STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0000 Bldg. 01	A Post Survey Revisit was conducted for the Preoccupancy survey that was conducted for the bed increase of 20 T18/19 beds in rooms 400-411, 500, 506, 508, 510, 512, 514, 301 and 302 on 08/03/22 by the Indiana Department of Health in accordance with 42 CFR 483.90(a) Survey Date: 09/19/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this PSR survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 111 and had a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/21/22	K 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of at least 40 resident room corridor doors was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 409. Findings include: Based on observation Interim Administrator on 09/19/22 at 1:37 p.m., the corridor door to resident room 409 did not latch into the frame when tested several times by the Interim Administrator. Based on interview at the time of observation, the Interim Administrator stated that Maintenance was scheduled to fix the door and she wasn't sure why the door didn't latch into the door frame. This finding was reviewed with the Interim Administrator during the exit conference. This deficiency was cited on 08/03/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(a)	K 0363	**K363** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The one identified latch on the corridor door (room 409) was repaired/adjusted and now latches properly as required.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **All doors protecting the corridor openings will be inspected to ensure that alldoors protecting corridor openings will be smoke resistive; have no impediments to closing; are self-latching and provided with positive latching hardware** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Ongoing, the Administrator or designee will monitor corridor doors to ensure continued compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Results of the monitoring will**	09/22/2022

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			be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	
K 9999 Bldg. 01	3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(k)(7) Except in private rooms, each bed must have ceiling suspended cubicle curtains or screens of flameproof or flame-retardant material, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains. 3.1-19(u)(1) The nurses' station must be equipped to receive resident calls through a communication system from the resident rooms. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide privacy curtains in 9 of 20 resident sleeping rooms containing at least 2 residents. This deficient practice could affect at least 9 residents. Findings include: Based on observations with the Interim Administrator on 09/19/22 between 1:20 p.m. and 1:50 p.m., the following resident rooms were not equipped with two privacy curtain and hooks as	K 9999	What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **The privacy curtains and hooks have been ordered and will be installed when we receive them.** How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken; **An audit was completed and only the 11 rooms that were identified during the survey were found to be missing.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Ongoing, the Administrator or designee will monitor all required rooms to ensure continued compliance.** How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; **Results of the monitoring will**	10/24/2022

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	required: 301, 302, 400, 401, 404, 403, 405, 407, 410, 411, and 500. Based on interview with the Interim Administrator at the time of the observations, the hooks and additional privacy curtains are on order. This finding was reviewed with the Interim Administrator during the exit conference. This deficiency was cited on 08/03/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		**be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.**	