

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 01/28/2015
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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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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: 01/28/15</p> <p>Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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</p>	K010000	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 the deficiency exists or that the deficiency was cited correctly. This 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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K010038 SS=F	<p>census of 55 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/05/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 4 of 8 exit doors with electromagnetic locks remained unlocked until the fire alarm system was reset. LSC 7.2.1.6.2 (d) requires doors shall automatically unlock and remain unlocked until the fire protective signaling system has been manually reset. This applies to electromagnetic locks on all doors to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National</p>	K010038	<p>A Proposal and Contract with Simplex/Grinnell was signed on February 11, 2015 to correct the magnetic locks of the four doors that were cited. New locks and relays have been ordered. Installation has begun. No other doors containing magnetic locks, in the skilled nursing unit, failed to remain disengaged while the alarm was activated and the door was approached with a "wander guard" device. Systemically, to prevent reoccurrence, all doors will be tested monthly during each fire drill, utilizing a "wander guard" device. This is a new practice. The documented results of all fire drills, including the doors</p>	02/27/2015

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K010051 SS=F	<p>Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 01/28/15 at 3:10 p.m. during a fire alarm test with the Maintenance Supervisor the electromagnetic locks on 200 hall, 300 hall and two exits out of the Dining room on 100 hall did released upon activation of the fire alarm system, but when approached with a wander guard device the electromagnetic locks engaged. Based on interview concurrent with the observations with the Maintenance Supervisor it was acknowledged the aforementioned exit doors equipped with electromagnetic locks would relock when approached with a wander guard device.</p> <p>3.1-19(b)</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</p>		disengaging, will be reviewed by the Environmental Enrichment Committee, a subcommittee of the quality assurance program. This practice will be on going each month.				

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	<p>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 install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/28/15 at 2:10 p.m., with the Maintenance Supervisor the fire alarm system circuit breaker could not be located. Based on interview on 01/28/15 at 2:15 p.m. with the</p>	K010051	<p>The fire alarm panel circuit disconnect has been identified, labeled as the Fire Alarm Circuit Control, marked in red and is only accessible to authorized personnel. The electrical panel where this circuit disconnect is located is powered by the emergency generator. This is an isolated deficiency that has existed since the original construction and will not reoccur.</p> <p>If the disconnect circuit ever has to be moved in the future, a member of the Environment Enrichment Committee, a subcommittee of the quality assurance program, will supervise the process to assure all of the elements above are in place.</p>	02/27/2015

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K010052 SS=E	<p>Maintenance Supervisor it was acknowledged the location of the breaker for the fire alarm panel was unknown..</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 1 of 10 manual fire alarm boxes were unobstructed and readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice could affect any resident as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 01/28/15 at 1:00 p.m. with the Maintenance Supervisor the manual fire alarm box at</p>	K010052	A second, manual fire alarm box will be installed inside of the exit door where the magnetic lock is located. An audit has revealed no other manual pull stations are located in an area secured by a magnetic lock or unobstructed in any way. The manual pull stations will be inspected and documented monthly during each fire drill. These results will be reported to the Environmental Enrichment Committee, a subcommittee of the quality assurance program. This practice will be on going each month.	02/27/2015	

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K010066 SS=E	<p>the front entrance was on the other side of exit doors with magnetic locks which were only accessible by the use of a keypad override code which would disengage the magnetically locked doors thus delaying alarm notification to facility occupants.</p> <p>Based on interview on 01/28/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the manual fire alarm box was not accessible once inside the facility unless the keypad override code was used to first disengage the magnetically locked doors.</p> <p>3.1-19(b)</p> <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</p>						

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	<p>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 Based on observation, record review and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect 17 residents on 200 hall adjacent to the dock where smoking is permitted as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/28/15 at 2:25 p.m. with the Maintenance Supervisor, sixty one cigarette butts were observed deposited on the ground outside the dock area adjacent to the generator where smoking is allowed. Based on review of the smoking policy on 01/28/15 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts into a metal container. Based on interview on 01/28/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the facility's employees were throwing their cigarette butts on the ground instead of</p>	K010066	<p>All of the cigarette butts have been removed from the area. An ashtray of a noncombustible material and of a safe design is available for use. To prevent reoccurrence, all staff have been in-services on the need to dispose of smoking materials in the appropriate container. Failure to comply will result in disciplinary action, up to and including termination. The designated smoking area will be monitored weekly for the proper disposal of smoking materials by the Environmental Services Director or his designee. The results of his audit will be reported to the Environmental Enrichment Committee, a subcommittee of the quality assurance program. Weekly inspections will continue until 100% compliance is achieved for two consecutive inspections. If compliance cannot be achieved, consideration will be made to ban smoking from the entire campus.</p>	02/27/2015

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K010070 SS=E	<p>into a noncombustible metal container.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in non resident rooms. This deficient practice could affect 17 residents on 200 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/28/15 at 2:45 p.m. with the Maintenance Supervisor, one portable space heater was not plugged in but, available for use and located in the MDS office adjacent to 200 hall. Based on interview on 01/28/15 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the space heater was being used, even though the portable space heater policy indicated they could not be used in non resident rooms unless the</p>	K010070	The portable space heater has been removed. An environmental audit has been conducted and no other space heaters were found that did not comply with the facility's policy. To prevent reoccurrence, all staff have been in-serviced on the facility's policy regarding the use of portable space heaters. All areas of the building will be monitored weekly for the presences of portable space heaters that do not comply with the facility's policy by the Environmental Service Director or his designee. The results of his audit will be reported to the Environmental Enrichment Committee. Weekly inspections will continue until 100% compliance is achieved for two consecutive inspections.	02/27/2015

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K010147 SS=B	<p>heating elements of the portable heater did not exceed 212 degree F. No documentation pertaining to the portable space heaters was available for review.</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 1 of 1 multiplug adapters was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires unless specifically permitted, multiplug adapters, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 17 residents on 200 hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 01/28/15 at 1:33 p.m. with the Maintenance Supervisor, there was one, six prong multiplug adapter connected to a wall outlet which was used to power a office equipment at the Unit manager's office adjacent to 200 hall. Based on interview concurrent with the observation with the Maintenance</p>	K010147	The multi-plug adaptor located in the Unit Manager's Office has been removed. An environmental audit has been conducted and no other multi—plug adaptors have been found. To prevent reoccurrence, all staff have been in-serviced on the need not to use multi-plug devices. All areas of the building will be monitored weekly for the presence of multi-plug adaptors by the Environmental Service Director or his designee. The results of the audit will be reported to the Environmental Enrichment Committee, a subcommittee of the quality assurance program. Weekly inspections will continue until 100% compliance is achieved for two consecutive inspections.	02/27/2015

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	Supervisor it was acknowledged it is the policy of the facility not to use multiplug adapters and to plug all office equipment into the wall outlet, however, the aforementioned six prong multiplug was used as a substitute for fixed wiring. 3.1-19(b)				