STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/17/2022

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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 05/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/17/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Emergency Preparedness survey, Briarcliff Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 111 certified beds. At the time of the survey, the census was 88. Quality Review completed on 06/21/22	E 0000	**K 000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness E 009Survey conducted at Briarcliff Health & Rehabilitation May 10, 2022. The facility is respectfully requesting desk review regarding this survey.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/17/22 Facility Number: 013420 Provider Number: 155831	K 0000	**K 000** Attached is the plan of correction for the Life Safety Code with Emergency Preparedness E 009Survey conducted at Briarcliff Health & Rehabilitation May 10, 2022. The facility is respectfully requesting desk review regarding this survey.	

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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	AIM Number: 201293620 At this PSR Life Safety Code 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 88 at the time of this survey. At the time of this survey, Halls 100 and 200 were unoccupied and experiencing significant and comprehensive remodeling. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/21/22			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have			

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	fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier door sets on 300 hall had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect up to 25 staff, visitors and residents. Findings include: Based on observation and interview during the facility tour with the Administrator, Administrator in Training, Maintenance Assistant and Director of Maintenance from another facility on 06/17/22 between 11:15 a.m. and 12:45 p.m., the double smoke door set on the 300 hall failed to close completely into the doorframe and resist the passage of smoke, leaving approximately a 3 inch gap. The Director of Maintenance from another facility stated that the vendor had been on site recently and spent considerable time attempting to fix the issue with the doors. Unsuccessful in fixing the aforementioned doors, the facility was ordering new doors and would be replacing them once they arrived. This finding was acknowledged by the Administrator, Administrator in Training, Maintenance Assistant and Director of Maintenance from another facility at the time of discovery and again at the exit conference. This deficiency was cited on 05/10/22. The facility failed to implement a systemic plan of correction	K 0374	**K374(1)** What corrective actions will be accomplished for those residents found to have affected by the deficient practice; **300-hall smoke doors have been repaired (new door closers installed and doors realigned) to create the required proper seal.** 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 other smoke doors will be inspected and tested to ensure a proper seal.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: **Maintenance/designee will check smoke doors throughout facility once quarterly to check for a proper seal between doors.** 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; /b>/b>	06/23/2022

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	to prevent recurrence. 3.1-19(b)		Date of Completion: June 23, 2022	