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	07/19/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/19/23 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 64. Quality Review completed on 07/21/23	E 0000	Cardinal Nursing and Rehab respectfully requests desk review and compliance in this matter. Thank you for your consideration. 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 of any violation of regulation.	
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: 07/19/23 Facility Number: 000048 Provider Number: 155115 AIM Number: 100275330	K 0000	Cardinal Nursing and Rehab respectfully requests desk review and compliance in this matter. Thank you for your consideration. 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	

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

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			of any violation of regulation.	
	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			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	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			
	1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations during a tour of the facility with the Director of Maintenance on 07/19/23 between 11:45 a.m. and 2:11 p.m. the facility has a supervised antifreeze sprinkler system with two gauges. The top gauge was dated 02/2018. The second gauge on the bottom of the riser was	K 0353	Cardinal Nursing and Rehab respectfully requests desk review and compliance in this matter. Thank you for your consideration. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The dry sprinkler system was flushed on 7/26/23 The sprinkler system gauges were replaced on 7/27/23. **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:** No other recommendations were noted during the last 5-year Internal Pipe Inspection **What measures will be put into place or what systemic**	07/28/2023

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	dated 2016. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observation, the Director of Maintenance did not know if the gauges at the riser had been recalibrated or tested and acknowledged the dates are older than 5 years. Findings were discussed with the Director of Maintenance and Executive Director at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect approximately 30 residents and staff in the Cottage Wing. Findings include:		**changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director was educated regarding follow up of sprinkler inspection reports. The Maintenance Director will review all deficiencies noted during 5-year Internal Pipe Inspection and ensure follow up is completed as part of the preventative maintenance program. **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 review the 5-year Internal Pipe Inspection report with the Maintenance Director prior to the compliance date to ensure all sprinkler inspection report recommendations are followed up on. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that the checks were completed.	

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	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 Maintenance and Executive Director present, the 5-year Internal Pipe Inspection report dated 03/28/23 stated 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 was able to get ahold of the sprinkler technician 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 Regional Director had advised him to only clean 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 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 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			

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	Based on observation and interview, the facility failed to ensure 2 of 30 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 20 residents and staff in 100 Hall. Findings include: Based on observation with the Director of Maintenance on 07/19/23 from 11:45 a.m. to 2:11 p.m., the corridor resident room doors to room 114 had a bedside table in front of the door which would impede the door to closing. Furthermore, the shower room spa door was propped open with a chair. Based on interview at the time of observations, the Director of Maintenance acknowledged the aforementioned corridor doors would not close unless the table and chair were removed first. Findings were discussed with the Executive Director and Director of Maintenance at exit conference. 3.1-19(b)	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The bedside table in front of room 114 was removed. The chair that was used to prop open the shower room door was removed. **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 rooms were inspected to ensure that there were no objects in front of a door that would prevent it from closing and that there weren't any objects used to prop a door open. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff educated that doors cannot be propped open and that nothing can be placed in front of any door that would impede it from closing. Door inspections will be added to the monthly preventative maintenance program. **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	07/28/2023

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			prior to the compliance date to ensure the doorways are clear. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that the checks were completed.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect approximately 20 residents and staff in two smoke compartments. Findings include:	K 0374	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The smoke barrier doors separating the Cottage Hall were repaired. **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:**	07/28/2023

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	Based on observation on 07/19/23 between 11:45 a.m. and 2:11 p.m. during a tour of the facility with the Director of Maintenance, the set of smoke barrier doors separating the Cottage Hall did not close completely due to one of the doors catching on the door frame. There was an approximately 3 inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Director of Maintenance acknowledged these smoke barrier doors did not close completely due to sticking on the door frame and stated that one of the doors had a bent plate which caused the doors to not completely close. This finding was reviewed with the Executive Director and Director of Maintenance at the exit conference. 3.1-19(b)		All smoke barrier doors were inspected to ensure that they close completely. **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 was educated regarding smoke barrier 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 put into place:** The Executive Director will round with the Maintenance Director to ensure that the smoke barrier doors close completely. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that the checks were completed.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following			

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	provisions: (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. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 07/19/23 between 11:45 a.m. and 2:11 p.m., in the patio	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The cigarette butts were removed from the ground in the smoking area and placed in the metal container. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	07/28/2023

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	smoking area there were over approximately 15 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observations, the Director of Maintenance agreed there were cigarette butts on the ground in the aforementioned location. This finding was reviewed with the Director of Maintenance and Executive Director during the exit conference. 3.1-19(b)		**action(s) will be taken:** No other cigarette butts were found on the ground in the smoking area. **What measures will be put into 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 added to the monthly preventative maintenance rounds. **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 Maintenance Director/Housekeeping Supervisor will round monthly to ensure that all cigarette butts are placed in the metal container. The Executive Director will review the preventative maintenance checks performed by the Maintenance Director monthly and sign off that the checks were completed.	