PRINTED: 08/04/2023

EPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
ENTERS FOR	MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING COMPLETED		LETED		
		155115	B. W	ING		07/19	/2023	
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
CARDIN	AL NURSING AND	REHABILITATION CENTER			H BEND, IN 46617			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
g.	An Emergency Pre	paredness Survey was	E 0	000	Cardinal Nursing and Rehab			
		ndiana Department of Health in		300	respectfully requests desk rev	iew		
	accordance with 42	-			and compliance in this matter			
					Thank you for your considerate			
	Survey Date: 07/1	9/23						
	j				The creation and submission	of		
	Facility Number: (000048			this plan of correction does no			
	Provider Number:	155115			constitute an admission by thi			
	AIM Number: 100	0275330			provider of any conclusion se			
					in the statement of deficiencie			
	At this Emergency	Preparedness survey, Cardinal			of any violation of regulation.	,		
		oilitation Center was found in						
	compliance with E	mergency Preparedness						
	Requirements for N	Medicare and Medicaid						
		ders and Suppliers, 42 CFR						
	483.73							
	The facility is licen	sed for 144 dually certified						
	Medicare and Med	icaid beds; however it is						
	operating at only 1	22. At the time of the survey,						
	the census was 64.	•						
	Quality Review con	mpleted on 07/21/23						
K 0000								
Bldg. 01		5						
	•	Recertification and State	K 0	000	Cardinal Nursing and Rehab			
		vas conducted by the Indiana			respectfully requests desk rev			
	_	lth in accordance with 42 CFR			and compliance in this matter			
	483.90(a).				Thank you for your considerate	ion.		

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

Survey Date: 07/19/23

Facility Number: 000048

Provider Number: 155115

AIM Number: 100275330

TITLE

(X6) DATE

The creation and submission of this plan of correction does not

constitute an admission by this

provider of any conclusion set forth

in the statement of deficiencies, or

Scheree Michelle Eads **Executive Director** 08/02/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Facility ID: 000048 Page 1 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155115		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2023
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP COD LASALLE AVE I BEND, IN 46617	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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 64. 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 07/21/23		of any violation of regulation.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NQGK21 Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		155115	B. WING		_ 07/19/2023
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	112	EET ADDRESS, CITY, STATE, ZIP CO 1 E LASALLE AVE JTH BEND, IN 46617	DD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFII TAG	CROSS-REFERENCED TO THE AF	OULD BE COMPLETION
	accordance with I Inspection, Testin Water-based Fire Records of syster inspection and tessecure location at a) Date sprinkled b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkled 9.7.5, 9.7.7, 9.7.8 1. Based on observed failed to ensure 2 of were replaced every 5 year calibrated gauge. Inspection, Testing Water-Based Fire I Edition, Section 5.5 replaced every 5 year calibrated or recould affect all residually. Findings include: Based on observating with the Director of between 11:45 a.m supervised antifree gauges. The top garden and the side of the page of the p	supply source RKS information on non-required or partial er system.	K 0353	Cardinal Nursing and Respectfully requests de and compliance in this Thank you for your con What corrective action be accomplished for the residents found to have affected by the deficie practice: The dry sprinkler system gas replaced on 7/26/23 The sprinkler system gas replaced on 7/27/23. How other residents he potential to be affected same deficient practice identified and what con action(s) will be taken. No other recommendate noted during the last 5-linternal Pipe Inspection What measures will be place or what systemic	esk review matter. sideration. a(s) will hose ve been nt m was auges were aving the d by the e will be rrective : ions were year e put into

