

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/05/2016
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NAME OF PROVIDER OR SUPPLIER  SUMMIT CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/05/16</p> <p>Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160</p> <p>At this Life Safety Code survey, Summit City Nursing and Rehabilitation 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 two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 93 and had</p>	K 0000	<p>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. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after January 22, 2016. We respectfully request a desk review in lieu of a post survey revisit.</p>	
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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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K 0027 SS=E Bldg. 01	<p>a census of 81 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. This deficient practice could affect approximately 38 residents on the second floor.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 01/05/16 at 1:11 p.m., the set of smoke doors on the second floor by room 218 had three half inch holes at the top of both doors. Based on interview at</p>	K 0027	<p>K 027 NFPA 101Life Safety Code Standard It is the policy of this facility to ensure that the door openings in the smoke barriers are to restrict the movement of smoke for at least 20 minutes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <i>The 3/4-inch holes in both smoke doors near room 218 have been properly sealed.</i></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what</p>	01/22/2016

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	<p>the time of observation, the Environmental Supervisor acknowledged and provided the measurements of the holes.</p> <p>3.1-19(b)</p>		<p>correctiveaction(s) will be taken;</p> <ul style="list-style-type: none"> <li>·Allresidents have the potential to be affected by the alleged deficient practice.</li> <li>·TheMaintenance Director/Designee will be in-serviced on door openings in the smokebarriers are to restrict the movement of smoke for at least 20 minutes by theExecutive Director by January 22, 2016.</li> <li>·All doors located on a smoke barrier wallwill be checked by Maintenance Director/Designee for20 minute smoke restriction.</li> <li>·AllManagement will be in-serviced on door openings in the smoke barriers are torestrict the movement of smoke for at least 20 minutes Education will beprovided by the Maintenance Director/ Designee completed by January 22, 2016.</li> </ul> <p>What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur;</p> <ul style="list-style-type: none"> <li>·TheMaintenance Director/Designee will be in-serviced on door openings in the smokebarriers are to restrict the movement of smoke for at least 20 minutes by theExecutive Director by January 22, 2016.</li> <li>·All doors located on a smoke barrier wallwill be checked by Maintenance Director/Designee for to ensure door openings in the</li> </ul>	

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K 0029 SS=E Bldg. 01	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		<p><i>smoke barriers are to restrict the movement of smoke for at least 20 minutes.</i></p> <ul style="list-style-type: none"> <li>· All Management will be in-serviced on door openings in the smoke barriers are to restrict the movement of smoke for at least 20 minutes. Education will be provided by the Maintenance Director/ Designee completed by January 22, 2016.</li> </ul> <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; and</p> <ul style="list-style-type: none"> <li>· A CQI monitoring tool called Smoke Barrier Doors CQI will be utilized every week x 4 and Monthly x 5.</li> <li>· Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</li> <li>· Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>· January 22, 2016</li> </ul>		

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	<p>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>1. Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas in the basement, such as a boiler room, was smoke resistive. This deficient practice was not in a resident care area but could affect all staff in the basement.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 01/05/16 at 11:45 a.m., in the ceiling of the basement boiler room there were two unsealed one inch penetrations around pipes. Also, on the ceiling there was a drywall patch that had a one inch hole in it and had a quarter inch gap around the edges of the drywall patch. Based on interview at the time of observation, the Environmental Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K 0029	<p>K 029 NFPA 101Life Safety Code Standard It is the policy of this facility to ensure that all hazardous areas are smoke resistive. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <i>· Two one inch holes around pipes in the basement boiler room ceiling and the drywall patch were sealed properly.</i> <i>· The Maintenance Director added self closing device to the kitchen dry storage door to cause the door to automatically close and latch into the door frame.</i></p> <p>How other residents having the potential to be affected by the</p>	01/22/2016

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	<p>the facility failed to ensure 1 of 3 corridor doors to the kitchen was provided with a self closing device causing the doors to automatically close and latch into the door frame. This deficient practice was not in a resident care area but could affect all staff in the basement hallway and in the kitchen.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Environmental Supervisor on 01/05/16 at 11:20 a.m., the dietary receiving door which led form the corridor to the kitchen was not equipped with a self closing device. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>same deficient practice will be identified and what correctiveaction(s) will be taken;</p> <ul style="list-style-type: none"> <li>·Allstaff members have the potential to be affected by the alleged deficientpractice.</li> <li>·TheMaintenance Director/Designee will be in-serviced that hazardous areas aresmoke resistive by the Executive Director by January 22, 2016.</li> <li>·All hazardous areas will be checked byMaintenance Director/Designee to ensure is smoke resistive.</li> <li>·AllManagement will be in-serviced that hazardous areas are smoke resistive. Education will be provided by the Maintenance Director/ Designee completed by January22, 2016.</li> </ul> <p>What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur;</p> <ul style="list-style-type: none"> <li>·TheMaintenance Director/Designee will be in-serviced that hazardous areas aresmoke resistive by the Executive Director by January 22, 2016.</li> <li>·All hazardous areas will be checked byMaintenance Director/Designee to ensure is smoke resistive.</li> <li>·AllManagement will be in-serviced that hazardous areas are smoke resistive. Education will be provided by the Maintenance Director/ Designee</li> </ul>	

