

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2012
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NAME OF PROVIDER OR SUPPLIER  IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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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
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K0000	<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: 12/17/12</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Ironwood Health 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, 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 on all levels including the corridors, areas open</p>	K0000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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>to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 198 with a census of 134 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 12/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0018 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. Based on observation and interview, the facility failed to ensure 2 of 14 doors to resident rooms in the 200 and 300 hall closed and latched into the door frame. This deficient practice had the potential to affect residents in the 200 and 300 halls.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the doors to resident rooms 205 and 309 did not latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the doors to resident rooms 205 and 309 did not latch into their door frames.</p>	K0018	<p>K0181. Rooms 205 and 309 had hinges adjusted and latch plates replaced on 12/17/12 to ensure these doors closed appropriately.2. Rounds were made on 1/4/13 to identify other resident room doors that potentially were affected and corrected as needed.3. Rounds will be conducted by maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4. The results of the rounds will be brought to QA to ensure compliance monthly x3 then quarterly thereafter5. 1/15/13</p>	01/15/2013

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	3.1-19(b)			

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K0027 SS=F	<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 Based on observation and interview, the facility failed to ensure 6 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires 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 all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the smoke barrier doors throughout the facility did not close completely, leaving a two inch gap between the doors. Based on</p>	K0027	K0271. Hinges on smoke barrier door leading from main hallway into resident living room were adjusted to close properly leaving a 1/8 inch gap or less on 12/17/12.2. Rounds were made on 01/04/13 to identify other smoke barrier doors that potentially were affected and corrected as needed.3. Rounds will be conducted by maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4. The results of the rounds will be brought to QA to ensure compliance monthly x 3 then quarterly thereafter.5. 01/04/13	01/04/2013			

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	interview at the time of observation, the Maintenance Director acknowledged the smoke barrier doors did not completely close, leaving a two inch gap between the doors.  3.1-19(b)			

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K0029 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 doors to 1 of 2 hazardous areas, such as a medical records room, 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 resident, visitors, and staff located in the 500 hall.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the medical records room did not have a self closing device on the door. The medical records room stored combustible paper on top of the metal storage cabinets and on the floors. The medical records room size is approximately twelve by forty. Based on interview at the time of observation, the</p>	K0029	<p>K0291. Closer for the door to Medical Records office was ordered on 12/21/12 and was installed on 01/04/13.2. Rounds were made on 01/04/13 to identify other corridors leading to hazardous areas had a self closing device and corrected as needed. 3. Rounds will be conducted by maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4. The results of the rounds will be brought to QA to ensure compliance monthly x3 then quarterly thereafter.5. 01/04/13.</p>	01/04/2013			

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	Maintenance Director acknowledged the medical records room did not have a self closing device on the door.  3.1-19(b)			

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K0046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 battery operated emergency lights were tested monthly for thirty seconds and annually for ninety minutes. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the six battery operated emergency lights located throughout the facility</p>	K0046	<p>K0461. Maintenance department inserviced on importance of conducting a test and completing paperwork to show emergency lighting function test is being done monthly and annually on 01/03/13.2. Paperwork for the last year was printed on 01/03/13 to show emergency lighting function test has been completed monthly.3. Maintenance will conduct emergency lighting function test monthly to ensure compliance.4. The results of the function test will be brought to QA to ensure compliance monthly x3 then quarterly thereafter. 5. 01/03/13</p>	01/03/2013			

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	<p>worked but there was no written record of a monthly function test or an annual test regarding the battery operated emergency lights available for review. Based on interview at the time of observation, the Maintenance Director acknowledged that there was no emergency lighting function test or an annual test for the battery operated emergency lights available for review.</p> <p>3.1-19(b)</p>				

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K0066 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 any staff utilizing the designated smoking area adjacent to the activity room during a fire emergency.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour</p>	K0066	K0661. Maintenance department ensured appropriate containers are provided in the resident smoking area on 12/17/12.2. In-service was conducted with smoker aides, housekeeping and maintenance on the proper disposal of cigarette butts on 12/17/12.3. Maintenance or designee will audit resident smokers area daily for two weeks, three times a week for two weeks, weekly for two months and monthly thereafter.4. The results of the audits will be brought to QA to ensure compliance monthly x3 then	12/17/2012

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	<p>from 9:00 a.m. to 3:00 p.m., the smoking area had twenty three cigarette butts scattered around the bench, grass, and the bench area. Based on interview on 12/17/12 concurrent with the observations, the Maintenance Director acknowledged the facility's employees disposed of cigarette butts on the ground and throughout the grass area instead of using the approved long neck vessel which was provided.</p> <p>3.1-19(b)</p>		quarterly thereafter.5. 12/17/12		

