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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/20/2013 |
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| NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617 |
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| K010000 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/20/13</p> <p>Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist; Liberty Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Cardinal Nursing 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This three story facility with a basement was determined to be of Type II (111) construction with a one story addition determined to be of Type V (111) construction and both were fully</p> | K010000 | The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. | |

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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| | <p>sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 144 with a census of 111 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the followin:</p> | | | | |

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| K010018 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 75 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 12 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., resident room door 321 would not latch in its frame. Based on interview at the time of observation, the Maintenance Director acknowledged the door to resident room 321 would not latch in its frame.</p> <p>3.1-19(b)</p> | K010018 | <p>K018 It is the policy of this facility that resident room doors are provided with a means suitable for keeping the door closed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Appropriate repairs were immediately made to ensure that resident room 321 door latches properly into its frame. 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 alleged deficient practices had the potential to affect 12 residents on the third floor. The Maintenance Director and/or designee inspected all resident room doors throughout the facility and verified that all resident room doors latch</p> | 12/20/2013 | | | |

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| | | | properly into their respective frames. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping employees will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states all resident room doors must latch properly into its respective frame. Housekeepers and/or maintenance personnel will check daily that resident room doors latch properly into their respective door frames throughout the facility. Any issues noted during daily checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Resident Door Inspections" weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 98% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be | |

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| K010020 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection of 4 of 5 exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect any resident or staff using the stairwells.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the following was noted:</p> <ol style="list-style-type: none"> 1. The west first floor stairwell door lacked a door label indicating a fire resistance rating. 2. The east first floor stairwell door lacked a door label indicating a fire resistance rating. 3. The west second floor stairwell door lacked a door label indicating a fire resistance rating. 4. The north second floor stairwell door lacked a door label indicating a fire | K010020 | <p>It is the policy of this facility that stairwell enclosures maintain a minimum one hour fire resistance rating which is verifiable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the west first floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the west first floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the west first floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 2. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the east first floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the east first</p> | 12/20/2013 |

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| | <p>resistance rating.</p> <p>5. The north third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>6. The south third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>7. The east third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>Based on interview during the observations, the Maintenance Director acknowledged the stairwell doors missing fire door labels and indicated documentation showing the stairwell exit doors providing at least one hour fire resistance rating was not available.</p> <p>3.1-19(b)</p> | | <p>floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the east first floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 3. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the west second floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the west second floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the west second floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 4. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the north second floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the north second floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the north second floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling</p> | | |

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| | | | <p>requirements. 5. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the north third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the north third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the north third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 6. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the south third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the south third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the south third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 7. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the east third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately</p> | | |

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| | | | appropriately label the east third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the east third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 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 alleged deficient practice had the potential to affect any residents or staff using the stairwells. The Maintenance Director and/or designee inspected all stairwells throughout the facility and verified that either: (1) all vertical opens have appropriate doors with verifiable labels attached thereto or (2) such vertical opening doors will be tested by Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label any applicable vertical door(s), if indicated, (verifying the fire resistance rating will meet code requirements). If for any reason any applicable vertical opening door(s) are not appropriately labeled, new vertical opening door(s) will be purchased which meet all code and labeling requirements. What measures will be put into place or what systemic changes will be made to | |

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| | | | ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states that stairwell enclosures must maintain a minimum one hour fire resistance rating and must be appropriately labeled as such, without fail. Following any stairwell construction, installation, or stairwell repair work which has the potential to compromise a one hour fire resistance rating of vertical door openings, the Director of Maintenance/designee shall physically inspect said construction site, installation, repair work or vertical opening doors and ensure that any potential or actual applicable vertical opening door(s) will continue to be appropriately labeled without fail. New vertical opening door(s) will be purchased which meets all code and labeling requirements if or when indicated, necessary or applicable. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Stairwell Door Fire Rating Identification" weekly for 4 weeks and then | | |

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| | | | monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |

