STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted 05/21/12 and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a) and 410 IAC 16.2. Survey Date: 07/12/12 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 Surveyor: Bridget Brown, Life Safety Code Specialist At this PSR survey, South Shore Terrace Health and Rehabilitation 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.	K0000	K0000 Please accept this plan of correction as the facility's credible allegation.This plan of correction does not constitute an admission on the part of South Shore Health & Rehabilitation to the accuracy of the surveyor's findings, nor the conclusions there from. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or any of the deficiencies cited are correctly applied.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This one story facility was determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 98 and had a census of 89 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage, however, it was in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered with the exceptions noted in K-62, and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/20/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the			

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K0027 SS=E	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 Based on observation and interview, the facility failed to ensure 4 of 4 smoke barrier door sets were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors always close completely. CMS requires smoke barrier doors equipped with an astragal have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the maintenance director on 07/12/12 between 12:15 p.m. and 3:25 p.m., the smoke barrier doors in the exit corridors serving	K0027	K027 1.The coordinators have been ordered for four (4) smoke barrier door sets and will be installed immediately upon arrival. 2.Residents will not be affected upon implementation of above correction. 3.The following measure has been implemented to ensure the alleged deficient practice does not recur. Maintenance staff will review smoke barrier doors to ensure they are functioning properly. 4.The following QA programs have been implemented to ensure the alleged deficient practice will not recur. A. Administrator will continue to monitor on QA rounds to ensure compliance. B. Facility maintenance staff will monitor doors on his QA rounds to ensure compliance. Completion Date: 8/10/12	08/10/2012

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	Units 2, 3, 4, and 5 which swung in the same direction each lacked a door coordinator to allow the door which must close first to always close first. The maintenance director said at the time of observation, coordinators had not been added because they could not find a type which did not prevent the doors from closing when one door would hit the coordinator, holding it open. This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 89 of 89 residents. This deficient practice could affect occupants in all areas. Findings include: Based on observation with the maintenance director on 07/12/12 between 12:15 p.m. and 3:15 p.m., battery powered smoke detectors were located in the common restroom on Unit 2 near the nurses' station and in all resident rooms. Based on review of the facility's fire procedures with the maintenance director on 07/12/12 at 1:30 p.m., there was no procedure specific to the response to a battery powered smoke detector alarm. The maintenance director said at the time of record review, he knew of no procedure for responding to	K0048	K048 1) Corrective action taken and or how the deficiency will be corrected A) No residents were affected by the alleged deficient practice. B) Facility reviewed and revised the Fire Evacuation Plan on 6/1/12 to address areas of concern. C) Maintenance conducted fire drills monthly on different shifts and has reviewed the fire drill schedule to ensure all shifts are participating in the drills. D) The fire drill sign-in sheet has been revised to help identify if the drill is related to a battery smoke detector alarm on 7/27/12.. 2) Actions the facility will take to assure that no other examples of the deficiency exist in other parts of the building. However, due to the implantation of 1 B-D, the alleged deficient practice will not recur. 3) The following measures will be put into place or systematic changes made to ensure the deficient Practice would not recur.	08/10/2012

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	battery powered smoke detector alarms and no fire drill had been conducted by activating a battery powered smoke detector. This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		A) Inservice on new Fire Evacuation Plan for all staff . B) Maintenance Supervisor will continue to in service and educate staff on Fire Evacuation Plan during new hire orientation and quarterly in services. 4) Quality Assurance plans to monitor facility performance ensuring corrections maintained: A) Maintenance Supervisor will continue to educate and in service staff. B) Administrator will monitor in service training. C) Administrator will review completion of the fire drill schedule. Completion DAte 8/10/12	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5			
	Based on observation and record review, the facility failed to provide complete sprinkler coverage for 1 of 7 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 30 or more residents in the central smoke compartment which includes the main dining room. Findings include: Based on observations of the automatic sprinkler system and	K0056	K0056 1. For those residents found to have been affected by the alleged deficient practice, the following corrective action was implemented. Sprinklers were installed over the ice machine and in the 200 hall entry vestibule to provide complete sprinkler coverage. 2. All residents in the facility have the potential to be affected but due to the implementation of number 1, no resident has been affected. 3. The following systemic change has been implemented: Monitoring of all sprinkler by maintenance monthly. 4. The Administrator will monitor to ensure all installation is completed. 5. Any abnormalities will be reported immediately and discussed at monthly QA	08/10/2012

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	review of Sprinkler System Inspection, testing and maintenance reports with the maintenance director on 07/12/12 at 1:55 p.m., a 10/24/11 Sprinkler System Inspection report noted "other problems": 04/16/12: "... new head should be added over ice machine." The report noted "no changes from previous inspection report." During observation of the facility on 07/12/12 between 12:15 p.m. and 3:15 p.m. with the maintenance director, sprinklers were not provided over the ice machine and in the 200 hall entry vestibule. 3.1-19(b)		meetings. Completion Date: 8/10/12	

