been</p>	05/20/2013			

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	<p>visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., there were gaps around the cable, electrical, and telephone wires in the north hall smoke barrier wall adjacent to the nursing station. The gaps ranged in size from one fourth inch to three by three inches around the wires. Based on interview at the time of observation on 04/22/13 at 9:26 a.m., the Maintenance Director acknowledged the penetrations in the smoke barrier wall.</p> <p>3.1-19(b)</p>		<p>properly sealed. The Maintenance Director and/or designee inspected all cable, electrical, and telephone wires throughout the facility and verified that all cable, electrical, and telephone wires are protected so that the space between the penetrating item(s) and the smoke barrier(s) are filled with a material capable of maintaining smoke resistance of the smoke barrier or is protected by approved device(s) designed for the specific purpose. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states openings through barriers must be protected to maintain the smoke resistance of each smoke barrier. Immediately following any cable, electrical, and/or telephone wire repair work project which has the potential to cause structural penetrations or otherwise cause openings through barriers which were formerly protected to maintain the smoke resistance of each smoke barrier, the Director of Maintenance/designee shall physically inspect said cable, electrical, and/or telephone wire repair work site and ensure that</p>				

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			<p>openings through barriers are protected to maintain the smoke resistance of each smoke barrier. Results of the inspection will be reported to the ED. Any issues noted will be immediately reported to the Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Post Installation/Repair Inspection" following any applicable cable, electrical, and/or telephone wire repair work project(s) weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.</p>	

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect the 12 residents, staff and visitors in the north hall.</p> <p>Findings include:</p>	K010027	<p>It is the policy of this facility that doors in smoke barriers close the opening leaving only the minimum clearance necessary for proper operation (defined as 1/8 inch) to restrict the movement of smoke. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. The smoke barrier door in the north hall adjacent to the nursing station has been repaired and it now closes completely. 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: The alleged deficient practice had the potential to affect 12 residents, staff and visitors on the first floor north hall. The smoke barrier door in the north hall adjacent to the nursing station has been repaired and it now closes</p>	05/20/2013			

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	<p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the smoke barrier door in the north hall adjacent to the nursing station did not close completely, leaving a two and a half inch gap between the doors. Based on interview at the time of observation on 04/22/13 at 9:38 a.m., the Maintenance Director acknowledged the smoke barrier door did not completely close, leaving a two and a half inch gap between the doors.</p> <p>3.1-19(b)</p>		<p>completely. The Maintenance Director and/or designee inspected all smoke barrier doors throughout the facility and verified that all doors in smoke barriers close the opening proper leaving only the minimum clearance necessary for proper operation (defined as 1/8 inch) to restrict the movement of smoke. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include that all doors in smoke barriers close the opening leaving only the minimum clearance necessary for proper operation (defined as 1/8 inch) to restrict the movement of smoke. During regularly scheduled fire drills, the Director of Maintenance/designee shall physically inspect and ensure that doors in smoke barriers close the opening leaving only the minimum clearance necessary for proper operation (defined as 1/8 inch) to restrict the movement of smoke. Any issues noted during regularly scheduled fire drills will be immediately reported to the Maintenance Director/designee and corrected immediately. How the corrective action(s) will be monitored to ensure the</p>	

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			<p>deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Smoke Barrier Door Closure" following any regularly scheduled fire drills which occur weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.</p>		

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K010029 SS=D	<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 doors to 1 of 8 hazardous areas such as the basement room #b was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any staff located in the basement.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., basement room #b did not have a self closing device on</p>	K010029	<p>It is the policy of this facility that corridor doors to hazardous areas are provided with a self-closing device which will cause doors to automatically close and latch into their door frames. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. The corridor door for basement room #b been repaired. Such door now has a self-closing device and automatically closes and latches into its door frame. 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: The alleged deficient practice had the potential to affect any staff located in the basement. The</p>	05/20/2013			

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	<p>the door. Based on observation, basement room #b had had combustible boxes, paper, and wood chairs stored in the room. Based on interview at the time of observation on 04/22/13 at 12:15 p.m., the Maintenance Director acknowledged the door to basement room #b did not have a self closing device.</p> <p>3.1-19(b)</p>		<p>corridor door for basement room #b been repaired. Such door now has a self-closing device and automatically closes and latches into its door frame. The Maintenance Director and/or designee inspected all corridor doors to hazardous areas throughout the facility and verified that any such doors to hazardous areas have a self-closing device which will cause such doors to automatically close and latch into their respective door frames.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include that all corridor doors to hazardous areas must be provided with a self-closing device which will cause doors to automatically close and latch into their door frames. Not less than monthly, as part of the facility preventative maintenance program, the Director of Maintenance/designee shall physically inspect and ensure that that corridor doors to hazardous areas are provided with a self-closing device which will cause doors to automatically close and latch into their door</p>	
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			frames. Any issues noted during monthly checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Corridor Doors – Hazardous Areas" weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.		