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| K010025 SS=E | <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, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 10 smoke barriers were protected to maintain the smoke 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 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 30 residents 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 on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., there were</p> | K010025 | It is the policy of this facility that openings through barriers are protected to maintain the smoke resistance of each smoke barrier and 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. The first floor north wing smoke barrier which allegedly had a four by four inch square opening through the drywall smoke barrier above the ceiling tile above the sink in the north wing dining room is properly sealed. The cold and hot water line allegedly running through the opening is properly sealed. b. The second floor north wing smoke barrier with two alleged penetrations are properly sealed with an approved material. c. The third floor north wing smoke | 12/20/2013 | | | |

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| | <p>exposed penetrations through the smoke barriers above the ceiling tiles at the following locations which were not firestopped or sealed with expandable foam which is not an approved material for maintaining the smoke resistance of a smoke barrier:</p> <p>a. The first floor north wing smoke barrier had a four by four inch square opening through the drywall smoke barrier above the ceiling tile above the sink in the north wing dining room which was not sealed. There was a cold and hot water line running through the opening.</p> <p>b. The second floor north wing smoke barrier had at least two penetrations sealed with expandable foam</p> <p>c. The third floor north wing smoke barrier had at least two penetrations sealed with expandable foam.</p> <p>Based on interview during the times of observation, the Maintenance Director acknowledged the unprotected opening and use of expandable foam at the smoke barriers.</p> <p>3.1-19(b)</p> | | <p>barrier with two alleged penetrations are properly sealed with an approved material. 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 alleged deficient practice had the potential to affect up to a maximum of 30 residents as well as potentially affect staff and visitors. The Maintenance Director and/or designee physically inspected all smoke barriers above ceiling tiles throughout the facility and verified all such locations are fire-stopped or sealed with an approved material capable of maintaining appropriate smoke resistance of the smoke barrier or is protected by approved device(s) designed for the specific purpose. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states openings through barriers must be protected to maintain the smoke resistance of each smoke barrier. Following any stairwell construction, installation, or stairwell repair work which has the potential to cause structural</p> | | |

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| | | | penetrations or otherwise compromise a one hour fire resistance rating, the Director of Maintenance/designee shall physically inspect said construction site, installation or repair work and ensure that any potential or actual structural penetrations are appropriately sealed with an acceptable product which maintains a one hour fire rating. The ED will make additional random spot checks to ensure compliance. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Post Construction Repair Inspection" following any construction, renovation or repair project(s) weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |

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| K010029 SS=E | <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 the doors to 3 of 10 hazardous areas automatically closed and latched into their door frames. Doors to hazardous areas are required to automatically latch in the door frame when closed to keep the door tightly closed. These deficient practices affects at least 10 residents and staff throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the following was noted:</p> <p>a. The basement laundry room had a set of double doors which do not automatically latch. The leading door had a manual flush bolt that had to be manually latched before the</p> | K010029 | It is the policy of this facility that corridor doors to hazardous areas are provided with a self-closing device which will cause doors to automatically close and latch into their door frames. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. An appropriate self-closing latching device has been ordered and installed for the basement laundry room double doors so that the doors will automatically close and completely latch into its frame. b. An appropriate self-closing latching device is installed on the first floor shower room door so that the door will automatically close and completely latch into its frame. c. An appropriate self-closing latching device is installed on the second floor central supply door so that the door will automatically close and completely latch into its | 12/20/2013 | | | |

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| | <p>secondary door would latch into the leading door. Based on interview at the time of observation, the Maintenance Director acknowledged the basement laundry doors did not automatically latch into the frame.</p> <p>b. The first floor shower room was provided with a door closer but not a door latching device. The shower room had three, 32 gallon size containers full of soiled linen stored in the shower room. Based on interview at the time of observation, the Maintenance Director acknowledged the shower room was used for storage of soiled linen and the shower room door lacked a latching device.</p> <p>c. The second floor central supply room door was provided with self closing hinges but they did not completely close the door in order for the door to latch into the frame. The central supply room exceeded 50 square feet in size and was used for the storage of combustible materials such as cardboard boxes. Based on interview at the time of observation, the Maintenance Director acknowledged the second floor central supply room was used for storage of combustible materials and the spring loaded hinges on the door needed adjustment in order to close and latch properly.</p> <p>3.1-19(b)</p> | | <p>frame. 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 alleged deficient practice had the potential to affect at least 10 residents and staff throughout the facility. The Maintenance Director and/or designee inspected all corridor doors leading into hazardous areas throughout the facility and verified that all such doors have a self-closing device which will cause such doors to automatically close and latch completely into their respective door frames. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping employees will be conducted on or before 05/19/13 by the ED/Maintenance Director/designee. This in-service will include the topic that all corridor doors to hazardous areas must be equipped with a self-closing device which will cause doors to automatically close and latch completely into their door frames. Not less than monthly, as part of the facility preventative maintenance, the Director of Maintenance/designee shall physically inspect and ensure that that corridor doors to hazardous areas are provided with self-closing devices which will cause doors to automatically</p> | |

