

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2016
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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
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K 0000 Bldg. 01	<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: 03/15/16</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>At this Life Safety Code survey, West Bend Nursing 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) and 410 IAC 16.2. Building 01 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V</p>	K 0000	<p>K000</p> <p>The creation and submission of this plan of correction does not substitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>On March 15, 2016 a Life Safety Code Survey was conducted at West Bend Nursing and Rehabilitation. Attached is the plan of correction. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post survey revisit.</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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K 0015 SS=F Bldg. 01	<p>(111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 157 and had a census of 88 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/24/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish on the ceiling in 26 of 60 rooms had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning</p>	K 0015	<p>K015 It is the policy of this facility to make sure allinterior finishes for rooms and spaces not used for corridors or exit ways,including exposed interior surfaces of buildings such as fixed or movablewalls, partitions, columns, and ceilings has a flame spread rating of Class Aor Class</p>	04/14/2016

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	<p>Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 between 11:28 a.m. and 2:18 p.m., the two story facility contained wood or</p>		<p>B. (In fully-sprinkled buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from exit access corridors.)</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The faux wood wall covering below the handrails in the corridors were coated with a product made by Flame Control Coating, LLC during installation that effectively gave it a Class B flame spread rating. Documentation is maintained in maintenance binder in Maintenance Supervisor office. Residents have not experienced any negative outcomes related to the deficient concerns.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by this finding. The faux wood wall covering below the handrails in the corridors were coated with a product made by Flame Control Coating, LLC during installation that effectively gave it a Class B flame spread rating. Documentation is maintained in maintenance binder in Maintenance Supervisor office.</p> <p>What measures will be put into</p>		

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K 0025 SS=D Bldg. 01	<p>painted wood on the bottom half of the corridors. Based on interview at the time of observation, the Maintenance Supervisor was unable to provide documentation for a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the</p>	K 0025	<p>place or what systematic changes will be made to ensure that the deficient practice does not recur: All future replacement wall coverings will be fire-rated and the specifications for the products are maintained in a binder in the Maintenance Supervisor's office.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action the Maintenance Supervisor/Designee will be responsible for evaluating all replacement wall coverings and placing appropriate specifications for the materials in the Maintenance Supervisor's office.</p> <p>By what date the systematic changes will be completed: Compliance date: 4/14/16</p>	04/14/2016			

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	<p>facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/15/16 from 12:25 p.m. to 1:34 p.m., the following unsealed ceiling penetrations were discovered:</p> <p>a) three of four Maintenance ceiling tiles were missing b) eight of eighty eight Staff Break room ceiling tiles were missing c) one inch penetration around sprinkler pipe outside the Laundry room d) one eighth inch gap around a wire and a quarter inch gap in the floor in the 2nd floor Housekeeping room e) one eighth inch ceiling penetration in the East Stairwell</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p>It is the policy of this facility that smokebarriers shall be constructed to provide at least one half hour fire resistancerating and constructed in accordance with 8.3.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:</p> <p>1.The3 missing ceiling Maintenance tiles were replaced immediately uponnotification. 2.The8 staff break room ceiling tiles were replaced immediately upon notification. 3.Theone inch penetration around sprinkler pipe outside laundry room has been filledwith a fire resistance caulk. 4.Theone eighth inch gap around wire and quarter inch gap in floor in the 2ndfloor housekeeping room has been filled with a fire resistance caulk. 5.Theone eighth inch ceiling penetration in the East stairwell has been filled witha fire resistance caulk.</p> <p>Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective actions(s) will be taken:</p> <p>The deficient practice had the potential to affect staffonly. The Maintenance Director/Designeeinspected all floor, stairwells, and ceiling areas to ensure they were sealedin accordance with LSC 8.3.2.</p>				

