STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155804	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000		K010000		

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).

Survey Date: 04/10/14

Facility Number: 013017
Provider Number: 155804
AIM Number: N/A

Surveyor: Bridget Brown, Life Safety Code Specialist

At this Life Safety Code survey, Sprenger Health Care of Mishawaka was found not in compliance with Requirements for Participation in Medicare, 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 410 IAC 16.2.

This one story facility was determined to be of Type V (111) construction and was fully sprinklered except for the areas cited at K56. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors with hard wired smoke detectors in the resident sleeping rooms. The facility has a capacity of 70 and had a census of 40 at the time of this survey.

All areas accessible to residents were sprinklered except those cited at K56. Areas providing facility services were sprinklered.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency 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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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544	

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	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/15/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 7 smoke compartments in a one story building of Type V (III) construction. LSC 18.1.6.2 requires one story facilities of Type V (III) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 30 or more residents in the smoke compartment with the dining rooms. Findings include: Based on observation on 04/10/14 at 1:55 p.m. with the maintenance director, sprinkler protection was not provided for the three foot by six foot by four foot fireplace alcove which was open to the two dining rooms. The maintenance director acknowledged at the time of observation, the area was not protected by other sprinklers in the rooms. 3.1-19(b) 3.1-19(ff)	K010012	1. The sprinkler head has been installed in the alcove area around the electric fire place. There were no residents affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The maintenance department has been educated on the life safety code as it relates to adequate skrinler coverage by 5/10/14 4. The maintenance supervisor will perform audits on the sprinklers monthly. Monthly audits will be forwarded to the QA&A committee for review, These audits will be reported monthly for a period of 6-months until compliance is achieved. 5. Date of compliance 5/10/14	05/10/2014
K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke.			

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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544	

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	Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 7 smoke compartments were equipped with positive latches which latched into their door frames. This deficient practice affects staff, visitors and 30 or more residents in the smoke compartment housing the dining rooms, activities and Rehab services. Findings include: a. Based on observation with the maintenance director on 04/10/14 at 1:45 p.m., a swinging double door set provided access between the kitchen and dining rooms. The dining rooms were open to the corridor. The doors to the fully equipped kitchen, including a fryer, had no automatic latch to secure it into the door frame. The doors could be secured by turning a deadbolt latch. The maintenance director acknowledged at the time of observation, the doors would not automatically latch securely into the door frame. b. Based on observation with the maintenance director on 04/10/14 at 1:40 p.m., a double door set provided access between the community room and exit corridor. The doors were equipped with latches which had been locked in the open position to allow the doors to open without disengaging the latches. The only means to latch the doors required a key. The maintenance director acknowledged at the time of observation, the doors could not be	K010018	1. The dietary doors have had an automatic latch applied to meet this requirement. The community room doors have had been replaced to ensure proper latching. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The maintenance department have been educated on the life safety requirement as it relates to automatic door latches. 4. The Maintenance Director will perform audits on facility doors monthly. Results of those audits will be forwarded to QA&A monthly for 6-months and quarterly thereafter until compliance is acheived. 5. Date of Compliance 5-10-14	05/10/2014

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	155804		04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

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	latched without using a key.			
K010022 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 double door sets accessing the service corridor which could likely be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit, nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: NO exit. This deficient practice affects staff, visitors and 10 or more residents in the 100 and 200 hall smoke compartments. Findings include: Based on observation with the maintenance director on 04/10/14 at 2:25 p.m., the Main Street exit corridor was accessible from the 100 and 200 sleeping room smoke compartments. The path of egress from these smoke compartments had an illuminated exit sign with an arrow to direct evacuees into the Main Street corridor to exit from doors in the common activity smoke compartment. Below, and just beyond this exit sign, two doors with glass panels led into the service corridor. Another illuminated exit sign was visible in the natural line of sight through the vision panels. The maintenance director agreed at the time of observation, the doors could be mistaken for a means of exit.	K010022	1. The service hall double doors have had a NO EXIT sign placed on the door to ensure those doors are not mistaken as an exit. There were no residents directly affected by the alleged deficient practice. 2. Residents and/or visitors have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the life safety requirement as it relates to exit areas by 5-10-14 4. The Maintenance Director will perform monthly audits of exit areas for 6 months. The results of those audits will be forwarded to the QA&A committee monthly for a period of 6 months 5. Date of compliance 5-10-14	05/10/2014

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NAME OF PROVIDER OR SUPPLIER SPRENGER HEALTH CARE OF MISHAWAKA		STREET ADDRESS, CITY, STATE, ZIP CODE 60257 BODNAR BLVD MISHAWAKA, IN 46544	