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K0074 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 2 staff offices were flame retardant. This deficient practice could affect the staff that use the offices.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the window coverings in the maintenance office and the conference rooms lacked attached documentation confirming they were inherently flame retardant. Based on an interview with the Maintenance Director, there was no documentation regarding</p>	K0074	curtains removed	01/04/2013

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	flame retardancy for these window coverings available for review.  3.1-19(b)				

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 103 of 103 single station smoke detectors would operate. NFPA 101, 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice affects all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the Preventive Maintenance Book did not have documentation indicating a battery replacement program for the one hundred and three single station smoke detectors in resident rooms. Based on an interview with the Maintenance Director, it was stated there is no documentation for the replacement of single station smoke detector batteries.</p> <p>3.1-19(b)</p>	K0130	<p>K1301. Maintenance department in-serviced on importance of keeping proper documented in the Preventive Maintenance book to indicate a battery replacement program for smoke detectors is in place on 01/04/13.2. Maintenance printed off paperwork from the computer on 01/03/13 to show testing was conducted on smoke detectors, paperwork was placed in preventive maintenance book.3. Maintenance will conduct monthly testing on battery operated smoke detectors and place proper paperwok in the Preventive Maintenance book to ensure compliance.4. The Preventive Maintenance book will be brought to QA to ensure compliance monthly x3 then quarterly thereafter.5. 01/04/13</p>	01/04/2013			

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K0147 SS=B	<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>1. Based on observation and interview, the facility failed to ensure extension cords including power strips and nonfused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect approximately 20 of 134 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., an oxygen concentrator servicing the resident in room 408 was plugged into a power strip at the foot of the resident's bed and not directly into a wall outlet. Based on an interview with the Maintenance Director, it was acknowledge that the oxygen concentrator was plugged into a power strip.</p>	K0147	<p>K1471(a). Maintenance department audited resident rooms for appropriate use of extension cords and corrected as needed.2(a). In-service was conducted with employees on proper use of extension cords on 01/04/13.3(a). Rounds will be conducted by maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4(a). The results of the rounds will be brought to QA to ensure compliance monthly x3 then quarterly thereafter.1(b). Maintenance department will fix electrical junction boxes on 300 hall no later than 01/15/13.2(b). Rounds were made on 01/04/13 to identify other electrical junction boxes that potentially were affected and corrected as needed.3(b). Rounds will be conducted by maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4(b). The results of the rounds will be brought to QA to ensure compliance monthly x3 then quarterly thereafter.5. 01/15/13</p>	01/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155103		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/17/2012	
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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of 4 electrical junction boxes observed in the maintenance room were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect any staff using the maintenance room.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., there were two 24 inch by 12 inch electrical junction boxes with a number of wire connections jutting out of the uncovered electrical boxes located in the center of the ceiling in the 300 hall maintenance room, a 24 inch by 12 inch electrical junction box with a number of wire connections jutting out of another uncovered box on the right side of the maintenance room on the wall above the desk, and a 24 inch by 12 inch electrical</p>						

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	<p>junction box with a number of wire connections jutting out of an uncovered box on the wall in the maintenance room. Based on an interview with the Maintenance Director, this was not fixed because it was scheduled to be repaired the following week.</p> <p>3.1-19(b)</p>			

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K0211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>Based on observation and interview, the facility failed to ensure 1 of 10 alcohol based hand rub dispensers were not installed over an ignition source. This deficient practice could affect the residents and staff using the 300 hall day room.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/17/12 with the Maintenance Director during the tour from 9:00 a.m. to 3:00 p.m., the 300 hall day room had a twelve ounce container of alcohol based hand sanitizer mounted over an electric outlet. Based on an interview with the Maintenance Director, it was acknowledge the hand sanitizer was</p>	K0211	K2111. The twelve ounce container of alcohol based hand sanitizer in the 300 hall day room was moved to appropriate location on 12/17/12.2. Rounds were made on 01/03/13 to identify other twelve ounce containers of alcohol based hand sanitizer potentially were affected and corrected as needed.3. Rounds will be conducted by Maintenance during monthly Preventive Maintenance rounds to ensure continued compliance.4. The results of the rounds will be brought to QA to ensure compliance monthly x3 then quarterly thereafter.5. 01/03/13	01/03/2013			

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	mounted over an electrical outlet.  3.1-19(b)			