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			<p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. The 3 missing ceiling Maintenance tiles were replaced immediately upon notification. 2. The 8 staff break room ceiling tiles were replaced immediately upon notification. 3. The one inch penetration around sprinkler pipe outside laundry room has been filled with a fire resistance caulk. 4. The one eighth inch gap around wire and quarter inch gap in floor in the 2nd floor housekeeping room has been filled with a fire resistance caulk. 5. The one eighth inch ceiling penetration in the East stairwell has been filled with a fire resistance caulk. <p>The Maintenance Supervisor/Designee will inspect after any projects are completed that could have the potential of causing a penetration to a smoke barrier on any floor, corridor, or ceiling.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Supervisor/designee will inspect all floors, corridors, and ceilings weekly for 4 weeks, then monthly thereafter per the Preventative Maintenance Program and then</p>	

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K 0029 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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 Room 11 used as storage greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice was in a staff only area.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 at</p>	K 0029	<p>after the completion of any project thereafter. These inspections will be added to the Preventative Maintenance program and will be recorded on the daily/weekly/monthly PM forms as they apply.</p> <p>By what date the systematic changes will be completed: Compliance date: 4/14/16</p> <p>K029 It is the policy of this facility to have one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing systems in accordance with 8.4.1 and/or 19.3.5.4 protectshazardous areas. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A self-closing device was</p>	04/14/2016

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	<p>12:30 p.m., room 11 was used as storage. Room 11 contained nine mattresses, one recliner, and fifteen wooden head boards. The corridor door lacked a self-closing device. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>installed on the storageroom door and it now self closes and latches into place to meet LSC standards. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</p> <p>The deficient practice had the potential to affectstaff only. The MaintenanceSupervisor/designee inspected all doors to ensure that if they lead to a hazardousarea that they had self-closing devices and that they latched into the frameand that they provided a smoke barrier to the corridor. Whatmeasures will be put into place or what systematic changes will be made toensure that the deficient practice does not recur:</p> <p>A self-closing device was installed on the storageroom door and it now self closes and latches into place to meet LSC standards. The Maintenance Supervisor/designee will inspect alldoors to ensure that if they lead to a hazardous area then they have self-closing devices and that they latch into the frame and that they provide a smoke barrier to the corridor weekly for 4 weeks and then monthly thereafterper the Preventative Maintenance Program. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</p>	

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K 0038 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation, record review and interview, the facility failed to ensure 2 of 3 vertical exit egress stairwells provided a means of egress which discharges to the exterior or the public way in accordance with requirements of NFPA 101, 2000 edition, 7.7. 7.7.1 requires exits to discharge directly to a public way or exterior exit discharge. 7.7.2 allows no more than 50 percent of the exits or egress capacity to discharge into areas on the level of exit discharge. This deficient practice could affect 38 residents, staff and visitors on the second</p>	K 0038	<p>The Maintenance Supervisor/designee will inspect all doors to ensure that if they lead to a hazardous area then they have self-closing devices and that they latch into the frame and that they provide a smoke barrier to the corridor weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply. By what date they systematic changes will be completed: Date of compliance: 4/14/16</p> <p>K038 It is the policy of this facility to make sure exit access is arranged so exits are readily accessible at all times in accordance with section 7.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor obtained bids from contractors to provide facility with access to an approved exterior exit passageway at the first floor level when using the two stairwell exits by resident room 220 and 229.</p>	04/14/2016	

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	<p>floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 from 11:28 a.m. to 2:18 p.m., two stairwell exits by resident room 220 and resident room 229 discharged to the first floor corridor and not to an approved exterior exit passageway at the first floor level. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The deficient practice had the potential to affect staff, visitors, and at least 38 residents. The Maintenance Supervisor obtained bids from contractors to provide facility with access to an approved exterior exit passageway at the first floor level when using the two stairwell exits by resident room 220 and 229.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor obtained bids from contractors to provide facility with access to an approved exterior exit passageway at the first floor level when using the two stairwell exits by resident room 220 and 229.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will prepare all bids received and relay to home office for approval for work to begin.</p> <p>By what date the systematic changes will be completed:</p>		

