STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING -- B. WING	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/17/22 Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330 At this Emergency Preparedness survey, Cardinal Nursing 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 is licensed for 144 dually certified Medicare and Medicaid beds; however it is operating at only 122. At the time of the survey, the census was 71. Quality Review completed on 03/24/22	E 0000	This plan of correction constitutes the facility's written allegation of compliance for deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the ISDH inspection report. Due to the relative low scope and severity of this survey, the facility respectfully requests consideration for a desk review in lieu of a post-survey revisit. The facility is also submitting a request for a 90 day construction waiver, as we are unable to access a necessary fire door	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/17/22 Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330	K 0000	This plan of correction constitutes the facility's written allegation of compliance for deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the ISDH inspection report. Due to the relative low scope and severity of this survey, the facility	

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

Any deficiencystatement 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.

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	At this Life Safety Code survey, Cardinal Nursing 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 three-story facility with a basement was determined to be of Type II (111) construction with a one-story addition determined to be of Type V (111) construction and both were fully sprinklered except for the housekeeping closet in the kitchen and the outside attached walk-in-freezer. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The building is fully protected by a 600-kW diesel powered generator. The facility is licensed for 144 dually certified Medicare and Medicaid beds; however it is currently operating only 122. At the time of this survey, the census was 71. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the housekeeping closet in the kitchen, the outside attached walk-in-freezer, and two detached storage sheds. Quality Review completed on 03/24/22		respectfully requests consideration for a desk review in lieu of a post-survey revisit. The facility is also submitting a request for a 90 day construction waiver, as we are unable to access a necessary fire door	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 2 of 4 spa rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Furthermore, NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track.	K 0353	K353 Sprinkler System – Maintenance and Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Privacy curtains in the spa rooms have been changed, ensuring at least 18 inches of clearance below the level of the sprinkler deflectors. **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:** All residents and staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/designee inspected all sprinkler deflectors	04/07/2022

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	(2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. In addition, Section 8.6.6.1 states the clearance between the deflector and the top of storage shall be 18 inches or greater. This deficient practice could affect 24 residents, 4 staff, and 2 visitors. Finding includes: Based on observations made with the Maintenance Director during a tour of the facility on 03/17/22 from 11:30 a.m. to 1:58 p.m., the following was noticed: 1) the spa room located on the first floor West-hall had 4 shower curtains hanging in the shower stalls that had only ten inches of mesh. This would not allow full sprinkler coverage within the spa area. 2) the spa room located on the first floor East-hall had 3 shower curtains hanging in the shower stalls that had only ten inches of mesh. This would not allow full sprinkler coverage within the spa area. Based on interview at the time of the observations, the Maintenance Director agreed the privacy curtains in the aforementioned spa rooms provided sprinkler spray pattern obstruction of less than 18 inches from the ceiling. During the exit conference with the facility Executive Director and the Maintenance Director at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		to ensure properly clearance for all of them. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee will complete and document the inspection of the clearance of all sprinkler heads monthly during his preventative maintenance rounds to ensure all have appropriate clearance. **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:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure all sprinkler heads have proper clearance. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and will sign off that the checks were completed. **By what date the systemic changes will be completed:** Compliance Date = 4/7/2022	
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1) Based on observation and interview, the facility failed to ensure 1 of 1 West-hall ice machine was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. (7) Sinks - Located in areas other than kitchens where receptacles are installed within 1.8 m. (6 ft.) of the outside edge of the sink. This deficient practice affects up to 24 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 03/17/22 at 11:45 a.m., the West-hall had an ice machine that was not plugged into a G.F.C.I. protected outlet. When looking behind the ice machine, water pipes were within eight inches of the electrical outlet that the ice machine was plugged in to. When asked if the aforementioned outlet was GFCI protected, the Maintenance Director said that it was not. The Maintenance Director acknowledged that the	K 0511	K 511 Utilities – Gas and Electric **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director changed the outlet that is used for the ice machine to an approved ground fault circuit interrupter (GFCI) protected outlet. The Maintenance Director/designee replaced the cracked face plate covering on the noted electric receptacle in the kitchen prior to the end of the survey. **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:** All residents, visitors, and staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/designee checked all outlets to ensure all have appropriate outlets and appropriate covers. **What measures will be put into place or what systemic**	04/07/2022