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K010033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, it was not possible to determine if the facility maintained the vertical opening protection for 4 of 4 exit stairways. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect any resident or staff using the stairwells.</p>	K010033	<p>It is the policy of this facility that vertical opening protection for stairways have a visible fire resistance rating of at least one hour. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. 1. The paint was been removed which covered the fire resistance door label rating of at least one hour on the Alzheimer Unit stairwell door. Such door label rating is now visible. 2. The paint was been removed which covered the fire resistance door label rating of at least one hour on the basement stairwell door. Such door label rating is now visible. 3. The paint was been removed which covered the fire resistance door label rating of at least one hour on the laundry room stairwell door. Such door label rating is now visible. 4. The paint was been removed which covered the fire resistance door label rating of at least one hour on the north hall stairwell door. Such door label rating is now</p>	05/20/2013			

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	<p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the following was noted:</p> <ol style="list-style-type: none"> 1. The Alzheimer unit stairwell door label indicating the fire resistance rating on the door was painted. 2. The Basement stairwell door label indicating the fire resistance rating on the door was painted. 3. The Laundry room stairwell door label indicating a fire resistance rating was painted. 4. The label indicating a fire resistance rating was painted on the North hall stairwell door adjacent to resident room # 107. <p>Based on interview at the time of observation, the Maintenance Director acknowledged the fire resistance labels were painted and we were unable to determine the fire rating of the doors.</p>		<p>visible. 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: The alleged deficient practice had the potential to affect any resident, staff or visitor using the Alzheimer Unit, basement, laundry room or north hall stairwell doors. The Maintenance Director and/or designee inspected all stairwell doors throughout the facility and verified that all vertical opening protection for stairways have a visible fire resistance rating of at least one hour. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include that all that vertical opening protection for stairways must have a visible fire resistance rating of at least one hour. Immediately following any painting project which has the potential to cover the fire resistance door label rating of at least one hour on stairwell doors, the Director of Maintenance/designee shall physically inspect said stairwell doors, and ensure that vertical opening protection for stairways have a visible fire resistance</p>		

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	3.1-19(b)		rating of at least one hour. Any issues noted during such inspections will be immediately reported to the Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Visible Fire Resistant Rating on Doors" following any applicable painting project(s) weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 means of egress exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice has the potential to affect all residents without a diagnosis for specialized security measures, visitors, and staff.</p>	K010038	<p>It is the policy of this facility that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents found to have been affected by the alleged deficient practice. All residents had and continue to have an appropriate clinical diagnosis requiring specialized security measures. All residents had and have a physician's order to reside on the memory care unit. 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: All residents had and continue to have an appropriate clinical diagnosis requiring specialized security measures. The MD, Director of Nursing Services, Memory Care Facilitator and/or designee has reviewed medical documentation and verified that all residents, without exception had and continue to have an appropriate clinical diagnosis requiring specialized security measures. What measures will be put into place or what</p>	05/20/2013

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	<p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., all exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. Based on interview at the time of observation, on 04/22/13 at 1:37 p.m., not all residents have a clinical diagnosis to be in a secure building. The Maintenance Director stated residents without the clinical diagnosis requiring specialized security measures did not have access to the code.</p> <p>3.1-19(b)</p>		<p>systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance staff will be conducted on or before 05/20/13 by the ED/Director of Nursing/Memory Care Coordinator /designee. This in-service will include re-education that as a prerequisite to admission to the Alzheimer's Unit, all residents must have an appropriate clinical diagnosis requiring specialized security measures. All residents had and continue to have an appropriate clinical diagnosis requiring specialized security measures. All residents residing on the memory care unit had and will continue to have a physician's order to reside on the specialty unit. The IDT will review all residents on the unit upon admission and significant change to ensure all residents are appropriately placed and have a physician's order to reside on the unit. 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: The Memory Care Facilitator/designee will be responsible for completing the CQI Audit Tool titled, "Residents with Alzheimer's/Dementia Diagnosis on the Alzheimer's Unit" daily for 4 weeks and then weekly for six months. This audit</p>		

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			will be reviewed by the Director of Nursing Services. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.		