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| | | | close and latch completely into their respective door frames. Any issues noted during monthly checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Corridor Doors – Hazardous Areas" weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |

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| K010033 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection of 4 of 5 exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect any resident or staff using the stairwells.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the following was noted:</p> <ol style="list-style-type: none"> 1. The west first floor stairwell door lacked a door label indicating a fire resistance rating. 2. The east first floor stairwell door lacked a door label indicating a fire resistance rating. 3. The west second floor stairwell door lacked a door label indicating a fire resistance rating. 4. The north second floor stairwell door lacked a door label indicating a fire | K010033 | <p>It is the policy of this facility that stairwell enclosures maintain a verifiable minimum one hour fire resistance rating and are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the west first floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the west first floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the west first floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 2. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the east first floor</p> | 12/20/2013 | | | |

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| | <p>resistance rating.</p> <p>5. The north third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>6. The south third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>7. The east third floor stairwell door lacked a door label indicating a fire resistance rating.</p> <p>Based on interview during the observations, the Maintenance Director acknowledged the stairwell doors missing fire door labels and indicated documentation showing the stairwell exit doors providing at least one hour fire resistance rating was not available.</p> <p>3.1-19(b)</p> | | <p>stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the east first floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the east first floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 3. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the west second floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the west second floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the west second floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 4. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the north second floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the north second floor stairwell door indicating the fire resistance rating which will meet code</p> | | |

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| | | | <p>requirements. If for any reason the north second floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 5. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the north third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the north third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the north third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 6. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been engaged to test the south third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the south third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the south third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 7. Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) has been</p> | | |

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| | | | <p>engaged to test the east third floor stairwell door on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label the east third floor stairwell door indicating the fire resistance rating which will meet code requirements. If for any reason the east third floor stairwell door is not appropriately labeled, a new door will be purchased which meets all code and labeling requirements. 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 alleged deficient practice had the potential to affect any residents or staff using the stairwells. The Maintenance Director and/or designee inspected all stairwells throughout the facility and verified that either: (1) all vertical opens have appropriate doors with verifiable labels attached thereto or (2) such vertical opening doors will be tested by Guardian Fire Testing Laboratories, Inc. (www.firetesting.com) on 12/10/2013. Following appropriate testing, Guardian Fire Testing Laboratories, Inc will immediately appropriately label any applicable vertical door(s), if indicated, (verifying the fire resistance rating which will meet code requirements). If for any reason any applicable vertical opening door(s) are not appropriately</p> | |

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| | | | <p>labeled, new vertical opening door(s) will be purchased which meets all code and labeling requirements. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states that stairwell enclosures must maintain a minimum one hour fire resistance rating and must be appropriately labeled as such, without fail. Following any stairwell construction, installation, or stairwell repair work which has the potential to compromise a one hour fire resistance rating of vertical door openings, the Director of Maintenance/designee shall physically inspect said construction site, installation, repair work or vertical opening doors and ensure that any potential or actual applicable vertical opening door(s) will continue to be appropriately labeled without fail. New vertical opening door(s) will be purchased which meets all code and labeling requirements if or when indicated, necessary or applicable. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p> | |

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| | | | put into place: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, " Stairwell Door Fire Rating Identification" weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |

