

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155824	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/17/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637
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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: 11/17/15</p> <p>Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730</p> <p>At this Life Safety Code survey, the portion of Wellbrooke of South Bend which will be certified, the first floor, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical standards of the Indiana Health Facilities Rules for Comprehensive care facilities.</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two</p>	K 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusion set forth on the Statement of Deficiencies. The Plan of Correction is submitted in order to repsond to the allegation of noncompliance cited during the Annual survey. Please accept this Plan of Correction as credible allegation of compliance. The facility respectfully requests a desk review wiith paper compliance to be considered	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0025 SS=E Bldg. 01	<p>separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The facility has a fire alarm system with smoke detection in the corridor 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 rooms. The facility has a capacity of 70 and had a census of 43 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 11/19/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke</p>						

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	<p>barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 up to 19 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/17/15 at 1:30 p.m. then again at 1:33 p.m., the 200 Hall/ Main Entrance smoke barrier wall had nine unsealed penetrations above the ceiling tile measuring from 1/8 inch to 1/2 inch. Then again the 200 Hall had seven unsealed penetrations above the ceiling tile measuring from 1/8 inch to</p>	K 0025	<p>(1) 200 Hall/Main entrance smoke barrier wall all nine areas were sealed. 200 Hall seven unsealed areas were sealed. (2) All of the fire barrier walls were checked any deficiencies noted were corrected at that time. (3) Fire walls will be checked monthly. Smoke barrier walls will be check monthly. Director of Plant Operations will check areas monthly and document any findings. Director of Plant Operations will document findings and report findings to QA&A monthly for 90 days or until 100% compliance is obtained. (4) DPO will report finding to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. (5) Completion date: 12/17/15</p>	12/17/2015

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K 0044 SS=E Bldg. 01	<p>1/2 inch. Based on interview at the time of each observation, the Director of Plant Operations acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 14 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 11/17/15 at 12:00 p.m., the 100 Hall fire door to the stairwell enclosure to the exterior exit</p>	K 0044	<p>K044</p> <p>(1) 100 Hall fire door to the stairwell enclosure to exterior exit was adjusted.</p> <p>(2) All other exit fire door was checked any deficiencies noted were corrected at that time.</p> <p>(3) All other doors will be checked monthly and adjusted if required. Director of Plant Operations will document findings and report this to QA&A. DPO will report findings monthly for 90 days or until 100% compliance is obtained</p> <p>(4) DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of Correction as needed.</p>	12/17/2015

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K 0046 SS=D Bldg. 01	<p>was tested to self close and latch. When released, the door was stuck on the carpet and did not self close. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</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 7.9.18.2.9.1</p> <p>Based on record review and interview; the facility failed to ensure 6 of 6 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.</p>	K 0046	<p>(5) Completion date: 12/17/15</p> <p>K046</p> <p>(1) Annual 90 minute test was completed and logged.</p> <p>(2) Area was effective per the 2567.</p> <p>(3) 90 minute test was placed on monthly inspection sheet. DPO will run test monthly and document on the inspection sheet and report findings to QA&A monthly for 90 days or until 100% compliance is obtained.</p> <p>(4) DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of Correction as needed.</p>	12/17/2015

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K 0050 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 11/17/15 at 10:16 a.m., the facility provided 30 second monthly testing. Based on interview at the time of record review, the Director of Plant Operations was unaware that an annual 90 minute test was supposed to be performed and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all staff and residents.</p> <p>Findings include: Based on record review with the Director of Plant Operations of the fire drill</p>	K 0050	<p>(5) Completion date: 12/17/15</p> <p>K050</p> <p>(1) Fire Drill was missed for the 1st quarter of the year. No adverse effects were noted</p> <p>(2) Per 2567 all other fire drills were completed</p> <p>(3) Fire drills will be completed</p>	12/17/2015	

