

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 08/11/14</p> <p>Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare of South Bend 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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping</p>	K010000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. <b>This facility requests a desk review for paper compliance for all.</b></p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010025 SS=E	<p>rooms. The facility has a capacity of 157 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was fully sprinklered and one wooden storage shed which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/14/14.</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 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/11/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 smoke barriers in the facility were protected to maintain the fire resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least 10 residents using the Therapy room as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director on 08/11/14 at 12:50 p.m., there were exposed penetrations through the smoke barrier above the ceiling near the Therapy wing where two, three inch penetrations by cable and a water pipe through the drywall were not firestopped. Based on interview at the time of observation, the Administrator and Plant Operations Director acknowledged the unprotected openings through the smoke</p>	K010025	<p>K025 1. Noresidents were directly affected by this alleged deficiency. 2. Residentswho utilize the therapy department were potentially affected by this allegeddeficiency. 3. Fire rated drywall installed and fire rated caulk used to ensure compliance inidentified areas, passageway leading toPhysical Therapy Department. 4.Maintenance Director or designee will utilize preventative maintenance rounds to ensure compliance. Reports will be reviewed in Quality Assurance Meetingmonthly x 3 months, and quarterly thereafter to ensure compliance. 5.Compliance is assured by September 10, 2014.</p>	09/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010029 SS=A	<p>barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors serving hazardous areas such as a laundry prevented the passage of smoke and closed and latched. This deficient practice occurred in a service hall and would not directly affect residents but would affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director on 08/11/14 at 12:35 p.m., the soiled laundry room door self closed but</p>	K010029	<p>K029</p> <p>1. No residents were directly affected by this alleged deficiency. 2. No residents had the potential to be affected by this alleged Deficiency. 3. Identified areas, soiled laundry room door, and clean laundry room door have been repaired to ensure regulatory compliance. 4. Maintenance Director or designee will utilize preventative maintenance rounds to ensure compliance. Reports will be reviewed in Quality Assurance Meeting monthly x 3 months, and quarterly thereafter to ensure</p>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010046 SS=E	<p>did not latch into the frame and the clean laundry room door had two pencil size holes through the door. Based on interview at the time of observation, the Administrator and Plant Operations Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1½ hour duration for 2 of 16 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 30 residents, staff and visitors if required to evacuate the facility from the South Unit, B Hall or North Unit, A Hall exits.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from</p>	K010046	<p>compliance. 5.Compliance is assured by September 10, 2014.</p> <p>K046</p> <p>1. Noresidents were directly affected by this alleged deficiency. 2. Allresident have the potential to be affected by this alleged deficiency. 3.Maintenance Director or Designee will perform monthly review of all interiorand exterior lighting to ensure compliance. Lights will be installed/repairedin identified areas/South Unit/B hall/ North Unit A hall/Generator interior, toensure compliance. 4. Maintenance Director or designee willutilize preventative maintenance rounds to ensure compliance. Reports will bereviewed in Quality Assurance Meeting monthly x 3 months, and quarterlythereafter to ensure</p>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/11/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>12:00 p.m. to 3:00 p.m. on 08/11/14, the South Unit, B Hall and North Unit, A Hall exits were not provided with exterior lighting. Based on interview at the time of observation, the Executive Director and the Plant Operations Director acknowledged the aforementioned exit discharges to the exterior of the facility were not provided with exterior emergency lighting</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview; the facility failed to ensure 4 of 4 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires 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>compliance.</p> <p>5.Compliance is assured by September 10, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010050 SS=C	<p>a. Based on review of electronic media documentation and interview with the Executive Director and the Plant Operations Director on 08/11/14 at 12:00 p.m., the annual 90 minute test for the four battery operated lights was not documented. Based on interview at the time of record review, the Executive Director and the Plant Operations Director acknowledged the annual 90 minute battery operated light test was not documented.</p> <p>b. Based on observation with the Executive Director and the Plant Operations Director on 08/11/14 from 12:00 p.m. to 3:00 p.m., the battery operated light located inside the generator housing did not illuminate when tested. Based on interview at the time of observation, the Executive Director and the Plant Operations Director acknowledged the battery operated light inside the generator did not function when tested.