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor on 03/15/16 between 10:18 a.m. and 11:28 a.m., three sequential first shift fire drills took place between 9:50 a.m. and 10:40 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p>	K 0050	<p>Date of compliance: 4/14/16</p> <p>K050 It is the policy of this facility to make sure 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 to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor/designee will</p>	04/14/2016

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	3.1-19(b) 3.1-51(c)		<p>conduct fire drills at unexpected times under varying conditions.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents and staff have the potential to be affected by this deficient practice.</p> <p>The Maintenance Supervisor has been in service regarding the staggering of quarterly fire drills, at unexpected times under varying conditions, by the Clinical Education Coordinator.</p> <p>The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Supervisor/designee will review all fire drills with the Executive Director/Clinical Education Coordinator to assure quarterly fire drills are staggered at</p>	

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K 0062 SS=D Bldg. 01	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Therapy storage room sprinkler head was maintained. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations the Maintenance Supervisor on 03/15/16 at 11:14 a.m., the Therapy storage room was missing one escutcheon. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the missing</p>	K 0062	<p>unexpected times under varying conditions. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and followup. The Executive Director/designee will review documentation after each fire drill occurs. These inspections will be added to Preventive Maintenance program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>By what date the systematic changes will be completed: Date of compliance: 4/14/16</p> <p>K062 It is the policy of the facility to ensure that the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor replaced the missing escutcheon cover on sprinkler head in Therapy storage room.</p>	04/14/2016

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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
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	escutcheon at the time of each observation. 3.1-19(b)		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The deficient practice had the potential to affect staff only. The Maintenance Supervisor inspected all sprinkler heads to ensure that all escutcheons were in place.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor inspected all sprinkler heads to ensure that all escutcheons were in place. The Maintenance Supervisor/designee will inspect all sprinkler heads to ensure all coverings are in place, weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: The Maintenance Supervisor inspected all sprinkler heads to ensure that all escutcheons were in place. The Maintenance Supervisor/designee will inspect all sprinkler heads to ensure all coverings are in place, weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program. These inspections will be added to the Preventative Maintenance</p>		

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K 0064 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Beauty Shop fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 at 12:03 p.m., the gauge on the portable fire extinguisher in the Beauty Shop indicated the extinguisher was overcharged. Based on interview at the time of observation,</p>	K 0064	<p>program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>By what date the systematic changes will be completed: Date of compliance: 4/14/16</p> <p>K064 It is the policy of this facility to ensure that portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The fire extinguisher in the beauty shop has been replaced by qualified vendor that meets the LSC standard. 2. The fire extinguisher in the beauty shop was lowered. 3. The fire extinguisher in the Laundry room has been replaced by qualified vendor that meets the LSC standard. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The deficient practice had the</p>	04/14/2016

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	<p>the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Beauty Shop portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 at 12:03 p.m., the fire extinguisher in the Beauty Shop measured 68 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>potential to affect staff and at least 2 residents. The Maintenance Supervisor/designee inspected all fire extinguishers to ensure that they were affixed to the wall in the proper position and that they were all charged properly.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Supervisor/designee inspected all fire extinguishers to ensure that they were affixed to the wall in the proper position and that they were all charged properly. The Maintenance Supervisor will inspect all fire extinguishers to ensure they are at the proper charge level daily for 7 days, weekly for 4 weeks, and then monthly per the Preventative Maintenance Program.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Supervisor will inspect all fire extinguishers to ensure they are at the proper charge level daily for 7 days, weekly for 4 weeks, and then monthly per the Preventative Maintenance Program.</p> <p>By what date the systematic changes will be completed:</p> <p>Date of compliance 4/14/16</p>		

