STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155376		10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN REHABILITATION AND HEALTHCARE CENTER	803 S HAMILTON ST SHERIDAN, IN 46069

(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 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/27/15 Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170 At this Life Safety Code survey, Sheridan Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 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 one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke alarms in all resident rooms. The facility has a capacity of 80 and had a census of 52 at	K 0000	Preparation and/or execution of this plan of correction does notconstitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	

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

Any defiencystatement 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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	the time of this visit.			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 8 exit doors would disengage the locking mechanism and remain unlocked until the fire alarm system was reset. LSC 7.2.1.6.2 (d) requires doors shall automatically unlock and remain unlocked until the fire protective signaling system has been manually reset. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect 20 residents on 100 hall north as well as staff and visitors. Findings include: Based on observation on 10/27/15 at 2:10 p.m. during a fire alarm test with the Maintenance Supervisor and	K 0038	1. No residents were found to be affected by the deficient practice. Facility had an electronics company assess the secondary exit for the 100 hall north residents for proper functionality and determined the door was functioning properly. A new sticker with instructions on emergency use has been placed on the door. 2. No residents were affected by the deficient practice. 3. Maintenance director or designee will continue to check the functionality of the 100 hall north secondary exit during the monthly fire alarm drills. These drills and door audits will be recorded monthly. 4. Maintenance director will share the results of the fire drills and door audits to the QAPI meeting monthly to ensure all exit doors are functioning properly during fire alarm drills. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.	11/26/2015

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	Administrator the breakaway sliding glass door serving as the secondary exit for 100 hall north residents did not release upon activation of the fire alarm system. The door required the input of a code on a keypad which when the fire alarm was activated the door did not release nor did the keypad work to unlock the door. When the fire alarm was reset, the door could again be opened with the keypad adjacent to the door. Based on interview concurrent with the observation with the Maintenance Supervisor and Administrator it was acknowledged the aforementioned exit door would not unlock when the fire alarm was activated and no explanation could be offered for its malfunction. 3.1-19(b)			
K 0068 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 20 residents on 100 hall	K 0068	1. No resident was impacted by the deficient practice. Maintenance director has replaced the electrically powered motor which opens the louvers in the ceiling above the two gas dryers to ensure fresh air intake. 2. No residents were impacted by the deficient practice. 3. Maintenance director will check the operation of the electrically	11/26/2015

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	north as well as visitors and staff. Findings include: Based on observation on 10/27/15 at 1:20 p.m. with the Maintenance Supervisor and Administrator, the two gas fueled dryers in the laundry room on 100 hall north was supplied with a fresh air intake from the outside, but it had been sealed off. Based on interview on 10/27/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor and Administrator the fresh air intake for the aforementioned gas appliances was operated by an electrically powered motor which opened the metal louvers in the ceiling above the two gas dryers, but the motor was not working and the louvers were sealed off. 3.1-19(b)		powered motors above the two gas dryers weekly during his preventative maintenance rounds and document his findings in a log. 4. The maintenance director will review this log weekly and will report the findings to the QAPI meeting monthly to ensure the proper functioning of the electrical powered motor above the gas dryers. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.	
K 0070 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in the facility. This	K 0070	1. No residents were affected by the deficient practice. The portable space heater was removed from the facility and central supply clerk was educated	11/26/2015

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	deficient practice could affect 15 residents on 100 hall northeast as well as visitors and staff. Findings include: Based on observation on 10/27/15 at 1:30 p.m. with the Maintenance Supervisor and Administrator, inside the central supply office was observed a portable space heater plugged in and available for use under an employee's desk. Based on interview on 10/27/15 concurrent with the observation, it was acknowledged by the Maintenance Supervisor and Administrator space heaters were not allowed in the facility, however, a portable space heater policy was not available to verify this. 3.1-19(b)		about not having portable space heaters at facility. 2. No residents were impacted by the deficient practice. 3. The maintenance director will monitor for the use of portable space heaters during his weekly rounds. All staff will be inserviced about portable space heaters at the facility: that they are not allowed on the property and should be removed immediately if discovered on the property.4. Maintenance director will share the results of the weekly rounds related to portable space heaters to the QAPI meeting monthly to ensure that they are not on the property. The QAPI team will determine if further	
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for the past 12 months	K 0144	1. The monthly generator log book was located and monthly generator load tests will recorded in the log book per guidelines. 2. No residents were impacted by the deficient practice. 3. The	11/26/2015

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	using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 10/27/15 at 3:04 p.m. with the Maintenance Supervisor and		maintenance director will ensure that the record of the monthly generator load test has been logged in the generator log book per guidelines. 4. The maintenance director will share the log of the monthly generator load test to the QAPI meeting monthly x3 to ensure that it is being completed. The QAPI team will determine if further action is needed and determine the continued time schedule for further monitoring.	

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	Administrator, the monthly generator log book could not be provided for review. Based on interview on 10/27/15 concurrent with record review with the Maintenance Supervisor and Administrator, it was acknowledged the facility had been running the generator monthly, but could not provide any documentation to demonstrate this nor was any other equivalent method used to comply with percentage of load capacity for the past twelve months. 3.1-19(b)			