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| K010038 SS=E | <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>1. Based on observation and interview, the facility failed to ensure 4 of 6 means of egress exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice has the potential to affect 32 alert and oriented residents without a diagnosis for specialized security measures, visitors, and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., all exit doors were magnetically locked and could be opened by entering a code. The code for the doors entering and exiting the</p> | K010038 | <p>It is the policy of this facility exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Appropriate signs have been ordered and are posted for the egress side of 4 of 6 egress exits with instructional keys describing the exit codes for residents without a clinical diagnosis requiring specialized security measures. 2. The Community Resource room has one-single action unlatching device installed on the door. 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 alleged deficient practice had the potential to affect 32 of the 81 residents not housed within the Cottage Unit (Alzheimer's) and/or any residents, staff or visitors using the Community Resource Room. The Maintenance Director and/or designee physically inspected egress exits (Cottage Unit excepted) throughout the facility and appropriate signs have been ordered for the egress side with instructional keys</p> | 12/20/2013 |

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| | <p>Cottage Unit (Alzheimer) is not required to be posted, however, the remaining magnetically locked exit doors throughout the facility lacked a posted code or instructions describing the code. Based on interview at the time of observation with the Social Service Director, 32 of the 81 residents not housed within the Cottage unit are alert and oriented but do not have access to the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit access in 1 of 1 doors for the Community Resource room was arranged to be readily accessible in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is that the method of release be one that is familiar to the average person. Generally, a two step release such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect any resident, staff or visitor using the Community Resource</p> | | <p>describing the exit codes for residents without a clinical diagnosis requiring specialized security measures. The Maintenance Director and/or designee physically inspected all doors throughout the facility and has ensured that all doors are arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for general staff will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy that states that exit access is arranged throughout the facility so that exits are readily accessible at all times in accordance with section 7.1 19.2.1. Instructional keys describing the intended purpose for exit codes for individuals without a clinical diagnosis requiring specialized security measures will be reviewed. In addition single action unlatching devices on doors will be reviewed including that the method of operation of its releasing device must be obvious, even in the dark. 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</p> | | | | |

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| | <p>room.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the Community Resource room on the second floor was provided with a door handle with a thumb turn latch and an independent dead bolt. Based on interview at the time of observation, the Maintenance Director acknowledged the latching device would require a two step release.</p> <p>3.1-19(b)</p> | | <p>into place: The Maintenance Director/designee will be responsible for completing the CQI Audit Tool titled, "Unlatching Door Devices" weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/20/2013 |
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| NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617 |
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| K010056 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains are provided were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems in 3 of 5 shower rooms. This deficient practice could affect any resident or staff using the shower rooms.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the Cottage, third floor north and third floor west shower rooms were provided with sprinkler heads but had shower curtains hung from the ceiling with no 1/2 inch diagonal mesh or a 70 percent open</p> | K010056 | <p>K056 In accordance with NFPA 13, it is the policy of this facility that the facility sprinkler system provide complete coverage for all portions of the building. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. New shower curtains have been ordered and installed for the third floor north and the third floor west shower rooms. The new showers curtains will contain a 1/2 diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector to ensure that the cubicle curtains do not block the coverage of the sprinkler heads. 2. The bi-fold doors in the in the basement medical records room was immediately removed to ensure that the medical records room closet receives</p> | 12/20/2013 |
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| | <p>weave top panel extending 18 inches below the sprinkler deflector. Areas of the shower room were not provided with sprinkler protection with all the shower curtains pulled close. Based on interview at the time of observation, the Maintenance Director acknowledged when closed, the cubicle curtains in the shower room blocked the coverage of the sprinkler heads.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 closets in the basement medical records room. This deficient practice affects staff using the basement medical records room.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., a closet with bifold doors in the basement medical records room lacked a sprinkler head to provide sprinkler coverage. Based on interview at the time of observation, the Maintenance Director acknowledged the basement medical records closet lacked a sprinkler head.</p> | | <p>appropriate coverage of the sprinkler heads. 3. The sprinkler head in the nourishment pantry was moved a minimum of 4 inches from the wall. 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 alleged deficient practice had the potential to any resident or staff using the shower rooms and/or staff using the basement medical records room and/or staff using the first floor nourishment pantry behind the nurses' station. The Maintenance Director and/or designee inspected all cubicle curtains in shower rooms and throughout the facility to ensure that all such curtains contain a ½ diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector to ensure that the cubicle curtains do not block the coverage of the sprinkler heads. Any cubical curtain(s) not conforming to these requirements were or will be replaced immediately upon receipt of new cubicle curtain shipment. The Maintenance Director and/or designee inspected all rooms throughout the facility to ensure that there are no closet doors or other impediments which prevent complete coverage of the sprinkler system for all portions of the building. The Maintenance Director and/or designee</p> | | |