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K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure 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>	K 0130	<p>K130</p> <p>It is the policy of this facility to ensure the penetration of fire barrier walls was maintained to ensure the fire resistance of the barrier.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. The fire barrier near resident room 111 with a one eighth inch unsealed penetration inside conduit has been sealed with a fire resistant caulk per LSC standard.</p> <p>2. The fire barrier near resident room 7 with a one half inch unsealed penetration has been sealed with a fire resistant caulk per LSC standard.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The deficient practice had the potential to affect staff, visitors, and at least 28 residents. The Maintenance Supervisor/designee inspected all fire barriers for any unsealed penetrations to ensure that they are maintained properly.</p> <p>What measures will be put into</p>	04/14/2016			

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	<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>This deficient practice could affect staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/15/16 at 1:59 p.m., the fire barrier near resident room 111 had a one eighth inch unsealed penetration inside conduit. Based on interview at the time of observation, the Maintenance Supervisor the each aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>1. The fire barrier near resident room 111 with a one eighth inch unsealed penetration inside conduit has been sealed with a fire resistant caulk per LSC standard.</p> <p>2. The fire barrier near resident room 7 with a one half inch unsealed penetration has been sealed with a fire resistant caulk per LSC standard.</p> <p>Maintenance Supervisor/designee will inspect all fire barriers for any unsealed penetrations to ensure they are maintained properly; weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>Maintenance Supervisor/designee will inspect all fire barriers for any unsealed penetrations to ensure they are maintained properly; weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program, then after any physical plant projects that have the potential to affect the integrity of their fire rating. These inspections will be added to the Preventative Maintenance</p>		

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K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/15/16</p>	K 0144	<p>program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>By what date the systematic changes will be completed: Date of compliance: 4/14/16</p> <p>K144 It is the policy of this facility to make sure generators are inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Maintenance Supervisor/designee will perform monthly generator testing with the proper percentage of load and keep all documentation of tests in binder in Maintenance office. 2. The Maintenance Supervisor/designee will perform monthly generator testing and will include the percentage of the load that was tested. How other residents have the potential to be affected by the same deficient practice will be</p>	04/14/2016

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K 0000	<p>between 10:18 a.m. and 11:28 a.m., the monthly generator #2 testing indicated on 01/18/16, the amount of load put on the generator was 27 percent. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed that no documentation for an annual load bank test was available for review.</p> <p>3-1.19(b)</p>		<p>identified and what corrective action(s) will be taken: The deficient practice had the potential to affect all staff, visitors, and residents. The Maintenance Supervisor/designee will perform weekly/monthly generator tests and keep accurate records in binder in Maintenance office. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor/designee will perform a weekly and monthly generator inspection and keep the checklist in a binder in the maintenance office. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will be responsible for completion of the "Emergency Generator – Weekly Inspection Checklist" audit tool. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the safety committee for review and followup. By what date the systematic changes will be completed: Compliance date: 4/14/16</p>		

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Bldg. 02	<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: 03/15/16</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>At this Life Safety Code survey, West Bend Nursing 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) and 410 IAC 16.2. Building 02 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the</p>	K 0000	<p>K000</p> <p>The creation and submission of this plan of correction does not substitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>On March 15, 2016 a Life Safety Code Survey was conducted at West Bend Nursing and Rehabilitation. Attached is the plan of correction. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post survey revisit.</p>		

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K 0027 SS=E Bldg. 02	<p>corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 157 and had a census of 88 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/24/16 - DA</p> <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 1o-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 1 of 5 sets of fire barrier doors would close to form a smoke resistant barrier. This deficient practice could affect at least 14 residents, staff and visitors.</p> <p>Findings include: Based on observation with the</p>	K 0027	<p>K027 It is the policy of this facility for door openingsin smoke barriers have at least a 20-minute fire protection rating or are atleast 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottomof the door are permitted. Whatcorrective action(s) will be accomplished for those</p>	04/14/2016