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NQGK21 Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	01	COMPL	ETED
		155115	B. WIN	NG		07/19/2023	
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
CADDINI	AL NUIDOING AND	DELLA DIL ITATIONI CENTED			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		5001H	BEND, IN 46617		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dated 2016. No reca	alibration date information was			changes will be made to		
	affixed to the sprink	der system gauges. Based on			ensure that the deficient		
	_	e of the observation, the			practice does not recur:		
		ance did not know if the			The Maintenance Director was	s	
		and been recalibrated or tested			educated regarding follow up		
		the dates are older than 5			sprinkler inspection reports. T		
	years.				Maintenance Director will revie		
	J				all deficiencies noted during 5		
	Findings were discu	ussed with the Director of			Internal Pipe Inspection and	, oui	
		xecutive Director at exit			ensure follow up is completed	as	
	conference.				part of the preventative	uo	
					maintenance program.		
	3.1-19(b)				How the corrective action(s)		
	3.1 17(0)				will be monitored to ensure t		
	2. Based on record review and interview, the				deficient practice will not	.116	
		sure a full hydrostatic flush was			recur, i.e., what quality		
	-	automatic sprinkler piping			assurance program will be p	ut	
	_	nternally inspected as required			into place:	ut	
		edition, the Standard for the			The Executive Director will rev	/iow	
	_	and Maintenance of			the 5-year Internal Pipe Inspec		
		rotection Systems in Chapter			report with the Maintenance	Cuon	
		vention. Section 14.3.2			Director prior to the compliance		
		all be examined for internal			date to ensure all sprinkler	,C	
		conditions exist that could			inspection report		
		oing. Section 14.3.3, states if			recommendations are followed	d un	
		stigation indicates the			on. The Executive Director wi		
		nt material to obstruct pipe or			review the preventative	11	
	_	ete flushing program shall be			maintenance checks performe	nd hv	
		ried personnel. Section 14.3.1			the Maintenance Director mon	-	
		on has not been corrected or				-	
	the condition is one				and sign off that the checks we completed.	CIC	
		g despite any previous			completed.		
		that have been performed,					
	· ·	examined internally for					
	-	years. This deficient					
	-	t approximately 30 residents					
	_						
	and staff in the Cott	age wing.					
	Findings include:						
	Findings include:						

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

PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCY (ACH ID BUSINGMARY STATEMENT OF DEFICIENCY TAG Bused on record review of the dry sprinkler system inspection reports on 07/19/29 a tenveen (9-0)-03 a.m. and 11-43 a.m. with the Director of Maintenance and Executive Director present, the 5-year Internal Pipe Inspection report dated (03/28/25) sated that the dry system failed the indicated 5-year internal pipe inspection and "recommend a flush". When interviewing the Director of Maintenance during record review, he stated that they were aware of the issue and had resolved the deficiency. However, based on an invoice of work done, a separate sprinkler company had only cleaned a valve and did a trip test of a dry valve, but did not do a flushing. The Director of Maintenance wars able to get abold of the sprinkler rechineian who conducted the work and stated that the system was in service and returned to normal, but was not advised to conduct a flush as that was not apart of the work order. When interviewing further, the Director of Maintenance stated that the Rejoinal Director had advised him to only clean the dry system valve. The Director of Maintenance was able to get into contact with the Rejoinal Director and was notified that bids for a flush of the dry sprinkler system was in the works, but a flush had not been conducted and would continue to follow up on progress to get the flush done. This finding was reviewed with the Director of Maintenance and Executive Director at the exit conference. 3-1.19(b) K 0363 NFPA 101 SS=E Corridor - Doors GX57 (X5) (X5) DID PROVIPERS NEANE CORRECTOX (X5) (X5) (X5) (X5) (X5) (X5) (X5) DID PROVIPERS NEANE CORRECTOX (X5)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155115		X2) MULTIPLE CONSTRUCTION X3) DATE SU A. BUILDING 01 COMPLE B. WING 07/19/2			LETED		
PRETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review of the dry sprinkler system inspection reports on 07/19/23 between 09/03 a.m. and 11/43 a.m. with the Director of Maintenanee and Executive Director present, the 5-year Internal Pipe Inspection and "recommend a flush." When interviewing the Director of Maintenance during record review, he stated that they were aware of the issue and had resolved the deficiency. However, based on an invoice of work done, a separate sprinkler company had only cleaned a valve and did a trip test of a dry valve, but did not do a flushing. The Director of Maintenance was able to get ahold of the sprinkler technician who conducted the work and stated that they system was in service and returned to normal, but was not advised to conduct a flush as that was not apart of the work order. When interviewing further, the Director of Maintenance stated that the Regional Director and was notified that bids for a flush of the dry system valve. The Director of Maintenance was able to get into contact with the Regional Director and was notified that bids for a flush of the dry system valve. The Director of Maintenance acknowledged that the flush had not been conducted with the flush had not been conducted with the Director of Maintenance and would continue to follow up on progress to get the flush done. This finding was reviewed with the Director of Maintenance and Executive Director at the exit conference. 3-1.19(b) K 0363 NFPA 101 SS=E COMPLETION TAG PRESEX TAG				•	1121 E	LASALLE AVE	•	
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valve. The Director of Maintenance was able to get into contact with the Regional Director and was notified that bids for a flush of the dry sprinkler system was in the works, but a flush had not been conducted yet. The Director of Maintenance acknowledged that the flush had not been conducted and would continue to follow up on progress to get the flush done. This finding was reviewed with the Director of Maintenance and Executive Director at the exit conference. 3-1.19(b) K 0363 NFPA 101 SS=E Corridor - Doors		Maintenance stated	d that the Regional Director					
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Maintenance and Executive Director at the exit conference. 3-1.19(b) K 0363 NFPA 101 SS=E Corridor - Doors		on progress to get	the flush done.					
Maintenance and Executive Director at the exit conference. 3-1.19(b) K 0363 NFPA 101 SS=E Corridor - Doors								
conference.		_						
3-1.19(b) K 0363 NFPA 101 SS=E Corridor - Doors			Executive Director at the exit					
K 0363 NFPA 101 SS=E Corridor - Doors		conference.						
SS=E Corridor - Doors		3-1.19(b)						
SS=E Corridor - Doors	K 0363	NFPA 101		İ				
	Bldg. 01							

