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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155804 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/06/2015 |
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| NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA | STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544 |
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| K 000 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: 05/06/15</p> <p>Facility Number: 013017 Provider Number: 155804 AIM Number: 201237680</p> <p>At this Life Safety Code survey, Sprenger Health Care of Mishawaka was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC16.2. The entire facility was surveyed with Chapter 18 New Health Care Occupancies due to the lack of a two hour fire barrier separation wall between Health Care and Assisted Living Wing.</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, in spaces open to the corridors with hard wired smoke detectors in the</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 018 SS=D Bldg. 01 | <p>resident sleeping rooms. The facility has a capacity of 70 and had a census of 60 at the time of this survey.</p> <p>All areas accessible to residents were sprinklered. Areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation, the facility failed to ensure doors protecting corridor openings did not have an impediment to the closing of 3 of 30 doors in the Assisted Living Wing. This deficient practice could affect approximately 2 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 05/06/15 between 12:33 p.m. and 12:41 p.m. the following was noted: a) A rubber door stop was found propping the assisted living personal laundry door open.</p> | K 018 | <p>1.The rubber door stops in the assisted livinglaundry room was immediately removed at the time of the observation, the rubberdoor stops in room 319 & 317 were immediately removed at the time of theobservation. . There were no residents affected by the alleged deficientpractice.</p> <p>2.Residents residing at the facility have thepotential to be affected by the alleged deficient practice.</p> <p>3.The maintenance department has been educated onthe life safety code as it relates to the utilization of door props by 6-5-15</p> <p>4.The maintenance supervisor will perform weeklyrounds to ensure no door props are utilized throughout the facility. .</p> | 06/05/2015 |

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| K 029 SS=E Bldg. 01 | <p>b) A rubber door stop was found propping resident room 319 open. c) A rubber door stop was found propping resident room 317 open. Based on interview at the time of observations, the Maintenance Director and Administrator acknowledged and removed each rubber door stop.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to 1 of 1 hazardous areas such as an area where hot oils are used for cooking was protected by self-closing doors that latch into the frame. This deficient practice could affect any resident, as well as staff and visitors near the Living Room near the Main Entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 05/06/15 at 2:30 p.m., a popcorn machine containing popcorn and storing cooking oil was observed in the Living</p> | K 029 | <p>Monthly audits will be forwarded to the QA&A committee for review, These audits will be reported monthly for a period of 6-months until compliance is achieved. 5. Date of compliance 6/5/15</p> <p>1. The Popcorn machine was relocated behind a fire-rated door that meets the life safety requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The maintenance department and the front office staff has been educated on the life safety requirement as it relates to hazardous areas by 6/5/15 4. The Maintenance Director will perform visual observations in relation to the location of the popcorn machine weekly. Results of those audits will be forwarded</p> | 06/05/2015 | |

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| K 038 SS=E Bldg. 01 | Room which was open to the corridor and lacked self-closing doors that separated the room from the corridor. Based on interview during the time of observation, the Maintenance Director and Administrator stated when used, the popcorn machine was used in the Living Room. 3.1-19(b) 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. 18.2.1 Based on observation and interview, the facility failed to ensure 6 of 17 external exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device | K 038 | to QA&A monthly for 6-months and quarterly thereafter until compliance is achieved K-38 1.The 3 doors on the Assisted living, Rehab room, Assisted Living diningroom & the main dining room have had a sign placed on the door with the verbiage of "Push until alarm sound, door can be opened after 15 seconds to ensure proper | 06/05/2015 |

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| | <p>there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " This deficient practice could affect 30 residents in Assisted Living, 4-6 residents in Rehabilitation, all residents within the Dining area, also staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 05/06/15 between 12:01 p.m. and 1:15 p.m., the following was discovered:</p> <p>a) All three external exit doors in the Assisted Living wing were provided with delayed egress but lacked delayed egress signage.</p> <p>b) The only exterior exit door in Rehabilitation had a plastic sign indicating it was an exit door and was provided with delayed egress but lacked delayed egress signage. Based on interview at the time of observation, the Maintenance Director stated that this door was not an exit.</p> <p>c) The only exterior exit door in the Assisted Living Dining room was provided with delayed egress but lacked delayed egress signage</p> | | <p>means of exit. There were no residents directly affected by the alleged deficient practice.</p> <p>2. Residents and/or visitors have the potential to be affected by the alleged deficient practice.</p> <p>3. The Maintenance Director has been educated on the life safety requirement as it relates to exit areas by 6/5/15</p> <p>4. The Maintenance Director will perform monthly audits of exit doors to ensure signage remains in place. Results of those audits will be forwarded to the QA&A monthly for a period of 6-months until compliance is achieved.</p> <p>5. Date of compliance 6/5/15</p> | |

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| K 040 SS=E Bldg. 01 | <p>d) The only exterior exit door in the Main Dining Room was provided with delayed egress but lacked delayed egress signage.</p> <p>Based on observation, the Maintenance Director and Administrator demonstrated each door was equipped with electromagnetic locks that released after 15 seconds. Based on interview at the times of observation, the Maintenance Director and Administrator acknowledged the lack of signage and the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 17 exit doors had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors in the means of egress from nursing homes shall be no less than</p> | K 040 | <p>K-40</p> <p>1.The Exit sign was removed by the private diningroom and the Rehabilitation room orderto meet this requirement. There were no residents directly affected by thealleged deficient practice. 2.Residents residing at the</p> | 06/05/2015 |

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| K 070 SS=D Bldg. 01 | <p>41.5 inches. These deficient practices affect residents evacuating near the Private Dining exit and 4-6 residents in the Rehabilitation Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 05/06/15 at 12:22 p.m. then again at 1:14 p.m., the exterior exit doors near the Private Dining room and the exterior exit door in the Rehabilitation room were each thirty six inches wide. Based on interview, these measurements were provided and confirmed by the Maintenance Director at the time of observation.</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) 18.7.8</p> <p>Based on observation, interview, and record review, the facility failed to enforce its portable space heater policy</p> | K 070 | <p>facility have the potential to be affected by the alleged deficient practice.</p> <p>3. The Maintenance Department has been in-serviced by 6/5/15 on Exit doors as it relates to the life safety requirement.</p> <p>4. The Director will perform monthly rounds to ensure no further use of these exits. Results of those rounds will be forwarded to the QA&A committee on a monthly basis for 6 months and the quarterly thereafter until compliance is achieved</p> <p>5. Date of Compliance 6/5/15</p> <p>K-70 1. The portable Space Heater was immediately removed at the time of the discovery of its use.</p> | 06/05/2015 | | | |

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| | <p>for the use of 1 of 1 portable space heater in the Director of Rehabilitation office in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Administrator on 05/06/15 between 10:45 a.m. to 12:13 p.m., the space heater policy states the facility does not allow space heaters. Based on observation with the Maintenance Director and Administrator at 1:11 p.m. a space heater was found in the Director of Rehabilitation office. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the space heater was a violation of the facility's policy.</p> <p>3.1-19(b)</p> | | <p>There were no residents directly affected by the alleged deficientpractice.</p> <p>2. Residents residing at the facility have thepotential to be affected by the alleged deficient practice.</p> <p>3. TheMaintenance Department as well as the therapy staff have been educated on theuse of portable space heaters and the life safety requirement by 6/5/15.</p> <p>4. TheMaintenance Supervisor will perform monthly rounds to ensure portable space arenot being utilized. Results of those audits will be forwarded to the QA&Amonthly for a period of 6 months until compliance is achieved.</p> <p>5. Dateof Compliance 6/5/15</p> | | |