

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 11/04/2011
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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, IN46614
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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: 11/03/11 and 11/04/11</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</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 built in 1969 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, resident sleeping rooms and spaces open to the</p>	K0000		

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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K0039 SS=E	<p>corridors. The facility has a capacity of 198 and had a census of 140 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/17/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 exit access corridors from the 500 hall had an exit width of at least 4 feet (48 inches). This deficient practice could affect approximately 24 residents, staff and visitors using the main hall corridor and its exit corridor.</p> <p>Findings include:</p> <p>Based on observation at 9:00 a.m. on 11/04/11 with the maintenance supervisor, the width of the main corridor of the 500 hall was</p>	K0039	<p>-Maintenance Director moved med carts and shower chairs out of 500 hall immediately.</p> <p>-Entire building was checked for corridor clearance.</p> <p>-All staff educated on requirements of maintaining a 4ft. exit width and the importance of keeping med carts, housekeeping carts, etc on the same side of the hallway to promote the maximum clearance possible on 11/21/2011.</p> <p>-Administrator and DON to perform daily rounds to check exit corridors to verify that proper clearance is being maintained. Any areas that do not exhibit proper clearance to be immediately rectified.</p>	12/01/2011	

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K0048 SS=E	<p>reduced to 36 inches by a bio-cart, two wheelchairs and a bed across from the exit access corridor. The width of the exit access corridor from the 500 hall was reduced to 30 inches by five med-carts, a shower chair, a wheelchair scale and two small carts. The maintenance supervisor acknowledged the blocked exit corridors at the the time of observation. When asked to correct the problem, the staff on duty refused to move the items blocking both sides of the corridors.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on record review and interview, the facility failed to provide a written fire plan which included the use of kitchen fire extinguishers for the protection of 198 of 198 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which</p>	K0048	<p>-K-Class Fire Extinguisher information will be added to the fire safety plan and included in the emergency preparedness manual on each unit.</p> <p>-All Staff will be educated on the revised fire safety plan with the addition of the K class extinguishers.</p> <p>-Fire Safety Plan will be updated annually and as needed.</p>	12/04/2011	

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	<p>shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect any occupants in and near the kitchen in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on interview and record review with the maintenance supervisor on 11/03/11 from 2:10 p.m. to 2:25 p.m., the written fire plan was found within the Emergency Procedure manual. The maintenance supervisor stated the policy and procedure was last</p>				

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K0144 SS=F	<p>reviewed 04/28/11. This Plan was the corporate policy which required information specific to the facility. The manual did not address the use of the K class fire extinguisher in relation to the use of the kitchen hood suppression system. The maintenance supervisor stated he was unaware of the requirement for the policy and procedure.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators were equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition,</p>	K0144	<p>-Remote shut off device was installed on 11-09-2011. Annual 90-minute test was conducted on emergency battery lighting system on 11-09-2011.</p> <p>-Requirement for performing annual functional tests on emergency battery lighting systems for not less than 90 minutes to be added to the preventative maintenance program.</p>	12/01/2011	

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	<p>3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the Generator Maintenance records on 11/03/11 at 2:35 p.m. with the maintenance supervisor, there was no documentation available which indicated the horsepower rating of the generator engine provided. Based on interview with the</p>						

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	<p>maintenance supervisor during record review, he stated no remote shut off devices existed for the generator and he was not aware of the requirement.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency task lighting in and around 1 of 1 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires that EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p>				

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K0154 SS=C	<p>Based on record review with the maintenance supervisor on 11/03/11 at 2:35 p.m., the maintenance supervisor acknowledged he had no record of the battery powered lighting at the generator being tested for 90 minutes annually. The maintenance supervisor stated he thought the annual 90 minute tests had been completed but he had no documentation .</p> <p>3.1-19(b)</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed, to protect 198 of 198 residents, in the event the automatic</p>	K0154	<p>-Appropriate phone numbers for Indiana State Department of Health and the local fire department added to the fire watch procedure and included in the emergency preparedness manual on each unit.</p> <p>-All staff will be educated on revised fire watch procedure.</p>	12/01/2011	

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	<p>sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department to be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also to be notified. This deficient practice could affect all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's policy and procedure book with the maintenance supervisor on 11/03/11 at 2:25 p.m., the fire watch procedure for an out of service automatic sprinkler system</p>		-Fire watch procedure will be updated annually and as needed.		

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K0155 SS=C	<p>was incomplete. The procedure lacked the telephone numbers for the Indiana State Department of Health (317-233-5359) and the local fire department. The interview with the maintenance supervisor at the time of the record review indicated no other policy or procedure was available to review.</p> <p>3.1-19(b)</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 198 of 198 residents, in accordance with LSC, Section 9.6.1.8. LSC,</p>	K0155	<p>-Appropriate phone numbers for Indiana State Department of Health and the local fire department added to the fire watch procedure. -All staff will be educated on revised fire watch procedure. -Fire watch procedure will be updated annually and as needed.</p>	12/01/2011

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	<p>19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's policy and procedure book with the maintenance supervisor on 11/03/11 at 2:25 p.m., the fire</p>				

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	<p>watch procedure for an out of service automatic alarm system was not complete. The procedure lacked the required telephone numbers for the local fire department and the Indiana State Department of Health (317-233-5359). The maintenance supervisor stated at the time of record review, he had no other policy or procedure available to review.</p> <p>3.1-19(b)</p>				