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Event ID:

 $NQGK21 \quad \text{Facility ID:} \quad 000048$

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

PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155115	A. BUILDING B. WING	01	COMPLETED 07/19/2023
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP COD LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	Doors protecting of than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary softammable or combustible or combustible mater hardware is not exceeded and the door closed what applied. There is a closing of the door release when the copermitted. Nonrate unlimited height are meeting 19.3.6.3.6 frames shall be late other materials in conference of glass assemblies.	orridor openings in other osures of vertical openings, areas resist the passage made of 1 3/4 inch wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or itals have positive latching atches are prohibited by hese requirements do not expaces that do not contain oustible material. In bottom of door and floor exeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the se. Hold open devices that door is pushed or pulled are and protective plates of the permitted. Dutch doors of are permitted. Door opeled and made of steel or compliance with 8.3,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $NQGK21 \quad \text{Facility ID:} \quad 000048$

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED	
		155115	B. W	ING		07/19/2023		
		<u> </u>		OTPER	ADDRESS CITY STATE TO SEE	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
CADDIN	AL MUIDOINO AND	DELIABILITATION CENTED		1121 E LASALLE AVE				
CARDINA	AL NUKSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		on and interview, the facility	K 0	363	What corrective action(s) will	II	07/28/2023	
		f 30 corridor doors were			be accomplished for those			
	-	eans suitable for keeping the			residents found to have been	n		
		impediment to closing,			affected by the deficient			
	_	resist the passage of smoke.			practice:			
	_	tice could affect approximately			The bedside table in front of re	oom		
	20 residents and sta	aff in 100 Hall.			114 was removed. The chair	that		
					was used to prop open the sh	ower		
	Findings include:				room door was removed.			
					How other residents having	the		
	Based on observation with the Director of				potential to be affected by the	ne		
	Maintenance on 07/19/23 from 11:45 a.m. to 2:11				same deficient practice will I	be		
	p.m., the corridor resident room doors to room 114				identified and what corrective	re		
		in front of the door which			action(s) will be taken:			
	-	door to closing. Furthermore,			All rooms were inspected to			
	_	ba door was propped open with			ensure that there were no obj	ects		
		nterview at the time of			in front of a door that would			
	· ·	Pirector of Maintenance			prevent it from closing and the	at		
		aforementioned corridor doors			there weren't any objects use	d to		
		less the table and chair were			prop a door open.			
	removed first.				What measures will be put in	nto		
					place or what systemic			
	-	ussed with the Executive			changes will be made to			
		tor of Maintenance at exit			ensure that the deficient			
	conference.				practice does not recur:			
					All staff educated that doors			
	3.1-19(b)				cannot be propped open and			
					nothing can be placed in front			
					any door that would impede it			
					closing. Door inspections will			
					added to the monthly preventa	ative		
					maintenance program.			
					How the corrective action(s)			
					will be monitored to ensure	tne		
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place:			
					The Executive Director will rou			
					with the Maintenance Director	-		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155115	î ´	LDING	nstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2023	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		1121 E	DDRESS, CITY, STATE, ZIP COD LASALLE AVE BEND, IN 46617	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ.	(X5) COMPLETION DATE
K 0374	NFPA 101	LEC DEVIN THO BY ORWATION			prior to the compliance date to ensure the doorways are clea. The Executive Director will reven the preventative maintenance checks performed by the Maintenance Director monthly sign off that the checks were completed.	r. view	5.1.12
SS=E Bldg. 01	Subdivision of Bu Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that i Nonrated protecting are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of	resists fire for 20 minutes. we plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors.					
	Based on observation failed to ensure 1 or would restrict the nr 20 minutes. LSC 1 barriers shall compressed to opening leaving necessary for proper	on and interview, the facility f 2 sets of smoke barrier doors novement of smoke for at least 9.3.7.8 requires doors in smoke ly with LSC Section 8.5.4. LSC ors in smoke barrier shall close g only the minimum clearance or operation. This deficient et approximately 20 residents	K 03	74	What corrective action(s) wibe accomplished for those residents found to have been affected by the deficient practice: The smoke barrier doors separating the Cottage Hall w repaired. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	ere the ne oe	07/28/2023