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	<p>Maintenance Supervisor on 03/15/16 at 2:09 p.m., a one eighth inch unsealed gap was discovered in the fire barrier door near Room 20. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>residents found to have been affected by the deficient practice: The one eighth inch unsealed gap in the fire barrier door has been fixed and now closes to form a smoke resistant barrier. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The deficient practice had the potential to affect staff, visitors, and at least 14 residents. The Maintenance Supervisor/designee inspected all door openings in smoke barriers to ensure that they offer a smoke barrier in accordance with LSC. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The one eighth inch unsealed gap in the fire barrier door has been fixed and now closes to form a smoke resistant barrier. The Maintenance Supervisor/designee will inspect all door openings in smoke barrier to ensure that they offer a smoke barrier to the corridor weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program. How the correction action(s) will be monitored to ensure the deficient practice will not recur,</p>	

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K 0050 SS=C Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.</p>	K 0050	<p>i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will inspect alldoor openings in smoke barriers to ensure they offer a smoke barrier weekly for 4 weeks and then monthly thereafter per the Preventative Maintenance Program. These inspections will be added to the Preventative Maintenance program and will be recorded on the weekly and monthly PM forms as they apply. By what date the systematic changes will be completed: Date of compliance: 4/14/16</p> <p>K050 It is the policy of this facility to make sure 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</p>	04/14/2016

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	<p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor on 03/15/16 between 10:18 a.m. and 11:28 a.m., three sequential first shift fire drills took place between 9:50 a.m. and 10:40 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>established routine. Responsibility for planning and conducting drills is assigned to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00PM and 6:00AM a coded announcement may be used instead of audible alarms.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor/designee will conduct fire drills at unexpected times under varying conditions.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents and staff have the potential to be affected by this deficient practice. The Maintenance Supervisor has been in service regarding the staggering of quarterly fire drills, at unexpected times under varying conditions, by the Clinical Education Coordinator. The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p>		

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K 0064 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the	K 0064	The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will review all fire drills with the Executive Director/Clinical Education Coordinator to assure quarterly fire drills are staggered at unexpected times under varying conditions. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and followup. The Executive Director/designee will review documentation after each fire drill occurs. These inspections will be added to Preventive Maintenance program and will be recorded on the weekly and monthly PM forms as they apply. By what date the systematic changes will be completed: Date of compliance: 4/14/16	04/14/2016	

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	<p>facility failed to ensure 1 of 1 Laundry fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/15/16 at 12:22 p.m., the gauge on the portable fire extinguisher in the Laundry room indicated the extinguisher was undercharged. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>It is the policy of this facility to ensure that portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ol style="list-style-type: none"> 1. The fire extinguisher in the beauty shop has been replaced by qualified vendor that meets the LSC standard. 2. The fire extinguisher in the beauty shop was lowered. 3. The fire extinguisher in the Laundry room has been replaced by qualified vendor that meets the LSC standard. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The deficient practice had the potential to affect staff and at least 2 residents. The Maintenance Supervisor/designee inspected all fire extinguishers to ensure that they were affixed to the wall in the proper position and that they were all charged properly.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Supervisor/designee inspected all fire extinguishers to ensure that</p>	

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K 0072 SS=D Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other	K 0072	they were affixed to the wall in the properposition and that they were all charged properly. The Maintenance Supervisor will inspect allfire extinguishers to ensure they are at the proper charge level daily for 7days, weekly for 4 weeks, and then monthly per the Preventative MaintenanceProgram. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur; i.e., what quality assurance program will be put into place: The Maintenance Supervisor will inspect all fireextinguishers to ensure they are at the proper charge level daily for 7 days,weekly for 4 weeks, and then monthly per the Preventative Maintenance Program. Bywhat date the systematic changes will be completed: Dateof compliance 4/14/16 K072 It is the policy of this facility to make sure meansof egress shall be continuously maintained free of all obstructions orimpediments to full instant use in the case of	04/14/2016			