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K0062 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all occupants. Findings include: Based on observations of the automatic sprinkler system and review of Sprinkler System Inspection, testing and maintenance reports with the maintenance director on	K0062	K0062 1. For those residents found to have been affected by the alleged deficient practice, the following corrective action was implemented. Sprinklers were installed over the ice machine and in the 200 hall entry vestibule to provide complete sprinkler coverage. 2. All residents in the facility have the potential to be affected but due to the implementation of number 1, no resident has been affected. 3. The following systemic change has been implemented: Monitoring of all sprinkler by maintenance monthly. 4. The Administrator will monitor to ensure all installation is completed. 5. Any abnormalities will be reported immediately and discussed at monthly QA meetings. Completion Date: 8/10/12	08/10/2012

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	07/12/12 at 1:55 p.m., a 10/24/11 Sprinkler System Inspection report noted "other problems:" 10/24/11: "... Air gauge on system Needs water gauge;" 04/16/12: "... new head should be added over ice machine." The report noted "no changes from previous inspection report. During observation of the facility on 07/12/12 between 12:15 p.m. and 3:15 p.m. with the maintenance director, sprinklers were not provided over the ice machine or in the 200 hall entry vestibule. The maintenance director said he did not know if the air gauge had been replaced on the system at the time of observations. No record of the work was found in documents provided by the maintenance director on 07/12/12 at 1:55 p.m. The administrator said at the time of record review , she thought all the work had been completed. The maintenance director called the contractor at 2:30 p.m. on 07/12/12 and confirmed the gauge had not been changed, they would "send a tech out Monday or Friday"; no date was set for adding			

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	the missing sprinkler heads. This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			

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K0066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 record review, observation and interview; the facility failed to provide complete written smoking regulations to protect 89 of 89 residents. This deficient practice could affect visitors, staff and four or more residents observed in the designated smoking areas. Findings include: Based on review of facility	K0066	K0066 1. For those Residents found to have been potentially affected by the alleged deficient practice, the following corrective action was implemented: A. No residents were affected by the alleged deficient practice. B. Employees were reeducated Re: cigarettes only in ashrays – no Trash – and trash in appropriate recepticles –	08/10/2012

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	smoking policies with the maintenance director and administrator on 07/12/12 at 3:10 p.m., the facility's policy on smoking designated a resident smoking area located on the patio in front of the dining room; employees smoked on the patio in an area at one side of the dining room with butt disposal to be made in smoke towers designed for that, however, upon observation of the smoking sites on 07/12/12 at 1:15 p.m. with the maintenance director, cigarette butts were commingled with plastic wrappers and paper in open waste containers in both smoking areas. The maintenance director said at the time of observation, the staff and residents had been directed not to dispose of their smoking materials in this manner. This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		no cigarettes. C. As of 8/1/12, no staff smoking is allowed on the premises. D. All designated smoking areas have been reviewed to ensure that approved receptacles are being used. 2. All Residents in the facility have the potential to be affected by the alleged practice. However, due to the implementation of 1B-D the alleged deficient practice will not recur. 3. The following measure has been implemented to ensure the alleged deficient practice does not recur: Facility Maintenance Director will monitor compliance to ensure that approved receptacles are being used in designated smoking areas only. 4. The following Quality Assurance Programs have been implemented to ensure the alleged deficient practice will not recur: A. Maintenance Director will continue to monitor on QA rounds. B. Any issue of employee identified non-compliance will be reported to the Administrator For appropriate disciplinary action. **Completion Date: 8/10/12**	

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K0069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, record review and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned by properly trained and qualified people. NFPA 96 section 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s). This deficient practice could affect 3 kitchen staff. Findings include: Based on record review with the maintenance director on 07/12/12 at 2:30 p.m., a record of a kitchen exhaust hood and duct cleaning was not found in the records provided. The hood was	K0069	K069 1. For those Residents found to have been potentially affected by the alleged deficient practice, the following corrective action was implemented: A. No residents were affected by the alleged deficient practice. B. The semi-annual inspection and cleaning of the kitchen hood system was completed on 7/22/2012. C. The semi-annual inspections (and as necessary cleanings) of the range hood, duct and filters have been scheduled with an outside vendor has been contracted to occur every 6 months. 2. All residents in the facility have the potential to be affected by the alleged practice. However, due to the implementation of 1B – C the alleged deficient practice will not recur. 3. The following systematic changes have been implemented to ensure the alleged deficient practice does not recur: A. Facility Maintenance Director will monitor compliance to ensure the semi-annual	07/22/2012

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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402	

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	checked with the maintenance director at 2:35 p.m. on 07/12/12 for evidence of a professional hood exhaust cleaning. A sticker noted a hood cleaning in 2007. The maintenance director said at the time of record review, he thought the hood had been cleaned, but he wasn't sure. The inspection record did not reflect a cleaning was done and an immediate call to the contractor by the administrator required she leave a message. The dietary manager was called in at the time and reported no knowledge of the hood being cleaned. No record was produced by 07/12/12 at 3:15 p.m. This deficiency was cited on 05/21/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		inspections (and as necessary cleanings) are completed. B.Completed inspection documentation will be reviewed by the administrator. 4. The following Quality Assurance Programs have been implemented to monitor and ensure the alleged deficient practice will not recur: A. Quality Assurance Committee will assure compliance through the internal Quality Assurance Process. B. Maintenance Supervisor will continue to monitor on his QA rounds 5. Completion Date:7/22/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/12/2012

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