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K010038 SS=E	3.1-19(b) 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. 18.2.1 Based on observation and interview, the facility failed to ensure 3 of 13 exit doors were accessible. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6.1(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect visitors, staff and 30 or more residents in the smoke compartment housing Rehab, the dining rooms, the beauty shop, pub, theatre, Internet cafe, and community room. Findings include: Based on observation with the maintenance director on 04/10/13 between 1:00 p.m. and 4:00 p.m., all emergency exit doors were equipped with electromagnetic locks which released after pressure was applied to the latch for fifteen seconds. Exit doors near the pub, Internet cafe and community room each had no code posted to unlock the doors using the adjacent keypad override, and lacked the signage notifying occupants of the delayed egress feature. The maintenance director acknowledged at the time of observations, these doors released after 15 seconds but	K010038	K-38 1.The 3 doors have had a sign placed on the door with the verbiage of "Push until alarm sound, door can be opened after 15 seconds to ensure proper means of exit. There were no residents directly affected by the alleged deficient practice. 2.Residents and/or visitors have the potential to be affected by the alleged deficient practice. 3. The Maintenance Director has been educated on the life safety requirement as it relates to exit areas by 5-10-14 4. The Maintenance Director will perform monthly audits of exit Doors to ensure proper signage monthly for a period of 6 months and then quarterly there after until compliance is achieved Date of compliance 5-10-14	05/10/2014

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	the signs were missing.			
K010056 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 7 smoke compartments. This deficient practice could affect visitors, staff, and 30 or more residents in the dining rooms. Findings include: Based on observation with the maintenance director on 04/10/14 at 1:55 p.m., sprinkler protection was not provided for the three foot by six foot by four foot fireplace alcove which was open to the two dining rooms. The maintenance director acknowledged at the time of observation, the area was not protected by other sprinklers in the rooms. 3.1-19(b) 3.1-19(ff)	K010056	1. The sprinkler head has been installed in the alcove area around the electric fire place. There were no residents affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The maintenance department has been educated on the life safety code as it relates to adequate sprinkler coverage by 5/10/14 4. The maintenance supervisor will perform audits on the sprinklers monthly. Monthly audits will be forwarded to the QA&A committee for review, These audits will be reported monthly for a period of 6-months until compliance is achieved.	05/10/2014

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SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

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K010062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure a supply of at least two spare sprinkler heads of each type and temperature rating was kept on the premises in a cabinet. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 04/10/14 at 2:15 p.m., six different types of sprinkler sprinkler heads were in the spare sprinkler head cabinet. Two different pendant heads were found to have only one spare head each. The maintenance director acknowledged at the time of observation, there were not two of these pendant heads in the cabinet of spare heads. 3.1-19(b)	K010062	5. Date of compliance 5-10-14 1. Additional spare sprinkler heads have been obtained and are on site to meet this requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. The Maintenance Department have been educated on the equirement related to additional sprinkler heads by 5-10-14. 4. The Maintenance Director will perform environmental/life safety rounds which will include spare sprinkler heads. The maintenance director will forward the results of those round to the QA&A committee on a monthly basis and quarterly there after until compliance is achieved 5 Date of Compliance 5-10-14	05/10/2014
K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration			

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	areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (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 Based on observation and interview, the facility failed to ensure 3 of 3 cylinders of nonflammable gases were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents on the 100 hall. Findings include: Based on observation with the maintenance director on 04/10/14 between 1:00 p.m. and 4:00 p.m., one oxygen e-cylinder was standing without support in resident room 125 and although there was a rack available, two oxygen e-cylinder stood without support in the oxygen supply storage room. The maintenance director acknowledged at the time of observations, the cylinders should not have been left without support.	K010076	1. The three identified oxygen cylinders were immediately placed into the proper storage carrier upon notification of the alleged deficient practice. There were no residents directly affected by the alleged deficient practice 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Facility staff has been in-serviced by 5-10-14 on the proper storage of oxygen cylinders. Environmental/life safety rounds will be performed which will include oxygen on a monthly basis. 4. Environmental/Life safety round reports will be forwarded to the QA&A monthly for 6-months and quarterly thereafter until compliance is achieved.. 5 Date of Compliance 5-10-14	05/10/2014
K010147 SS=D	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD			

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	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 4 of 4 multitap adapters and/or extension cords were not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, 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, visitors and 3 or more residents accessing the beauty shop and offices in the administration area. Findings include: a. Based on observation with the maintenance director on 04/10/14 between 1:00 p.m. and 4:00 p.m., multitap outlet adapters were used to provide power to equipment in the activities office, social services office, and the discharge planning office. The maintenance director said at the time of observation, he didn't know this electrical equipment was not permitted. b. Based on observation with the maintenance director on 04/10/14 at 2:25 p.m., a power strip extension cord was used to supply power to two curling irons and a blow dryer in the beauty shop. The maintenance director said at the time of observation, he was unaware the power strip could not be used for this equipment. 3.1-19(b)	K010147	1. The four multi adapters were removed from the Activities office, social services office and the discharge planning office. The power strip in the beauty shop was removed in order to meet this requirement. There were no residents directly affected by the alleged deficient practice. 2. Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3. Staff has been in-serviced by 5-10-14 on power strip use age as well as multi use adapters as it relates to the life safety requirement. 4. The Director will perform monthly rounds to ensure no further use of this electrical equipment. Results of those rounds will be forwarded to the QA&A committee on a monthly basis for 6 months and the quarterly there after until compliance is achieved	05/10/2014