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| | <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the automatic sprinkler system, was installed in accordance with NFPA 13, The 1999 Edition Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 5-6.3.3 requires sprinklers be located a minimum of 4 inches from a wall. This deficient practice could affect any staff using the first floor nourishment pantry behind the nurses station.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the first floor nourishment pantry had a sprinkler head that was one inch from the wall. Based on interview at the time of observation, the Maintenance Director acknowledged the sprinkler head in the nourishment pantry was one inch from the wall.</p> <p>3.1-19(b)</p> | | <p>inspected every sprinkler throughout the facility and validated that all sprinkler heads are located a minimum of four (4) inches from a wall. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance and housekeeping employees will be conducted on or before 12/20/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy that the facility sprinkler system must provide complete coverage for all portions of the building without impediments. Not less than monthly, the Director of Maintenance, Director of Housekeeping or designee shall physically inspect each cubicle curtain and ensure that all such curtains contain a ½ diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector to ensure that the cubicle curtains do not block the coverage of the sprinkler heads. Not less than monthly, the Maintenance Director and/or designee shall inspect every room throughout the facility to ensure that there are no closet doors or other impediments which prevent complete coverage of the sprinkler system for all portions of the building. In additional, following any room construction</p> | | | | |

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| | | | or renovation which has the potential to compromise sprinkler system coverage, the Director of Maintenance/designee shall physically inspect said construction site or room. S/he shall ensure that the sprinkler system continues to provide complete coverage for all portions of the building without impediments and that sprinkler heads are located a minimum of four inches from a wall. Any issues noted during monthly checks will be immediately reported to the ED/designee and corrected immediately. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Sprinkler System Coverage" for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |

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| K010072 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are 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 obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 1 of 6 exits. This deficient practice could affect at least 25 residents as well as staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the set of first floor west exterior exit doors required excessive force to open. Based on interview at the time of observation, the Maintenance Director acknowledged the doors were difficult to open and tried removing the attached rubber sweep at the bottom of the doors but the doors were still difficult to open.</p> <p>3.1-19(b)</p> | K010072 | <p>It is the policy of this facility means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A new first floor west exterior double door set has been ordered and installed. 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 alleged deficient practices had the potential to affect 25 residents as well as staff and visitors throughout the facility. The Maintenance Director and/or designee inspected all exterior exit doors throughout the facility and verified that all such doors operate properly with ease and are free of impediments to full instant use, in case of fire or other emergency. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service with general</p> | 12/20/2013 | |

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| | | | staff will be conducted on or before 12/19/13 by the ED/Maintenance Director/designee. This in-service will include a review of the facility policy which states all means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Housekeepers and/or maintenance personnel will check daily that all means of egress are continuously maintained free of all obstructions or impediments to full instant use, in the case of fire or other emergency. Any concerns/issues noted during daily checks will be immediately reported to the Maintenance Director/designee and corrected immediately. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Egress Door Maintenance" weekly for 4 weeks and then monthly for 6 months. This audit will be reviewed by the ED. If a threshold of 100% each is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | |

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| K010144 SS=C | <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.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the generator annunciator panel was hanging by wires upside down under the first floor nurses' station counter and the "test" toggle switch was broken off. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned conditions with the</p> | K010144 | <p>It is the policy of this facility that documentation is readily available which validate that generators are inspected weekly and exercised under load for 30 minutes per month and that any device, equipment, or system required for compliance shall be continuously and properly maintained. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. The generator's remote annunciator "test" toggle switch has been repaired. In addition, the generator annunciator panel has been moved to a highly visible location readily observed by operating personnel at the nurse' station and is positioned in an upright and proper manner. b. The Maintenance Director/designee has been re-educated regarding acceptable and proper documentation requirements which will provide sufficient information to meet the requirements of NFPA 110. Specific re-education focused on the load percentage documentation requirements. How other residents having the potential to be affected by the same deficient practice will be</p> | 12/20/2013 | | | |