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	<p>emergency for 1 of 2 Laundry exit discharge paths. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/16/16 at 1:00 p.m., the Laundry corridor exit path of egress was obstructed by linen carts. The carts only provided a clear width of thirty inches. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>fire or emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor removed the linen cart from the laundry exit egress corridor. Residents did not have any negative outcomes related to this deficient finding.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Only staff had the potential to be affected by the deficient practice. The Maintenance Supervisor removed the linen cart from the laundry exit egress corridor.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor removed the linen cart from the laundry exit egress corridor. The Maintenance Supervisor/designee provided and in-service for staff regarding the proper clearing of egress corridors.</p> <p>How the corrective action(s) will be monitored to ensure the</p>		

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K 0130 SS=E Bldg. 02	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure 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</p>	K 0130	<p>deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will be responsible for completing egress audits for all corridors weekly for 4 weeks, and then monthly thereafter per the Preventative Maintenance Program. If threshold is not 100% met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and followup. By what date the systematic changes will be completed: Compliance date: 4/14/16</p> <p>K130 It is the policy of this facility to ensure the penetration of fire barrier walls was maintained to ensure the fire resistance of the barrier. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The fire barrier near resident room 111 with a one eighth inch unsealed penetration inside conduit has been sealed with a fire resistant caulk per LSC standard. 2. The fire barrier near resident room 7 with a one half inch</p>	04/14/2016

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	<p>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 device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and at least 17 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/15/16 at 2:12 p.m., the fire barrier near resident room 7 had a one half inch unsealed penetration. Based on interview at the time of observation, the Maintenance Supervisor the each aforementioned condition and provided the measurement.</p>		<p>unsealed penetration hasbeen sealed with a fire resistant caulk per LSC standard.</p> <p>Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:</p> <p>The deficient practice had the potential to affectstaff, visitors, and at least 28 residents. The Maintenance Supervisor/designee inspected all fire barriers for anyunsealed penetrations to ensure that they are maintained properly.</p> <p>Whatmeasures will be put into place or what systematic changes will be made toensure that the deficient practice does not recur:</p> <p>1.Thefire barrier near resident room 111 with a one eighth inch unsealed penetrationinside conduit has been sealed with a fire resistant caulk per LSC standard.</p> <p>2.Thefire barrier near resident room 7 with a one half inch unsealed penetration hasbeen sealed with a fire resistant caulk per LSC standard.</p> <p>Maintenance Supervisor/designee will inspect all firebarriers for any unsealed penetrations to ensure they are maintained properly; weeklyfor 4 weeks and then monthly thereafter per the Preventative MaintenanceProgram.</p> <p>Howthe corrective action(s) will be monitored to ensure the</p>				

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K 0144 SS=F Bldg. 02	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 generators was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available</p>	K 0144	<p>deficient practicewill not recur; i.e., what quality assurance program will be put into place: Maintenance Supervisor/designee will inspect allfire barriers for any unsealed penetrations to ensure they are maintainedproperly; weekly for 4 weeks and then monthly thereafter per the PreventativeMaintenance Program, then after any physical plant projects that have thepotential to affect the integrity of their fire rating. These inspections willbe added to the Preventative Maintenance program and will be recorded on theweekly and monthly PM forms as they apply. Bywhat date the systematic changes will be completed: Dateof compliance: 4/14/16</p> <p>K144 It is the policy of this facility to make suregenerators are inspected weekly and exercised under load for 30 minutes permonth and shall be in accordance with NFPA 99 and NFPA 110. Whatcorrective action(s) will be accomplished for those</p>	04/14/2016	

