STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 01 B. WING	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

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K 0000 Bldg. 01	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: 02/18/16 Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300 At this Life Safety Code survey, Morningside Nursing and Memory Care Center 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 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. The facility has a fire alarm system with automatic smoke detection in the corridors, in areas open to the corridors, and battery operated smoke alarms in all resident rooms except the hard wired smoke detectors in	K 0000	**The facility requests paper compliance for this survey.** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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

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	resident room 112, 113, 115 and 116. The facility has a capacity of 40 and had a census of 26 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a wood shed. Quality Review on 02/19/16 by Lex Brashear, LSC Specialist			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all occupants. Findings include: Based on observations with the	K 0025	Penetration was repaired on 2/29/2016 by maintenance. Entire facility inspected for other breaches in smoke barrier on 2/29/2016 and 3/1/2016. Monthly audit to be performed by maintenance or designee to ensure no breaches are in any smoke barrier within facility. Audit will also be completed as outside contractors complete work that might include breaching the smoke barrier. The findings of these audits will be reported to the QA Committee for a period of 6 months or until a pattern of substantial compliance is	03/04/2016

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	Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 10:59 a.m., a three quarter inch ceiling penetration was discovered in the Dining Room. Based on interview at the time of observation, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged and provided the measurements for the unsealed penetration. 3.1-19(b)		achieved.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Beauty Shop used as storage greater than 50 square feet, a hazardous area, was provided with a self-closer and would latch into the frame. This deficient practice could affect staff and up to 12 residents. Findings include:	K 0029	Self-closure for Beauty Shop door was installed on 2/29/2016 All other self-closure doors were inspected on 2/29/2016, with no other doors found to be deficient. A monthly audit will be performed by maintenance or designee to ensure that all self-closing doors work properly and are in compliance. The findings of these audits will be reported to the QA Committee for a period of 6 months or until a pattern of substantial compliance is	03/04/2016

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	Based on observation with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 11:12 p.m., the Beauty shop was used as storage. The room contained two separate six feet by eight feet linen storage carts, piles of resident clothing, and parts for the Kitchen remodel. When tested, the door only self-closed half way not touching the frame. Based on interview at the time of observation, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b)		achieved.	
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 1. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4	K 0050	A Fire Drill Schedule will be created by Administration and Maintenance to ensure that fire drills are performed on a random	03/04/2016

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	quarters. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 9:23 a.m., four sequential second shift fire drills took place between 4:00 p.m. and 5:40 p.m. for four of the last four quarters. Based on interview at the time of record review, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 10 of 12 fire drills were conducted under varied conditions. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 9:23 a.m.,		and unexpected schedule (both for times of day and days within the month). Fire Drills and the new Fire Drill Schedule will be given to the QA Committee to ensure compliance with the need for times and dates to be unexpected and random for staff. This shall be ongoing.	

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	10 of 12 fire drills conducted over the past four quarters were conducted on or after the 27th of each month. Based on interview at the time of record review, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b) 3.1-51(c)			
K 0053 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3 1. Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 12 of 12 resident room smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect staff and at least 18 residents. Findings include:	K 0053	All single station smoke detectors were tested and the batteries replaced on 2/29/2016. All batteries for smoke detectors to be marked with the date of installation. All batteries for the 12 smoke detectors will be replaced on 6 month intervals and dated accordingly. Smoke detectors will be checked on a weekly basis to ensure they are properly working. The weekly smoke detector audit will be reported to the QA Committee for a period of 6 months or until a pattern of substantial compliance is achieved.	03/04/2016

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	Based on record review with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 9:42 a.m., the "Smoke Detector Weekly Check" did not have documentation prior 03/26/15 nor after 06/01/15 for the twelve single station smoke detectors in resident rooms. Based on an interview at the time of record review, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 12 of 12 single station smoke detectors would operate. This deficient practice affects staff and at least 18 residents. Findings include: Based on record review with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 9:42 a.m., the "Smoke Detector Weekly Check" did not have documentation indicating a battery replacement program for the twelve			

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	single station smoke detectors in resident rooms. Based on an interview at the time of record review, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were maintained in proper working order. Once obstructive material is observed during an investigation as described in NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.3 requires a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all occupants. Findings include:	K 0062	The recommended System Flush will be performed on 3/15/2016 due to the current below freezing temperatures and the potential for pipe rupture. Non-system items found to be hanging from the sprinkler system have been removed. Staff to be re-educated that no items are to be supported by the sprinkler system unless designed for the system specifically. A monthly audit will be performed by Maintenance or designee to ensure compliance. Findings from monthly sprinkler audit will be given to the QA Committee for a period of 6 months or until a pattern of substantial compliance is achieved. Future sprinkler inspection reports will be forwarded to the QA Committee to ensure compliance with the inspection findings and to	03/15/2016

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	Based on record review with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on 02/18/16 at 10:00 a.m., Ryan Fire Protection internal pipe inspection report dated 12/29/15 indicated: "system (lines & mains) should be flushed to remove obstructing material. " Based on an interview at the time of record review, the Maintenance Supervisor, Administrative Assistant, and the Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 on		maintain a properly working automatic sprinkler system. The QA Committee or designee will follow up on any inspection report recommendations to guarantee the work has been completed.	

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	02/18/16 at 11:02 a.m., a paint roller and a caulking gun were being supported by the sprinkler line. Based on interview at the time of observation, the Maintenance Supervisor, Administrative Assistant, and Maintenance #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99) (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.			

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	Based on observation and interview, the facility failed to ensure 1 of 4 exit discharges was free of cigarette butts. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observations with the Maintenance Supervisor on 02/18/16 at 11:33 a.m., there was snow on the ground but at least 50 cigarette butts were seen and estimated on the ground by the employee entrance. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0066	Cigarette butts and waste were picked up on 2/22/2016. On 2/29/2016, Administration created a smoking policy explaining the new designated smoking area for staff members, which will be located in the rear of the property. A new Cigarette Waste Collector was installed on 2/26/2016. Department Managers/Charge Nurse to ensure compliance with staff smoking in the designated area. Maintenance to perform weekly rounds to monitor compliance. Result to be reported to the Administrator.	03/04/2016