</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 2 of 8 fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters included the verification of transmission of the fire alarm signal to the monitoring station in fire drills. 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. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 08/11/14 at 11:00 a.m. with the Executive Director and Plant Operations Director, the documentation for the following drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal for drills: on 03/13/14 at 6:30 p.m. and on 06/19/14 at 8:45 p.m.</p> <p>Based on interview at the time of record</p>	K010050	<p>K050</p> <ol style="list-style-type: none"> <li>1. Noresidents were directly affected by this alleged deficiency.</li> <li>2. Allresident have the potential to be affected by this alleged deficiency.</li> <li>3.Maintenance Director or Designee will conduct fire drills in accordance withfacility policy and regulatory standards to include fire alarm simulation ofemergency fire conditions.</li> <li>4.Maintenance Director or designee will utilize Fire Drill Audits to ensurecompliance. Reports will be reviewed in Quality Assurance Meeting monthly x 3months, and quarterly thereafter to ensure compliance.</li> <li>5.Compliance is assured by September 10, 2014.</li> </ol>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010054 SS=C	<p>review, the Executive Director and Plant Operations Director acknowledged the transmission of the fire alarm signal for the aforementioned fire drills was not documented.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 100 % of smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If</p>	K010054	<p>K054 1. Noresidents were directly affected by this alleged deficiency. 2. Allresidents had the potential to be affected by this alleged Deficiency. 3.Maintenance Director or Designee will perform sensitivity testing on alldetectors in accordance with regulatory standards. 4.Maintenance Director or designee will utilize preventative maintenance roundsto ensure compliance. Reports will be reviewed in Quality Assurance Meetingmonthly x 3 months, and quarterly thereafter to ensure compliance. 5. Compliance is assured by September 10,2014. We have the documentation, see attached, that shows the smoke detector ranges, we the company</p>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</li> <li>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p>		that did the inspection did not initially give us the paperwork showing compliance r/t range, it arrived shortly after the inspection ended	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010056 SS=B	<p>Based on review of fire alarm documentation dated 08/04/14 on 08/11/14 during record review at 10:45 a.m., the test report did not give the sensitivity range for the smoke detectors. Although each detector was listed as "Pass", the test report had a column labeled as "Read Sensitivity" and listed each detector as "Low/1." The report had no explanation as to how the results were to be interpreted. Based on interview at 3:30 p.m. on 08/11/14, the Executive Director acknowledged the aforementioned condition regarding the smoke detector sensitivity test. The previous smoke detector sensitivity test provided by a different vendor occurred on 03/06/12.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. This deficient practice could affect residents, staff and/or visitors in the corridor near the activity room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director on 08/11/14 at 1:55 p.m., a two foot by seven display built in the corridor wall outside the activity room lacked sprinkler protection. Based on interview at the time of observation, the Executive Director and the Plant Operations Director acknowledged the lack of sprinkler protection in the display case outside the activity room.</p> <p>3.1-19(b)</p>	K010056	<p>K056</p> <ol style="list-style-type: none"> <li>1. Noresidents were directly affected by this alleged deficiency.</li> <li>2. Allresidents had the potential to be affected by this alleged Deficiency.</li> <li>3. Sprinkler coverage that will meetrequirements in identified area, activity display case, meet regulatory compliance will be installedby qualified technician.</li> <li>4. Maintenance Director or designee will utilize preventative maintenance roundsto ensure compliance. Reports will be reviewed in Quality Assurance Meetingmonthly x 3 months, and quarterly thereafter to ensure compliance.</li> <li>5. Compliance is assured by September 10, 2014.</li> </ol>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/11/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure portable space heaters were not used in areas accessible to residents. This deficient practice affects any resident using the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director on 08/11/14 at 12:35 p.m., there was a portable electric fireplace with a functioning heating element in the main entrance. Based on interview at the time of observation, the Executive Director and the Plant Operations Director acknowledged the portable electric fireplace had recently been added and the heating element was functional.</p> <p>3.1-19(b)</p>	K010070	<p>K070</p> <ol style="list-style-type: none"> <li>1. Noresidents were directly affected by this alleged deficiency.</li> <li>2. Allresidents had the potential to be affected by this alleged Deficiency.</li> <li>3. Heatingelement has been disabled from identified device, in main lobby, to ensurecompliance with regulatory standards.</li> <li>4.Maintenance Director or designee will utilize preventative maintenance roundsto ensure compliance. Reports will be reviewed in Quality Assurance Meetingmonthly x 3 months, and quarterly thereafter to ensure compliance.</li> <li>5. Complianceis assured by September 10, 2014.</li> </ol>	09/10/2014			
