PRINTED: 07/20/2017
FORM APPROVED
OMB NO. 0938 0391

155752 B. WING	07/05/2017
NAME OF PROVIDER OR SUPPLIER  18	REET ADDRESS, CITY, STATE, ZIP CODE 325 BAILEY AVE DUTH BEND, IN 46637
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETION
K 0000	
Bldg. 01  A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/05/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  This visit was done in conjunction with T24D22 Survey.  Survey Date: 07/05/17  Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300  At this PSR 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 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with automatic smoke	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   155752	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER  MORNINGSIDE NURSING AND MEMORY CARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  detection in the corridors, and battery operated  smoke alarms in all resident rooms except the hard wired smoke detectors in resident room 112, 113, 115 and 116.  The facility has a capacity of 40 and had	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u>		COMPLETED		
MORNINGSIDE NURSING AND MEMORY CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (Additional in the corridors, and battery operated smoke alarms in all resident rooms except the hard wired smoke detectors in resident room 112, 113, 115 and 116.  The facility has a capacity of 40 and had			155752	B. WING		07/05/2017	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 resident room 112, 113, 115 and 116.  The facility has a capacity of 40 and had			1832	25 BAILEY AVE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 resident room 112, 113, 115 and 116.  The facility has a capacity of 40 and had	(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  DATE  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 resident room 112, 113, 115 and 116. The facility has a capacity of 40 and had	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
to the corridors, and battery operated smoke alarms in all resident rooms except the hard wired smoke detectors in resident room 112, 113, 115 and 116.  The facility has a capacity of 40 and had	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
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 completed on 07/05/17 - DA  K 0291 SS=F Bldg. 01 Emergency Lighting Emergency Lighting Emergency Lighting in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview; the facility failed to ensure battery operated emergency lights in 1 of 3 corridors was maintained in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for  All areas where espicals areas providing facility services were sprinklered. All areas providing facility services were sprinklered with the exception of a wood shed.  Cuality Review completed on 07/05/17 - DA  K 0291 The Facility requests paper compliance for this citation 1. No residents were affected by this practice 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. The light in question was replaced with a new unit and tested for functionality with success.  4. No further follow up is needed at this time 5. Date of compliance: July 17th,	SS=F	to the corridors, smoke alarms in except the hard was resident room 11. The facility has a a census of 30 at the facility sprinklered with shed.  Quality Review DA  NFPA 101  Emergency Lighting Emergency Lighting duration is provide accordance with 7 18.2.9.1, 19.2.9.1  Based on record the facility failed operated emerge corridors was may with LSC 7.9. Later Testing of Emergency Equipment, required the conducted for intervals and an conducted on every single to the facility failed the conducted on every smoke and an acconducted on every smoke alarms in the conducted on every smoke alarms in the c	and battery operated all resident rooms wired smoke detectors in 12, 113, 115 and 116. a capacity of 40 and had a the time of this survey.  residents have customary inklered. All areas y services were the exception of a wood completed on 07/05/17  ng ng g of at least 1-1/2-hour ed automatically in 7.9.  review and interview; all to ensure battery ency lights in 1 of 3 a aintained in accordance as C 7.9.3 Periodic gency Lighting aires a functional test to be ery required battery	K 0291	compliance for this citation 1. No residents were affected this practice 2. Due to the nature of the violation all residents in the fa had the potential to be affecte 3. The light in question was replaced with a new unit and tested for functionality with success. 4. No further follow up is need at this time	by cility d.	

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K0Z422

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 07/05/2017	
	PROVIDER OR SUPPLIER IGSIDE NURSING AND MEMORY CARE CENTER	18325 F	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE I BEND, IN 46637		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants because the facility does not have generator.  Findings include:  Based on observation with the Administrator on 07/05/17 at 1:34 p.m., the Dining room exit discharge battery operated emergency light failed to illuminate when tested. Based on interview at the time of observation, the Administrator acknowledged the aforementioned condition.  3.1-19(b)  This deficiency was cited on 05/05/17. The facility failed to implement a systemic plan of correction to prevent		2017		
IV 0070	recurrence.				
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING <u>01</u>		01	COMPLETED		
		155752	B. WING		07/05/2017		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
MORNINGSIDE NURSING AND MEMORY CARE CENTER				BAILEY AVE I BEND, IN 46637			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	nn overneng nv. vv. on on negerov		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Smoke barriers shaterminate at an atrare not required in ducted HVAC syst sprinkler system is compartments adjustrier.  19.3.7.3, 8.6.7.1(1) Describe any med system in REMAR Based on observing facility failed to caused by the particular conduit through walls were protes moke resistance LSC Section 19. barriers to be conwith LSC Section minimum ½ hour This deficient proccupants.  Findings included Based on observing Administrator or five separate smorth penetrations were ranging from one Based on intervito observation, the	raill be permitted to rium wall. Smoke dampers a duct penetrations in fully tems where an approved is installed for smoke acent to the smoke  1) chanical smoke control exs.  ation and interview, the ensure the penetrations ssage of wire and/or  1 of 1 smoke barrier cted to maintain the e of each smoke barrier.  3.7.5 requires smoke enstructed in accordance in 8.5 and shall have a rifre resistive rating.  actice could affect all  2:  ations with the in 07/05/17 at 1:55 p.m., oke barrier unsealed the discovered in the attice in the four inches.  Even at the time of	K 0		The Facility requests paper compliance for this citation  1. No residents were affected negatively from this practice. 2. Due to the nature of the violation all residents in the fact had the potential to be affected. 3. The smoke barrier penetrati were repaired by 7/17/17. Smotharrier was also brought up to code in fire retardancy. 4. No further follow up is necessary at this time. Maintenance department will visually inspect the smoke bar compartment after any maintenance done in the atticensure smoke barrier integrity. 5. Date of completion 7/17/17	d. ons oke rier	07/17/2017
	3.1-19(b)						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPL		
		155752	B. WING		07/05/	/2017	
NAME OF PROVIDER OR SUPPLIER  MORNINGSIDE NURSING AND MEMORY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  18325 BAILEY AVE SOUTH BEND, IN 46637				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	The facility faile	was cited on 07/05/17. d to implement a correction to prevent					

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