STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. BUILDING -- B. WING	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/06/2021 Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930 At this Emergency Preparedness survey, Southfield Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 53. Quality Review completed on 05/10/21	E 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This plan is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/06/2021 Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930 At this Life Safety Code survey, Southfield Village, was found not in compliance with Requirements for Participation in	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This plan is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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

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	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. The 2020 Therapy addition, was evaluated under Life Safety Code (LSC), Chapter 18, New Health Care Occupancies This one story facility was determined to be of Type V (111) construction, with a 2020 Therapy addition with Type II (000) construction, and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The hard-wired smoke detection in the resident sleeping rooms is not supervised by the fire alarm system. The facility is connected to a three story Assisted Living facility, from which it is separated by a Fire Wall with a 2-Hour Fire Resistive Rating. The original facility and the 2020 addition are separated by a Fire Wall with a 1-hour Fire Resistive Rating. The Healthcare facility is fully protected by a diesel powered 200 kW generator. The facility has 60 certified beds. At the time of the survey, the census was 53. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/10/21			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas with combustible storage, such as linen storage rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Linen Storage room near Resident Room 201. Findings include:	K 0321	The self closing device on the linen storage room, located on the 200 hallway, was adjusted to assure the door fully closes and latches. All other doors through out the skilled nursing unit, with self closing devices were inspected and found to be functioning properly.	06/05/2021

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	During a tour of the facility with the Administrator and the Maintenance Technician on 05/06/2021 at 12:05 p.m., the corridor door to the linen storage room near room 201 was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. Based on interview at the time of observation, the Maintenance Technician acknowledged the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		In the future, to prevent reoccurrence, all self closing devices will be inspected at least once per quarter, in conjunction with fire drills. The testing will be documented on the Fire Drill form. The Environmental Services, Quality Improvement Committee is responsible to oversee the execution of the plan of correction. Failure to execute the plan could result in disciplinary action.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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 record review and interview, the facility failed to maintain 1 of 1 backflow device in	K 0353	The backflow preventer has been replaced and tested successfully	05/11/2021

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	accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. This deficient practice could affect all occupants in the facility. Findings include: During record review with the Administrator and Maintenance Technician on 05/06/2021 at 10:40 a.m., vendor documentation dated 11/10/2020 stated that the backflow relief valve would not open when tested. On 11/16/2020 a quote was submitted to the facility to repair the backflow device. Based on interview at the time of record review, the Administrator confirmed the malfunction and stated that the repairs were scheduled to be completed between May 10, 2021 and May 14, 2021. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)		on May 11, 2021. There are no other backflow devices in the facility that have the potential for the same deficiency. In the future, to prevent reoccurrence, the Environmental Services, Quality Improvement Committee will be responsible to review all testing of the backflow preventers with every test. The Environmental Services, Quality Improvement Committee is responsible to oversee the execution of the plan of correction. Failure to execute the plan could result in disciplinary action.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction			

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	2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling assembly smoke barrier was maintained in accordance with LSC Section 19.3.7.5. Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. Section 8.5.2 states that smoke barriers shall be continuous from outside wall to outside wall and continuous through all concealed spaces. This deficient practice could affect all facility occupants. Findings include: During a tour of the facility with the Administrator and the Maintenance Technician on 05/06/2021 at 1:50 p.m. a 6 inch by 6 inch unsealed penetration was found in the ceiling assembly smoke barrier above the suspended ceiling tiles near the South Fire Doors. Based on interview at the time of observation, the Maintenance Technician agreed that there was a 6 inch by 6 inch unsealed penetration in the ceiling. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)	K 0372	The penetration in the ceiling smoke barrier has been repaired. All other smoke barriers have been inspected and no additional penetrants have been found. To prevent reoccurrence, the Maintenance staff will inspect each smoke barrier following any activity that could disrupt the integrity of the structure. The Environmental Services, Quality Improvement Committee is responsible to oversee the plan of correction. Failure to execute the plan could result in disciplinary action.	06/05/2021

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K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 3 of 12 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents,	K 0521	The three smoke dampers were repaired prior to this Life Safety Survey. All other smoke dampers were inspected in December 2020, in accordance with Life Safety requirements. Three were found not to be functioning and the were replaced. Documentation is available from the contractor verifying the replacement occurred prior to this survey. In the future, as in the past, smoke dampers will be inspected and tested annually. If any are found not to be working, they will be repaired or replaced. The Environmental Services, Quality Improvement Committee is responsible to oversee the execution of the plan of correction. Failure to execute the plan could result in disciplinary action.	05/14/2021