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K 0038 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 exits in the "Cottage" was readily accessible for residents with a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that	K 0038	completed by January 22, 2016.  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; and · A CQI monitoring tool called Smoke Resistive Hazardous Area CQI will be utilized every week x 4 and Monthly x 5. · Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. · Non-Compliance with facility procedure may result in disciplinary action up to and including termination.  By what date the systemic changes will be completed. January 22, 2016  K 038 NFPA 101 Life Safety Code Standard It is the policy of this facility to ensure that exits are readily accessible at all times. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · A descriptive exit code was posted on the key pad. How other residents having the	01/22/2016

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	<p>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 could affect 21 residents in the cottage that require special security measures.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor and the Administrator on 01/05/15 at 12:57 p.m., the exit door in the "Cottage", a unit requiring special security measures, was equipped with a magnetic lock and a key pad to unlock the door. When the code was inputted on the key pad by the Environmental Supervisor, the door did not release. A Certified Nurse's Aide (CNA) was asked to open the door, but when the code was inputted on the key pad the door did not release, but the door did release upon activation of the fire alarm. Based on interview at the time of observations, the Environmental Supervisor, Administrator, and the CNA stated they</p>		<p>potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken;</p> <ul style="list-style-type: none"> <li>·Allresidents, visitors and staff have the potential to be affected by the allegeddeficient practice.</li> <li>·TheMaintenance Director/Designee will be in-serviced that the exit doors must bereadily accessible at all times by the Executive Director by January 22, 2016.</li> <li>·All exit doors will be checked for readilyaccessibility by Maintenance Director/Designee.</li> <li>·AllManagement will be in-serviced that the exit doors must be readily accessibleat all times. Education will be provided by the Maintenance Director/Designee completed by January 22, 2016.</li> </ul> <p>What measures will be put into place or what systemic changes will be madeto ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> <li>·TheMaintenance Director/Designee will be in-serviced that the exit doors must bereadily accessible at all times by the Executive Director by January 22, 2016.</li> <li>·All exit doors will be checked for readilyaccessibility by Maintenance Director/Designee.</li> <li>·AllManagement will be in-serviced that the exit doors must be readily accessibleat all times. Education will be provided by the Maintenance Director/Designee completed by</li> </ul>	

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K 0062 SS=E Bldg. 01	<p>were not sure what the correct code is to unlock the exit door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 12 sprinklers in the kitchen and 1 of 20 sprinklers in the basement hallway which were corroded or damaged. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance</p>	K 0062	<p>January 22, 2016.</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; and</p> <ul style="list-style-type: none"> <li>· A CQI monitoring tool called Accessible Exit Doors CQI will be utilized every week x4 and Monthly x 5.</li> <li>· Data will be collected by Executive Director/Designee and submitted to the CQI Committee.</li> </ul> <p>If the threshold of 95% is not met, an action plan will be developed.</p> <ul style="list-style-type: none"> <li>· Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>· January 22, 2016</li> </ul> <p>K 062 NFPA 101 Life Safety Code Standard It is the policy of this facility to ensure that the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. What corrective action(s) will be accomplished for those</p>	01/22/2016

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	<p>of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect all staff in the basement hallway and in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Environmental Supervisor on 01/05/16 between 11:30 a.m. and 11:45 a.m., the automatic sprinkler in the kitchen above the dish washer was corroded with a green substance. Also, the automatic sprinkler in the basement hallway by laundry storage had a damaged deflector with prongs bent up. Based on interview at the time of observation, both automatic sprinklers were acknowledged by the Environmental Supervisor.</p> <p>3.1-19(b)</p>		<p>residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> <li>· Both sprinkler heads were replaced immediately.</li> </ul> <p>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;</p> <ul style="list-style-type: none"> <li>· All residents and staff have the potential to be affected by the alleged deficient practice.</li> <li>· The Maintenance Director/Designee will be in-serviced that each sprinkler head is operating per manufacture guidelines by the Executive Director by January 22, 2016.</li> <li>· An audit was conducted ensuring sprinkler heads are operating per manufacture guidelines by Maintenance Director/Designee.</li> <li>· All Management will be in-serviced by the Executive Director by January 22, 2016 that that each sprinkler head is operating per manufacture guidelines</li> </ul> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will be in-serviced that each sprinkler head is operating per manufacture guidelines by the Executive</li> </ul>		

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			<p><i>Director by January 22, 2016.</i></p> <ul style="list-style-type: none"> <li>·An audit was conducted ensuring sprinkler heads are operating per manufacture guidelines by Maintenance Director/Designee.</li> <li>·All Management will be in-serviced by the Executive Director by January 22, 2016 that that each sprinkler head is operating per manufacture guidelines</li> </ul> <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; and</p> <ul style="list-style-type: none"> <li>·A CQI monitoring tool called Sprinkler System CQI will be utilized every week x 4 and Monthly x 5.</li> <li>·Data will be collected by Executive Director/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.</li> <li>·Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</li> </ul> <p>By what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> <li>·January 22, 2016</li> </ul>	