

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2014
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NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637
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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: 02/10/14</p> <p>Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Morningside Nursing and Memory 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 18, New 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 automatic smoke</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.

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K010046 SS=F	<p>detection in the corridors, in areas open to the corridors, and battery operated smoke detectors in resident rooms 110, 111, and 114 with hard wired smoke detectors in the other fourteen resident sleeping rooms. The facility has a capacity of 40 and had a census of 38 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a wood shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, observation and interview; the facility failed to ensure 11 of 11 battery operated emergency lights</p>	K010046	No residents were affected by this citation. The battery operated emergency lights will be repaired. The battery operated	03/12/2014

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	<p>in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 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 residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lighting" documentation with the Activity Director during record review from 12:00 p.m. to 1:30 p.m. on 02/10/14 and observation with the Activity Director from 1:30 p.m. to 3:00 p.m., the following was noted:</p> <p>a. The southeast exterior, northeast exterior, courtyard exterior and main entrance exterior battery operated emergency lights were not functional when tested. Based on interview at the time of observation, the Activity Director acknowledged four of the five</p>		<p>emergency light form will be updated to include necessary documentation specifying the duration of the monthly test and the duration of the annual test. The maintenance director or designee is responsible for completing the form correctly. The administrator or designee will review the completed forms on a monthly basis to ensure the duration of the test is included. The quality assurance committee will review the forms quarterly to ensure proper completion. After three months if it is determined the forms are completed properly then monitoring by the quality assurance committee will cease.</p>		

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K010048 SS=F	<p>exterior battery operated emergency lights did not function when tested.</p> <p>b. Functional testing of the eleven battery operated emergency lights in the facility was indicated by a check mark for each month on 2013. Based on interview at the time of record review, the Activity Director acknowledged the battery operated emergency light documentation did not specify the duration of the monthly test or document the annual 90 minute test.</p> <p>3.1-19(b)</p> <p>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. 18.7.1.1 Based on record review and interview, the facility failed to ensure the written fire safety plan for the facility included staff response to alarms and extinguishment of fire. LSC 18.7.2.2 requires written health care occupancy fire safety plans shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire</p>	K010048	No residents were affected by this citation. The fire safety plan has been updated to include the use of fire extinguishers located in the facility. The fire safety plan has been updated to include staff response to the battery powered smoke detectors. The maintenance director or designee and the administrator are responsible to monitor to ensure the policy is followed. The quality assurance committee will review	02/12/2014

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	<p>department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice affects any resident, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan and policy and procedures from 12:00 p.m. to 1:30 p.m. on 02/10/14 with the Activity Director, the following was noted:</p> <p>a. The fire safety plan did not address the use of portable fire extinguishers located in the facility.</p> <p>b. The fire safety plan did not address staff response to the three resident rooms with battery operated smoke detectors or the fourteen resident rooms with hardwired smoke detectors that provide only a visual and audible signal at the nurses station and outside the resident room.</p> <p>Based on interview during the time of record review, the Activity Director acknowledged the written fire safety plan for the facility did not include use of the portable fire extinguishers or staff</p>		<p>the updated Fire Safety policy at the next committee meeting. If it is determined that the policy is in compliance then no monitoring will be required.</p>				

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K010050 SS=F	<p>response to battery operated smoke detectors in the resident rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 1 of 9 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including</p>	K010050	<p>No residents were affected by this citation. Documentation is entered on the Fire Drill Form to indicate that the fire alarm system is activated. An in-service to review proper completion of the Fire Drill Form as well as proper procedures to follow was conducted on 2/12/2014. After fire drills are conducted, the Administrator or designee will review the forms to ensure proper documentation and follow through. The Quality Assurance Committee will review the Fire Drill Forms for three months to determine compliance. If it is determined the Fire Drill Forms are completed properly, then</p>	02/12/2014

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K010062 SS=C	<p>staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Activity Director from 12:00 p.m. to 1:30 p.m. on 02/10/14, the documentation for the drill performed between the hours of 6:00 a.m. and 9:00 p.m. on 11/27/13 at 8:00 p.m. did not indicate the fire alarm system had been activated. Based on interview at the time of record review, the Activity Director acknowledged the transmission of alarm was not documented on the fire drill form.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler systems were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated</p>	K010062	<p>monitoring will cease.</p> <p>No residents were affected by this citation. The two pressure gauges were replaced. Dates to replace or recalibrate the gauges were noted on tags affixed to the gauges. Dates indicating time for replacement or recalibration have been entered onto the preventive maintenance calendar. The</p>	02/11/2014			