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	<p>EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 03/15/16 between 10:18 a.m. and 11:28 a.m., the monthly generator #1 testing failed to include the percentage of load that was tested. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed that no documentation for an annual load bank test was available for review.</p> <p>3-1.19(b)</p>		<p>residents found to have been affected by the deficient practice:</p> <p>1. The Maintenance Supervisor/designee will perform monthly generator testing with the proper percentage of load and keep all documentation of tests in binder in Maintenance office.</p> <p>2. The Maintenance Supervisor/designee will perform monthly generator testing and will include the percentage of the load that was tested.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The deficient practice had the potential to affect all staff, visitors, and residents.</p> <p>The Maintenance Supervisor/designee will perform weekly/monthly generator tests and keep accurate records in binder in Maintenance office.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Supervisor/designee will perform a weekly and monthly generator inspection and keep the checklist in a binder in the maintenance office.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>		

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K 0147 SS=D Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 multiplug was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 03/15/16 at 1:05 p.m., a multiplug adapter washing machine and soap dispenser. Based on interview at the</p>	K 0147	<p>i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will be responsible for completion of the "Emergency Generator – Weekly Inspection Checklist" audit tool. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the safety committee for review and followup. By what date the systematic changes will be completed: Compliance date: 4/14/16</p> <p>K147 It is the policy of this facility to make sure all electrical wiring and equipment shall be in accordance with National Electrical Code. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor removed the multi-plug adapter washing machine and soap dispenser immediately upon notification. Residents did not experience any negative outcomes related to the deficient findings. How other residents have the potential to be affected by the same deficient practice will be</p>	04/14/2016

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	<p>time of observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action(s) will be taken: The deficient practice had the potential to affect staff only. The Maintenance Supervisor removed the multi-plug adapter washing machine and soap dispenser immediately upon notification/ What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Supervisor removed the multi-plug adapter washing machine and soap dispenser immediately upon notification. The Maintenance Supervisor/designee will review and remove any multi-plug adapters or extension cords. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Supervisor/designee will be responsible for checking the identified areas to make sure the multi-plug adapters and/or extension cords have been removed. New equipment/appliances will need to be reviewed by the Maintenance Supervisor/designee for proper connection to a source of power. Any equipment/appliances not connected properly will be reported to the safety committee</p>	

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K 0000 Bldg. 03	<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: 03/15/16</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>At this Life Safety Code survey, West Bend Nursing 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) and 410 IAC 16.2. Building 03 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story,</p>	K 0000	<p>for review and follow-up. By what date the systematic changes will be completed: Compliance date: 4/14/16</p> <p>K000 The creation and submission of this plan of correction does not substitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. On March 15, 2016 a Life Safety Code Survey was conducted at West Bend Nursing and Rehabilitation. Attached is the plan of correction. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.</p>	

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K 0050 SS=C Bldg. 03	<p>fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 157 and had a census of 88 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/24/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview,</p>	K 0050	K050 It is the policy of this facility to	04/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/15/2016
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
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	<p>the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" forms with the Maintenance Supervisor on 03/15/16 between 10:18 a.m. and 11:28 a.m., three sequential first shift fire drills took place between 9:50 a.m. and 10:40 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>make sure 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 to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00PM and 6:00AM a coded announcement may be used instead of audible alarms.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Supervisor/designee will conduct fire drills at unexpected times under varying conditions.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents and staff have the potential to be affected by this deficient practice. The Maintenance Supervisor has been in service regarding the staggering of quarterly fire drills, at unexpected times under varying conditions, by the Clinical Education Coordinator. The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying</p>		

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			<p>conditions.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Supervisor/designee will stagger quarterly fire drills at unexpected times under varying conditions.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:</p> <p>The Maintenance Supervisor/designee will review all fire drills with the Executive Director/Clinical Education Coordinator to assure quarterly fire drills are staggered at unexpected times under varying conditions. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Safety Committee for review and followup. The Executive Director/designee will review documentation after each fire drill occurs. These inspections will be added to Preventive Maintenance program and will be recorded on the weekly and monthly PM forms as they apply.</p> <p>By what date the systematic changes will be completed:</p> <p>Date of compliance: 4/14/16</p>	