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	<p>reports titled "Fire Drill Report Form" on 11/17/15 at 10:16 a.m., the documentation for a third shift fire drill for the first quarter of 2015 was not available for review. Based on interview at the time of record review, the Director of Plant Operations acknowledged the lack of documentation.</p> <p>3.1-19(b)</p> <p>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> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations of the fire drill reports titled "Fire Drill Report Form" on 11/17/15 at 10:16 a.m., three sequential third shift fire drills took place between 4:15 a.m. and 5:45 a.m. for three of the last four quarters. No documentation was available for review for the first quarter third shift drill. Based on interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>monthly to ensure three sequential times. DPO will document fire drills and report findings to QA&A monthly for 90 days or until 100% compliance is obtained.</p> <p>(4) DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of Correction as needed.</p> <p>(5) Completion date: 12/17/15</p>		

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K 0069 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on record review and interview, the facility failed to maintain the range hood extinguishing system for cleaning in accordance with LSC Sections 9.2.3 and 19.3.2.6 and NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 4-3.3 requires exhaust fans with ductwork connected to both sides shall have access for cleaning and inspection within 3 ft (0.92 m) of each side of the fan. Additionally, NFPA 96, 4-8.2.2* requires fans shall be provided with safe access and a work surface for inspection and cleaning. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 11/17/15 at 10:39 a.m., the hood cleaning report by Hoosier Pressure Wash on 10/17/15 stated "NFPA 96 stats that all up blast fans and ducts replace proper access panels to properly clean duct & fan". Based on interview during the time of record review, the Director of Plant Operations</p>	K 0069	<p>K069 (1) The hood cleaning was completed on 11/18. (2) Area is now on a scheduled every 3 months. (3) DPO will ensure reports are being followed up on. Hoods will be on every 3 month schedule. DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. (4) DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of Correction as needed. (5) Completion date: 12/17/15</p>	12/17/2015			

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K 0130 SS=E Bldg. 01	<p>acknowledged the aforementioned condition and was unaware of the report deficiency statement.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview, the facility failed to ensure the water heaters in 6 of 6 boiler/water heaters had a current inspection certificate to ensure the water heaters were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 11/17/15 at 11:08 a.m., during record review documentation for water heater certificates were not available for review. Based on interview at the time of record review, the Director of Plant Operations acknowledged the missing documentation. Based on observation</p>	K 0130	<p>K130</p> <p>(1) Water heater certificates were obtained from vendor.</p> <p>(2) All water heaters were inspected</p> <p>(3) DPO will ensure the water heaters have certificates and located in the campus. DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained.</p> <p>(4) DPO will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendation to the Plan of Correction as needed.</p> <p>(5) Completion date: 12/17/15</p>	12/17/2015

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	<p>during the tour, six water heaters were observed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 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>		<p>K130</p> <p>(1) 200 Hall/Main entrance smoke barrier wall all nine areas were sealed. 200 Hall seven unsealed areas were sealed.</p> <p>(2) All of the fire barrier walls were checked any deficiencies noted were corrected at that time.</p> <p>(3) Fire walls will be checked monthly. Smoke barrier walls will be check monthly. Director of Plant Operations will check areas monthly and document any findings. Director of Plant Operations will document findings and report findings to QA&A monthly for 90 days or until 100% compliance is obtained.</p> <p>(4) DPO will report finding to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed.</p> <p>(5) Completion date: 12/17/15</p>	

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K 0144 SS=F Bldg. 01	<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 up to 20 residents plus occupants in the entry way.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Plant Operations on 11/17/15 at 1:25 p.m., the Entry way/ resident room fire barrier had four unsealed penetrations above the ceiling tile measuring from 1/8th inch to 1/2 inch.</p> <p>Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 generator</p>	K 0144	K144 (1) The monthly generator testing load bank has been	12/17/2015			

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	<p>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 Director of Plant Operations, the monthly generator testing indicated the highest amount of load put on the generator in twelve months was 24 percent. Based on interview at the time of record review, the Director of Plant Operations 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>scheduled for 12/16. (2) Generator load test is scheduled for 12/16. (3) Annual load bank testing will be done by contractor annually. DPO will report testing to the QA&A monthly for 90 days or until 100% compliance is obtained. (4) DPO will report finding to QA&A monthly for 90 days or until 100% compliance is obtained. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. (5) Completion date: 12/17/15</p>		