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	receptacle on the West-hall ice machine was not GFCI protected, and that the outlet had a water source well within six feet of the ice machine at the time of the observation. During the exit conference with the facility Executive Director and the Maintenance Director at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to ensure 1 of over 50 electrical outlets in the kitchen were fully protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 6 staff. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 03/17/22 at 12:35 p.m., the kitchen area nearest to the ABC portable fire extinguisher had an electric receptacle with a broken face plate cover on it. This left high voltage wires exposed and could cause a shock to anyone nearby. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. He then asked his assistant to replace the outlet cover. This deficiency was fixed prior to my exiting of the facility and was reviewed during the exit conference with the facility Executive Director and the Maintenance Director at 2:30 p.m. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/designee will inspect all outlets monthly during his preventative maintenance rounds to ensure all outlets are appropriate and all approved covers are in place. **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:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure all outlets are appropriate and all approved covers are in place. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and will sign off that the checks were completed. **By what date the systemic changes will be completed:** Compliance Date = 4/7/2022	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 second floor conference room did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects as many as 36 residents, 4 staff, and 2 visitors.	K 0920	K920 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Director removed the non-UL rated power strip from the conference room at time of the inspection. **How other residents having the**	04/07/2022

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	Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 03/17/22 at 11:45 a.m., a power strip was in use in the second-floor conference room and had an upright fan plugged into it. When asked if the power strip was U.L. rated, the Maintenance Director looked at it and stated that it was not. He then unplugged the fan and removed the power strip from the area stating that he would have a meeting with staff and remind them that power strips that are not U.L. rated were not allowed to be in use within the facility. During the exit conference with the facility Executive Director and the Maintenance Director at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, visitors, and staff have the potential to be affected by this alleged deficient practice. The Maintenance Director/designee checked all power strips for proper rating. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will check all power strips during monthly preventative maintenance rounds to ensure proper rating. **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:** The Executive Director will round with the Maintenance Director prior to the compliance date to ensure all power strips are properly rated. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and will sign off that the checks were completed. **By what date the systemic changes will be completed:** Compliance Date = 4/7/2022	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was separated properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect all residents, staff, and visitors while in the smoke compartment. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 03/17/22 at 12:18 p.m., the oxygen storage and transfilling room was not separated by a one-hour fire resistant barrier. The room walls stopped short of the ceiling by approximately 18 inches and therefore the room was left open to the corridor. The room also did not have a fire rated door, but rather a hollow	K 0927	K927 Gas Equipment – Transfilling Cylinders **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The oxygen storage and transfill room will be relocated to a space with brick walls that go to the ceiling. A new approved fire rated door will be placed in the new location, but is currently on back-order. **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:** All residents and staff have the potential to be affected by this alleged deficient practice. There is only one oxygen storage and transfill space. No other spaces	07/07/2022

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	unrated door. Based on interview at the time of the observation, the Maintenance Director stated that he had to leave the wall short of the ceiling to allow sprinkler piping to enter the room and did not know about the need for a fire barrier of 1 hour fire-resistive construction. During the exit conference with the facility Executive Director and the Maintenance Director at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		needed assessed for compliance related to this issue. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The oxygen storage room and transfill room will be moved to a space with brick walls that go the to the ceiling and a new fire rated door will be placed for this room. **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:** New space will be constructed. Oxygen and supplies will be stored in the new space. Walls and door will be permanent and will not need ongoing inspection for compliance. **By what date the systemic changes will be completed:** Compliance Date = 7/7/2022	