

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

PRINTED: 08/21/2023  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>155115</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>08/17/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CARDINAL NURSING AND REHABILITATION CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1121 E LASALLE AVE</b><br><b>SOUTH BEND, IN 46617</b>               |                      |   |
| (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 |   |
| {K 000}   | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/19/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 08/17/23</p> <p>Facility Number: 000048<br/>Provider Number: 155115<br/>AIM Number: 100275330</p> <p>At this Life Safety Code PSR, Cardinal Nursing and Rehabilitation Center was found 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.</p> <p>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. At the time of this survey, the census was 63.</p> | {K 000}   |   |                      |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE                 |  |   | TITLE   |                      | (X6) DATE   |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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| {K 000}   | Continued From page 1<br>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.<br><br>Quality Review completed on 08/18/23 | {K 000}   |   |                      |   |