

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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
--------------------	--	---------------	---	----------------------

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: 09/09/13</p> <p>Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Riverbend Health Care 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, 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, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000		
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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>capacity of 66 and had a census of 41 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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			
K010029 SS=E	<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 door to 1 of 1 laundry rooms, a hazardous area, would self close and latch into the door frame. This deficient practice could affect 15 residents in the east hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 09/09/13 at 12:18 p.m., the door latch on the east hall corridor door entering the laundry room was locked in the open position and the door did not latch into the door frame.</p> <p>Based on an interview with the Maintenance Director at the time of observation, the laundry staff does this to move carts in and out of the laundry room without entering the code required to unlatch the door.</p>	K010029	<p>Riverbend Health CareLife Safety POCK 0029 NFPA 101 LIFE SAFETY CODESS=E STANDARD Corrective actionEnvironmental/Laundry/Maintenance staff were educated on the importance of maintaining smoke barriers. Other residents identifiedAll residents on the East hall will be provided smoke barrier protection. Measures put in placeThe Maintenance Director/designee will inspect daily X 5 days per week for one week, then 2 X week for three weeks, then monthly thereafter to ensure deficient practices are corrected. MonitoringMaintenance Director/designee will report to the Executive Director any noncompliance. Further a report will be made to QAPI monthly of any irregularities in compliance with smoke barrier. Date: 09/25/2013</p>	09/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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	
	3.1-19(b)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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			
K010052 SS=E	<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</p> <p>Based on record review and interview, the facility failed to ensure 15 of 33 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method</p>	K010052	<p>K 052 NFPA 101 LIFE SAFETY CODESS=E STANDARD Corrective Action)All smoke detectors identified (15) have been replaced.)Maintenance Director/designee will follow up on items identified as needing action following inspection/sensitivity testing, by submitting quotes and scheduling the necessary work. Other Residents IdentifiedAll residents will be protected through properly functioning smoke alarms. Measures put into placeThe Executive Director will be provided a copy of the report on smoke alarm sensitivity testing for follow up, or submission of requests for replacement of poorly working equipment. MonitoringMaintenance Director/designee will notify the Executive Director of any problem with correcting poor working equipment and will report to QAPI committee corrective action needed or taken. Date: 09/25/2013</p>	09/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013	
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number of residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 09/09/13 at 2:12 p.m., the SafeCare smoke detector record titled "Inspection and Testing Form" listed fifteen smoke detectors that failed the sensitivity test. Based on an interview with Maintenance Director at the time of record review, he stated the smoke detectors had not been repaired or replaced.</p> <p>3.1-19(b)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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	
K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen K-Class portable fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/13 at 1:27 p.m., the K-Class fire extinguisher mounted on the wall in the kitchen measured five foot eight inches from the floor to the top of the fire extinguisher. Measurements were provided by the Maintenance Director.</p> <p>3.1-19(b)</p>	K010064	<p>K 064 NFPA 101 LIFE SAFETY CODESS=D STANDARDCorrective ActionThe K class fire extinguisher has been mounted no less than five feet off of the floor in the kitchen. Other Residents IdentifiedThe fire extinguisher not properly mounted was not in a resident area. Measures put in placeMaintenance Director and Dietary Manager were educated on proper placement for a fire extinguisher. Monitoring)During weekly kitchen inspections the fire extinguisher will be observed by the Dietary Manager to ensure it meets height from the floor NFPA rules.)The DM will report to the Maintenance Director any corrective action needed.)Maintenance will report to the QAPI committee any issues in maintaining proper placement of the fire extinguisher. Date: 09/25/2013</p>	09/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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	
K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure 2 of 5 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect 15 residents in the east hall and laundry staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 09/09/13 at 12:10 p.m., the Certificate of Inspection for the laundry room water heater registration number 315332 expired on 07/19/13. Based on record review with the Maintenance Director at 12:25 p.m., the east hall water heater registration number 244535 lacked a Certificate of Inspection. Based on interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K010130	<p>K 130 NFPA 101 LIFE SAFETY CODESS=D STANDARD Miscellaneous Corrective ActionWater Heaters were provided maintenance service by our contract HVAC vendor 09/25/2013, CNA Insurance and Homeland Security Vessels Division were notified of the need for an update inspection on two water heaters 9/21/2013 and will update the Certificates.MeasuresA maintenace system is in place to ensure compliance on dates of service and Inspection. Maintenance will check for compliance during monthly facility reporting. A list will be kept by Maintenance, and untis will be inspected as is required by expiration dates.MonitoringMaintenance will report to the Executive Director any difficulty completing required maintenance or obtaining inspections timely. QAPI will be informed of requested interventions.Date 09/26/2013 Corrective ActionWall penetrations – wall areas identified as not meeting the barrier requirements have been repaired to meet the standard. Others Residents identifiedNo other resident areas were identified as having deficiencies in smoke/fire penetration. Measures)The</p>	09/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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>the facility failed to ensure the penetrations in 3 of 4 fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</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</p>		<p>Maintenance Director conducted a check of other areas of the center to ensure no other penetrations existed in the walls or ceiling of the center.)The Maintenance Director/Designee will include inspection of walls and ceilings for potential smoke/fire penetration problems, and repair or cause to be repaired any identified areas with imperfections. Monitoring Any difficulty correcting imperfections in smoke/fire barriers will be reported to the Executive Direction, and reported to the QAPI committee. Date: 09/25/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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>device that is designed for the specific purpose. This deficient practice could affect the residents in 4 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/09/13 from 1:40 p.m. to 1:55 p.m., there was an unsealed penetration measuring one inch around an electrical conduit to the new exit sign on each hall above the drop down ceiling at the fire doors in the east hall, west hall and north hall . Additionally, there was an unsealed penetration measuring one half inch around TV cable at the north hall above the drop down ceiling. Based on an interview with the Maintenance Director at the time of observations, he acknowledged the aforementioned penetrations were not sealed.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/09/2013
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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	
K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 09/09/13 at 1:00 p.m., the oxygen room lacked a working light needed in order to transfill the portable oxygen cylinders with the oxygen room door closed. Based on an interview with the Maintenance Director</p>	K010143	<p>K 143 NFPA 101 LIFE SAFETY CODESS=E STANDARD Corrective Action)Lighting in the oxygen storage room has been replaced.)The Maintenance Director/Designee will inspect the room during routine rounds to ensure proper lighting is in place.)The nursing staff were instructed on the need to report lack of lighting in the oxygen storage room. Other Residents Identified This is a non patient area, however the center understands the need for proper lighting in the oxygen storage area.Measures put in placeThe Maintenance Director will inspect the room during monthly rounds to ensure adequate lighting is in place. The staff were provided work orders to use for notifying</p>	09/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>at the time of observation, he did not receive a work request for the oxygen room light nor was he aware the light was not working and was unable to confirm how long the oxygen transfilling room was without a light.</p> <p>3.1-19(b)</p>		<p>the Maintenance Director of any needed repairs. Monitoring A report will be made to the the Executive Director and the QAPI committee of any difficulty maintaining adequate lighting in the oxygen storage room. Date 09/25/2013</p>	