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NQGK21 Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLE	
		155115	B. WI	NG		07/19/2	2023
	1	REHABILITATION CENTER STATEMENT OF DEFICIENCIE		1121 E	ADDRESS, CITY, STATE, ZIP COD LASALLE AVE I BEND, IN 46617		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	COMPLETION
TAG	Based on observation a.m. and 2:11 p.m. the Director of Mai barrier doors separately doon the door frame. In inch gap between the fullest. Based on it observations, the Dacknowledged these close completely do and stated that one which caused the door this finding was re	a LSC IDENTIFYING INFORMATION on on 07/19/23 between 11:45 during a tour of the facility with intenance, the set of smoke uting the Cottage Hall did not use to one of the doors catching. There was an approximately 3 me doors when closed to their interview during the time of irrector of Maintenance is smoke barrier doors did not use to sticking on the door frame of the doors had a bent plate poors to not completely close. Viewed with the Executive or of Maintenance at the exit		TAG	All smoke barrier doors were inspected to ensure that they close completely. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated regarding smoke bas doors inspections and the requirement that they close completely. The barrier door inspections will be monitored during the monthly fire drill exercises. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: The Executive Director will row with the Maintenance Director ensure that the smoke barrier doors close completely. The Executive Director will review preventative maintenance che performed by the Maintenance Director monthly and sign off the checks were completed.	nto as as arrier the ut und to the ecks e	DATE
K 0741 SS=E Bldg. 01							

i î		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED		
		155115	B. WING		07/19/2023
NAME OF I	DROWDER OF CURRINE		STREE	T ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIEF	C	1121	E LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER	SOU	TH BEND, IN 46617	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	provisions:	be prohibited in any room,			
	` '	nent where flammable			
		le gases, or oxygen is			
	1 '	d in any other hazardous			
		a area shall be posted with			
		O SMOKING or shall be			
	_	ternational symbol for no			
	smoking.	•			
		occupancies where			
	smoking is prohib	ited and signs are			
	prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.				
	1 ' '	atients classified as not			
	responsible shall I	· ·			
		ent of 18.7.4(3) shall not			
		atient is under direct			
	supervision.				
	1 ' '	ncombustible material and			
	_	be provided in all areas			
	where smoking is				
	, ,	ers with self-closing cover n ashtrays can be emptied			
	smoking is permit	railable to all areas where			
	18.7.4, 19.7.4	iou.			
		on and interview; the facility	K 0741	What corrective action(s) wi	II 07/28/2023
		f 1 smoking areas were	150/71	be accomplished for those	0772072023
		osing cigarette butts in a metal		residents found to have bee	n
		container with self-closing		affected by the deficient	
		deficient practice could affect		practice:	
		iff and an unknown number of		The cigarette butts were remo	oved
	residents.			from the ground in the smokir	
				area and placed in the metal	
	Findings include:			container.	
				How other residents having	
		on during a tour of the facility		potential to be affected by the	
		f Maintenance on 07/19/23		same deficient practice will	
	between 11:45 a.m.	and 2:11 p.m., in the patio		identified and what corrective	/e

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

PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155115	B. W	ING		07/19/	/2023
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		1121 E	ADDRESS, CITY, STATE, ZIP COD LASALLE AVE I BEND, IN 46617		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
120	smoking area there cigarette butts disposaround the smoking the time of observa Maintenance agreed the ground in the af	were over approximately 15 osed on the ground in and g area. Based on interview at tions, the Director of d there were cigarette butts on forementioned location. viewed with the Director of xecutive Director during the			action(s) will be taken: No other cigarette butts were found on the ground in the smoking area. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff were educated to the smoking regulations. Inspection of the smoking area will be act to the monthly preventative maintenance rounds. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: The Maintenance Director/Housekeeping Super will round monthly to ensure that all cigarette butts are placed in metal container. The Executive Director will review the prever maintenance checks performed the Maintenance Director more and sign off that the checks we completed	ion Ided the visor hat n the re htative ed by nthly	DAIL

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