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K010047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 exit signs in the Alzheimer unit was continuously illuminated. This deficient practice had the potential to affect the residents, staff and visitors in the Alzheimer unit.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the Alzheimer stairwell exit sign above the stairway exit was not illuminated. Based on interview at the time of observation on 04/22/13 at 9:37 a.m., the Maintenance Director acknowledged the exit sign was not illuminated and that the exit sign light bulbs are burned out.</p> <p>3.1-19(b)</p>	K010047	<p>K047 It is the policy of this facility that exit and directional signs are displayed with continuous illumination. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to have been affected by this alleged deficient practice. The exit sign light bulb was immediately replaced and continues to be illuminated. 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: All residents, staff and visitors on the Alzheimer's Unit had the potential to have been affected. The exit sign light bulb was immediately replaced and continues to be illuminated. The Maintenance Director and/or designee inspected all facility exit and directional signs throughout the facility. All exit and directional signs were and are fully illuminated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping</p>	05/20/2013			

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			<p>employees will be conducted on or before 05/20/13 by the ED/Maintenance Director/designee. This in-service will include that all facility exit and directional signs must be displayed with continuous illumination. Maintenance and or housekeeping personnel/designee will check not less than daily that all facility exit and directional signs are displayed with continuous illumination throughout the facility.</p> <p>Any issues noted during daily checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Exit and Directional Sign Continuous Illumination" daily for 4 weeks and then weekly for 6 months. This audit will be reviewed by the ED. If a threshold of 98% each is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.</p>	

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K010062 SS=F	<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 provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper</p>	K010062	<p>It is the policy of this facility to provide a complete supply of spare sprinklers for the automatic sprinkler system.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>No residents were found to have been affected by this alleged deficient practice.</p> <p>The one missing spare sprinkler for the automatic sprinkler system was ordered and has been received by the facility. The spare sprinkler set is fully complete.</p> <p>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>All residents, staff and visitors had the potential to have been affected.</p> <p>The one missing spare sprinkler for the automatic sprinkler system was ordered and has been received by the facility. The spare sprinkler set is fully complete.</p> <p>The Maintenance Director and/or designee inspected all facility spare sprinklers by size and type and verified that the set is fully complete.</p>	05/20/2013			

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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	
	<p>sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., there were no upright, pendant, or sidewall sprinkler heads in the spare sprinkler cabinet. There were upright, pendant, and sidewall sprinkler heads observed during the tour throughout the facility. Based on interview at the time of observation on 04/22/13 at 2:11 p.m., the Maintenance Director acknowledged the lack of spare upright, pendant, and sidewall sprinkler heads.</p> <p>3.1-19(b)</p>		<p>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>A mandatory in-service for all maintenance employees will be conducted on or before 05/20/13 by the ED/designee. This in-service will include that the facility must provide a complete supply of spare sprinklers for the automatic sprinkler system.</p> <p>Maintenance personnel/designee will check not less than weekly that the facility provides a complete supply of spare sprinklers for the automatic sprinkler system. Any issues noted during weekly checks will be immediately reported to the Maintenance Director/designee and corrected swiftly.</p> <p>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>The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Spare Sprinklers for Automatic Sprinkler System" weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>By what date the systemic changes will be completed:</p>		

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			Compliance Date: 05/20/2013.	

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K010066 SS=D	<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 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 observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice had the potential to affect staff utilizing the designated employee smoking area exit during a fire emergency.</p>	K010066	<p>K066 It is the policy of this facility that cigarette butts are to be properly discarded in the designated smoking area. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to have been affected by this alleged deficient incident. Discarded cigarette butts were immediately disposed of properly. How other residents having the potential to be affected by the same deficient practice will be identified and</p>	05/20/2013			

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	<p>Findings include:</p> <p>Based on observations and interview on 04/22/13 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., there were discarded cigarette butts on the ground in the designated smoking area. Based on interview at the time of observation on 04/22/13 at 2:57 p.m., the Maintenance Director acknowledged the facility's employees discard cigarette butts on the ground.</p> <p>3.1-19(b)</p>		<p>what corrective action(s) will be taken: Staff utilizing the designated smoking area had a potential to be affected during a potential fire emergency. Discarded cigarette butts were immediately disposed of properly. All smoking areas were checked to ensure discarded cigarette butts were properly disposed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all employees will be conducted on or before 05/20/13 by the ED/designee. This in-service will include that cigarette butts are to be properly discarded in the designated smoking area, without exception. Housekeeping personnel/designee will check not less than four times daily that that cigarette butts are properly discarded in the designated smoking area. Any issues noted during housekeeping/designee checks will be immediately reported to the Executive Director/designee and corrected immediately. 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: The Housekeeping Director/designee will be responsible for completing the CQI Audit Tool titled, "Discarded Cigarettes" 4 times daily for 4</p>				

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			weeks and then daily for 6 months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 05/20/2013.	