

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2015
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NAME OF PROVIDER OR SUPPLIER  MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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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: 06/04/15</p> <p>Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500</p> <p>At this Life Safety Code survey, Michiana Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies.</p> <p>This one story facility built in 2010 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 spaces open to the corridors with hard wired smoke detectors in all the resident sleeping rooms. The facility has a capacity of 100 and had a census of 88 at</p>	K 0000		

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 0027 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for an eight by ten foot wood shed used for storage.</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 1¾-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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors were self closing and would restrict the movement of smoke for at least 20 minutes. This deficient practice could affect 26 residents in the 300 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/04/15 at 11:50 a.m., the smoke barrier door set between the 300 hall and service</p>	K 0027	Residents in this unit have been addressed with the repair to this door. All other doors have been inspected to ensure they have not been compromised by shifting structures. All Fire Doors will be inspected for proper and unimpeded closure monthly as part of routine maintenance rounds. Any discrepancy will be addressed immediately: work will be scheduled or immediate repairs will be made if they can be done internally. The Maintenance Director will bring records of rounds to Quality Assurance/Performance Improvement (QAPI) meetings for	07/04/2015

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K 0050 SS=F Bldg. 01	<p>hall would not self close due to the door catching on the floor. This caused the door to remain fully open. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.</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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:  Based on record review of the "Fire Drill Report" with the Maintenance Director</p>	K 0050	<p>six months and at least quarterly thereafter for review by the Administrator and committee members. Issues identified will be addressed at this time with immediate actions taken to correct any identified safety concerns.</p> <p>Resident safety has been assured with timely fire drills. Drills were conducted several times each quarter but the timing of this particular one was about 30 minutes too early. Drills on each shift will be conducted timely. Fire drills are now scheduled in advance with facility Administrator oversight to facilitate a strategically timed sequence each quarter. To preclude conducting one at a shift change, when the targeted shift</p>	07/04/2015

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K 0064 SS=E Bldg. 01	<p>on 06/04/15 at 10:00 a.m., there was no record of a second shift fire drill for the first quarter of 2015. Based on an interview during record review, the Maintenance Director stated no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to inspect 8 of 30 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no</p>	K 0064	<p>will not have sufficiently arrived and started work, they will be appropriately staggered. The Maintenance Director will bring records of Fire Drills to Quality Assurance/Performance Improvement (QAPI) meetings for six months and at least quarterly thereafter for review by the Administrator and committee members. Issues identified will be addressed at this time with immediate actions taken to correct any identified safety concerns.</p> <p>Resident safety has been assured with the timely and comprehensive inspection of all of these identified extinguishers. All were fully serviceable. All extinguishers in the facility have been inspected. The Maintenance Director will utilize a location specific checklist in extinguisher inspection rounds to ensure none are missed. The identified issue was that rounds had been interrupted and he lost track of where he left off in the inspection. Using the location specific checklist will ensure that interruptions will not cause missed extinguisher checks. The Maintenance Director will bring records of Fire Extinguisher Checks, including this location</p>	07/04/2015			

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K 0066 SS=E Bldg. 01	<p>obvious or physical damage or condition to prevent its operation. This deficient practice could affect 50 residents within the facility.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Maintenance Director on 06/04/15 between 10:30 a.m. and 1:00 p.m., the monthly inspection tag on the fire extinguisher in the following locations lacked documentation of a monthly inspection for the month of May of 2015.</p> <p>a.) three in the 400 hall b.) two in the service hall c.) two in the 300 hall d.) one in the therapy room</p> <p>Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location,</p>		<p>specific checklist, to Quality Assurance / Performance Improvement (QAPI) meetings for six months and at least quarterly thereafter for review by the Administrator and committee members. Issues identified will be addressed at this time with immediate actions taken to correct any identified safety concerns.</p>	

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	<p>and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>Based on observation, records review, and interview, the facility failed to follow 1 of 1 smoking policies and ensure cigarette butts were deposited into a noncombustible container in areas where smoking was obvious. This deficient practice would not have directly affected residents but could affect staff utilizing the employee entrance and the electrical room door.</p> <p>Findings include:</p> <p>Based on records review of the policy titled "IN Region Smoking Policy" with the Maintenance Director and the Administrator on 06/04/15 at 1:00 p.m. the policy stated smoking was allowed in designated areas, but the field for the designated area was left blank. Based on interview at 1:00 p.m., the Administrator</p>	K 0066	Smoking violations are being monitored in a more aggressive manner with infractions resulting in disciplinary action. No residents were affected by this citation. All staff has been given additional notice that smoking is not permitted on these premises and that violating this rule will result in progressive disciplinary action up to and including termination of employment. Any butt containers found on the property have been removed and discarded. Daily (M-F) rounds of outside areas will be conducted by the Maintenance Director and Housekeeping Supervisor. Any found cigarette butts are to be immediately cleaned up and locations found reported to the facility Administrator at daily Stand Up meeting the next workday. Anyone found smoking on this property will be given a progressive disciplinary write ups,	07/04/2015

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K 0076 SS=E Bldg. 01	<p>stated "This facility is a no smoking campus. That is why there is no designated smoking area stated in the policy, but employees can smoke in their cars because it is their personal property." Based on observation at 12:13 p.m., the ground around the concrete parking area adjacent to the emergency generator and employee entrance was littered with 50 plus cigarette butts. Also, outside of the electrical room door there was a long neck noncombustible container for cigarette butts with 10 plus cigarette butts on the ground around container and in the mulch adjacent to the door. The Maintenance Director acknowledged the facility staff disposed of cigarette butts on the ground at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 electrical</p>	K 0076	<p>that can result in termination of employment. The Maintenance Director will report to Quality Assurance / Performance Improvement (QAPI) meetings monthly for six months and at least quarterly thereafter to ensure compliance with smoking policies. Issues identified will be addressed at this time with immediate actions taken to correct any identified safety concerns.</p> <p>The switch was moved up to not less than five feet above the floor.</p>	07/04/2015			

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K 0147 SS=D	<p>outlets in the oxygen storage room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice was not in a resident treatment area but could affect any staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director at 12:06 p.m. on 05/04/15, there was one electrical outlet, a light switch, on the wall in the oxygen storage room 46 inches above the floor of the oxygen storage room located on the service hall. Based on interview at the time of observation, the Maintenance Director acknowledged the electrical outlet on the wall was less than five feet above the floor in the oxygen storage room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		No residents were affected by this citation. This is an isolated and solitary closet. No other oxygen storage is on the premises. There is nothing to monitor beyond relocating this light switch.				

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Bldg. 01	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. 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 could affect up to two residents in the Director of Nursing Office.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Director on 06/04/15 at 11:30 a.m., there was a microwave, a high current draw appliance, supplied with electricity by an extension cord power strip in the Director of Nursing office. Based on interview at the time of observation, the Maintenance Director acknowledged a microwave was supplied electricity by an extension cord power strip.</p> <p>3.1-19(b)</p>	K 0147	The microwave was plugged directly into a wall outlet. No residents were affected by this citation. The Maintenance Director will check all rooms routinely during safety rounds to ensure that appliances are plugged in appropriately. The Maintenance Director will bring records of rounds to Quality Assurance/Performance Improvement (QAPI) meetings for six months and at least quarterly thereafter for review by the Administrator and committee members. Issues identified will be addressed at this time with immediate actions taken to correct any identified safety concerns.	07/04/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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