

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 01/10/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/20/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/10/14</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 PSR survey, Cardinal Nursing and Rehabilitation Center was found in substantial 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</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.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>determined to be of Type V (111) construction and both were fully 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 113 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 01/16/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements.</p>				

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K010072 SS=C	<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, review 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 and interview on 01/10/14 with the Maintenance Director during the tour from 9:00 a.m. to 10:15 a.m., the set of first floor west exterior exit doors which had required excessive force to open had not yet been replaced. Additionally based on interview and record review, the Maintenance Director and Administrator provided documentation the doors had been ordered through the door contractor, but there was a delay in delivery to the facility and the facility had just got notification the doors had been delivered to the contractor and were awaiting</p>	K010072	<p>K072 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 arrived and was properly installed on 01/16/2014. 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 for</p>	01/24/2014			

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	<p>scheduling of installation.</p> <p>This deficiency was cited on 11/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		<p>employees will be conducted on or before 01/24/14 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 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: 01/24/2014.</p>		