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	<p>gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and patients.</p> <p>Findings include:</p> <p>Based on observation with the Activity Director from 1:30 p.m. to 3:00 p.m. on 02/10/14, the sprinkler system located in the sprinkler riser room had two pressure gauges with 11/2008 written on the gauges. Based on interview at the time of observation, the Activity Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>maintenance director or designee are responsible to monitor the dates. The quality assurance committee will review the documentation that indicates the gauges have been replaced.</p>		

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K010074 SS=B	<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. 18.7.5.1, 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, 18.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 window curtains in the sunroom were flame retardant. This deficient practice could affect residents, staff and visitors on the southeast wing.</p> <p>Findings include:</p> <p>Based on observation and interview with the Activity Director during a tour of the facility on 02/10/14 from 1:00 p.m. to 3:00 p.m., the five curtains in the sun room lacked attached documentation that they were inherently flame retardant. Based on interview at the time of observation with the Activities</p>	K010074	No residents were affected by this citation. The window curtains in the sun room were treated with a flame retardant product. The fire safety policy was updated to reflect the use of flame retardant products. The maintenance director or designee will treat all drapery that has no flame testing rating with a flame retardant product. The treatment of these items will occur every 6 months and will be properly documented by the maintenance director or designee. The quality assurance committee will review the documentation at the quarterly committee meeting to ensure compliance. If it is deemed corrected, then monitoring will cease.	02/12/2014			

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K010130 SS=B	<p>Director, there was no documentation regarding flame retardancy for these window curtains available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Activity Director on 02/10/14 during the tour from 1:00 p.m. to 3:30 p.m., there was a rolling fire door with a fusible link protecting the opening between the</p>	K010130	No residents were affected by this citation. Arrangements have been made to have the company responsible for service and maintenance of equipment to inspect and test for proper operation and full closure. The testing will be performed on a yearly basis. The maintenance director or designee is responsible to arrange for yearly testing. The quality assurance committee will monitor the testing on a yearly basis to ensure it is completed timely.	03/12/2014

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K010147 SS=E	<p>kitchen serving area and the dining room. Based on interview with the Activity Director at the time of observation, there was no documentation of an annual inspection or test to check for proper operation.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, 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 could affect at least 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Activity Director on 02/10/14 from 1:30 p.m. to 3:00 p.m. the following was noted:</p> <p>a. Resident room 108 had an extension</p>	K010147	No residents were affected by this citation. All extension cords were removed. The refrigerator was unplugged from the power strip and then plugged into the wall outlet. The Administrator or designee is responsible to monitor for use of extension cords and improperly used power strips. The "Rounds Sheet" used by department managers has been updated to include observing for use of extension cords and power strips. The Quality Assurance Committee will review the "Rounds Sheets" once per month for three months to determine compliance. If compliance is determined then monitoring will cease.	02/11/2014			

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K010154 SS=C	<p>cord plugged into a television and lamp.</p> <p>b. Resident room 106 has a refrigerator plugged into a power strip.</p> <p>c. The Living Room had a yellow extension cord plugged into a power strip behind the large screen television. Based on interview at the time of observation, the aforementioned conditions were acknowledged by the Activity Director.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 staff interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic 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. in order to protect 38 of 38 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of</p>	K010154	No residents were affected by this citation. The Fire watch policy was updated to include notification of the outage to the fire department, fire alarm monitoring company and the insurance carrier. The Administrator has reviewed the policy to ensure the proper agency notification. No further monitoring is necessary as the policy has been updated to meet regulations.	02/11/2014			

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	<p>Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department 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 be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Activity Director on 02/10/14 from 12:00 p.m. to 1:30 p.m., the facility did have a written fire watch policy and procedure for a sprinkler system failure but it did not address all components of NFPA 25, Chapter 11. Specifically, the plan did not include notification of the outage to the fire department, fire alarm monitoring company, or insurance carrier.</p> <p>3.1-19(b)</p>				

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. in order to protect 38 of 38 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Activity Director on 02/10/14 from 12:00 p.m. to 1:30 p.m., the facility did have a written fire watch policy and procedure for a fire alarm system failure but it did not address all components of LSC Section 9.6.1.8. Specifically, the plan did not include notification of the outage to the fire department.</p> <p>3.1-19(b)</p>	K010155	No residents were affected by this policy. The fire watch policy was updated to include notification of the fire department. The administrator has reviewed the policy to ensure the proper notification has been included. There is no other monitoring needed as the policy has been updated to meet the requirement.	02/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2014
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