K010074 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure curtains in two of two areas were flame retardant. This deficient practice could affect any resident as well as visitors or staff in the main dining room or staff in the conference room.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 12:00 p.m. to 3:00 p.m. on 08/11/14, the set of curtains in the main dining room on the north wall and the sets of curtains on the east and west walls of the conference room lacked attached documentation indicating they were inherently flame retardant. Based on</p>	K010074	<p>K074</p> <ol style="list-style-type: none"> <li>No residents were directly affected by this alleged deficiency.</li> <li>All residents had the potential to be affected by this alleged Deficiency.</li> <li>Identified curtains, main dining room and conference room, have been removed and replaced with curtains that meet regulatory guidelines.</li> <li>Maintenance Director or designee will utilize preventative maintenance rounds to ensure compliance. Reports will be reviewed in Quality Assurance Meeting monthly x 3 months, and quarterly thereafter to ensure compliance.</li> <li>Compliance is assured by September 10, 2014.</li> </ol>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010075 SS=E	<p>interview at the time of observation with the Executive Director and the Plant Operations Director, there was no documentation regarding flame retardancy for the aforementioned curtains available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 70 resident rooms. This deficient practice could affect at least 10 residents as well as staff and visitors on the South Unit, A Hall.</p> <p>Findings include:</p> <p>Based on observation with the Executive</p>	K010075	<p>K075</p> <ol style="list-style-type: none"> <li>1. No residents were directly affected by thisalleged deficiency.</li> <li>2. Residentswho require isolation precautions are potentially affected by this allegeddeficiency.</li> <li>3.Maintenance Director or Designee will audit identified rooms weekly x 2 months,and quarterly thereafter to ensure regulatory compliance.</li> <li>4. Maintenance Director or designee willutilize preventative maintenance rounds to ensure compliance. Reports will bereviewed in Quality Assurance Meeting monthly x 3 months, and</li> </ol>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010130 SS=E	<p>Director and the Plant Operations Director on 08/11/14 at 12:35 p.m., two 28 gallon biohazardous containers filled with soiled linen or trash were adjacent to one another in resident room 124. Based on an interview at the time of observation, the Executive Director confirmed the containers were used for biohazardous waste and linen.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 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. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. 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</p>	K010130	<p>quarterlythereafter to ensure compliance.</p> <p>5.Compliance is assured by September 10, 2014.</p> <p>K130 1. Noresidents were directly affected by this alleged deficiency. 2. Allresidents had the potential to be affected by this alleged Deficiency. 3.Identified rolling fire door, kitchen area, will be inspected in compliancewith regulatory standards. 4. Maintenance Director or designee willutilize preventative maintenance rounds to ensure compliance. Reports will bereviewed in Quality Assurance Meeting monthly x 3 months, and quarterlythereafter to ensure compliance. 5.Compliance is assured by September 10, 2014.</p>	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/11/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010143 SS=E	<p>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 using the main dining room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Plant Operations Director during a tour of the facility from 12:00 p.m. to 3:00 p.m. on 08/11/14, the kitchen was provided with a rolling fire door protecting the opening between the kitchen and the service hall corridor and it did not have any attached inspection tags. Based on interview at the time of review and observation, the Executive Director and the Plant Operations Director acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the vertical rolling fire door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where oxygen transferring takes place was provided with continuous mechanical ventilation. This deficient practice could affect 20 of 92 residents.</p> <p>Finding include:</p> <p>Based on observation on 08/11/14 at 2:30 p.m. with the Plant Operations Director, the North Unit oxygen storage/transfer room was provided with a mechanically operated vent fan but it was not working. The fan was checked with a strip of tissue. Based on interview at the time of observation, the Plant Operations Director acknowledged the fan was not running continuously.</p>	K010143	K143 1. Noresidents were directly affected by this alleged deficiency. 2. 20residents had the potential to be affected by this alleged Deficiency. 3.Mechanical ventilation installed in identified area, oxygen room, to ensureregulatory compliance. 4. Maintenance Director or designee will utilizepreventative maintenance rounds to ensure compliance. Reports will be reviewedin Quality Assurance Meeting monthly x 3 months, and quarterly thereafter toensure compliance. 5.Compliance is assured by September 10, 2014.	09/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/11/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-19(b)				