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| | <p>generator remote annunciator.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 6-4.2. for 6 of 12 months. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> | | <p>identified and what corrective action(s) will be taken: The alleged deficient practice had the potential to affect all residents, staff and visitors. The Maintenance Director and/or designee inspected and devices, equipment, or systems associated with the generator and ensured as all such devices, equipment and systems are functioning in proper working order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for all maintenance employees will be conducted on or before 05/19/13 by the ED/Maintenance Director/designee. This in-service will include a detailed review of the policy that documentation is readily available which validates that generators are inspected weekly and exercised under load for 30 minutes per month and that any device, equipment, or system required for compliance shall be continuously and properly maintained. Not less than weekly, as part of the facility preventative maintenance program, the Director of Maintenance/designee shall physically inspect and ensure generators are inspected and exercised under load for 30 minutes per month and that any device, equipment, or system required for compliance shall be continuously and properly</p> | | |

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| | <p>Findings include:</p> <p>Based on review of the "Emergency Generator -Weekly Exercise/ Monthly Load Test Log" with the Maintenance Director during record review from 8:30 a.m. to 10:00 a.m. on 11/20/13, monthly load testing was documented with measurements but did not provide sufficient information to meet the requirements of NFPA 110 in that the load percentage for the monthly generator load test was not documented. Based on interview during the time of record review, the Maintenance Director acknowledged the load percentage for the monthly generator load tests were about 89 percent but it was not documented.</p> <p>3.1-19(b)</p> | | <p>maintained. The ED/designee shall review such documentation and make unannounced physical spot checks to ensure full compliance. Any issues noted during weekly checks will be addressed and corrected immediately. 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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Facility Generator Systems and Documentation" weekly for 4 weeks and then monthly for six months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013.</p> | | |

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| K010147 SS=B | <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 electrical connections, flexible cords and multiplug adapters were maintained in a safe operating condition and not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the basement.</p> <p>Findings include:</p> <p>Based on observation on 11/20/13 with the Maintenance Director during the tour from 10:00 a.m. to 1:45 p.m., the following was noted:</p> <p>a. Power cords for two transformers that were plugged into an extension cord cord providing power to the main phone board in the basement # 1 mechanical room were spliced together and wrapped in electrical tape. The cord was not plugged in at the time of observation and was</p> | K010147 | <p>It is the policy of this facility that electrical wiring and equipment comply with all federal, state and local codes and ordinances.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. Power cords for two transformers which were allegedly plugged into an extension cord providing power to the main phone board in the basement #1 mechanical room have been removed and wiring properly repaired. b. The extension cord in the Environmental Services room was immediately removed. c. The extension cord in the basement laundry room was immediately removed. 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 alleged deficient practice had the potential to affect staff in the basement. The Maintenance Director and/or designee inspected each room throughout the facility and ensured that extension cords have been removed and any potential wiring issue or concern has been corrected according to code requirements. What measures</p> | 12/20/2013 | | | |

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| | <p>acknowledged by the Maintenance Director.</p> <p>b. A floorwasher in the basement Environmental Services room was plugged into the wall with an extension cord and was not in use.</p> <p>c. A radio in the basement laundry was plugged into the wall with an extension cord.</p> <p>Based on interview, the aforementioned conditions were acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> | | <p>will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory in-service for general staff will be conducted on or before 05/19/13 by the ED/Maintenance Director/designee. In addition, meetings will be held with residents during resident council and families during family meetings. These educational sessions will include a review of the facility policy which forbids the use of extension cords in the facility. Following any new facility wiring project, the Director of Maintenance/designee shall physically inspect said project to identify any potential electrical wiring concerns and take immediate action to have any potential issues resolved, if applicable. Housekeepers and/or maintenance personnel will check throughout the facility not less than weekly that extension cords are not in use anywhere in the building. Any infractions will be corrected immediately and reported to the ED for follow-up.</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 Director/designee will be responsible for completing the CQI Audit Tool titled, "Wiring and Electrical Compliance" weekly for 4 weeks and then monthly for six</p> | | |

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| NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617 | | |
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| | | | months. This audit will be reviewed by the ED. If a threshold of 100% is not met, action plan(s) will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/20/2013. | | |