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	staff and visitors. Findings include: During record review on 05/06/2021 at 11:15 a.m. with the Administrator and Maintenance Technician, the Fire/Smoke Damper Maintenance Record indicated that three of twelve fire dampers failed testing on 12/29/2020. Based on interview at the time of record review, the Maintenance Technician stated that all three dampers had been repaired, however could not provide documentation. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct 3 of 12 quarterly shift fire drills, or approved training per the COVID-19 Public Health Emergency waiver, during the most recent 12 month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under	K 0712	Since the date of survey, all three shifts have participated in a fire drill. To prevent reoccurrence, a schedule of fire drills have been	06/05/2021

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	varied conditions. This deficient practice affects all staff and residents. Findings include: During record review with the Administrator and Maintenance Technician on 05/06/2021 at 10:30 a.m., the facility was unable to provide documentation of a fire drill or training for the first shift for the third quarter of 2020; second shift for first quarter 2021; third shift for second quarter of 2020 and 2021. Based on interview at the time of record review, the Administrator agreed that fire drills were missing. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b) 3.1-51(c)		added to the building's electronic preventative maintenance program. This will notified management when fire drills are not completed timely. The Environmental Services, Quality Improvement Committee is responsible to oversee the plan of correction. Failure to execute the plan could result in disciplinary action.	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.			

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	19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Director of Nursing office was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff only. Findings include: During a facility tour with the Administrator and Maintenance Technician on 05/06/2021 at 12:30 p.m. two candles with wicks were located in the Director of Nursing office. Based on interview at the time of observation, the Environmental Services Director and the Maintenance Technician #1 acknowledged the aforementioned condition. This deficient finding was reviewed with the Administrator at the time of exit. 3.1-19(b)	K 0753	The decorative candles' have been removed. An environmental audit was conducted of the entire skilled unit. No other candles were discovered. To prevent reoccurrence, residents were reminded at the Resident Council Meeting and families were sent an email communication that candles with wicks are not permitted in the skilled unit. The Environmental Services, Quality Improvement Committee is responsible to oversee the plan of correction. Failure to execute the plan could result in disciplinary action.	06/05/2021
K 0920 SS=D 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			

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	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 Shift Supervisor office and 1 of 1 Nursing Office flexible cords were not used 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 staff only. Findings include: During a tour of the facility with the Administrator and Maintenance Technician on 05/06/2021 at 12:15 p.m. a surge protector was found powering a toaster and a coffee maker in the Shift Supervisor office. Then, a 12:35 p.m. a surge protector was found powering a coffee maker and a microwave in the Nursing Office. Based on interview at the time of each observation, the Administrator and Maintenance Technician agreed that the surge protectors were being improperly used. This deficient finding was reviewed with the Administrator at the time of exit.	K 0920	The surge protectors have been removed. An environmental audit was conducted of the entire skilled nursing unit. Any surge protectors that were found have been removed. To prevent reoccurrence, residents were reminded at the Resident Council Meeting and families were sent an email communication informing them that the use of surge protectors is prohibited. The Environmental Services, Quality Improvement Committee is responsible to oversee the plan of correction. Failure to execute the plan could result in disciplinary action.	06/05/2021

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K 0000 Bldg. 02	3.1-19(b) A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/06/2021 Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930 At this Life Safety Code survey, Southfield Village, 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. The 2020 Therapy addition, was evaluated under Life Safety Code (LSC), Chapter 18, New Health Care Occupancies This one story facility was determined to be of Type V (111) construction, with a 2020 Therapy addition with Type II (000) construction, and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The hard-wired smoke detection in the resident sleeping rooms is not supervised by the fire alarm system. The facility is connected to a three story Assisted Living facility, from which it is separated by a Fire Wall with a 2-Hour Fire Resistive Rating. The original facility and the 2020 addition are separated by a Fire Wall with a 1-hour Fire	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This plan is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

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	Resistive Rating. The Healthcare facility is fully protected by a diesel powered 200 kW generator. The facility has 60 certified beds. At the time of the survey, the census was 53. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/10/21			