

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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K010000	<p>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).</p> <p>Survey Date: 11/12/13</p> <p>Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Highland Nursing and Rehabilitation 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.</p> <p>This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors with battery</p>	K010000		
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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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	<p>powered smoke detectors in all resident rooms. The facility has the capacity for 35 and had a census of 31 at the time of this survey services are sprinklered</p> <p>All areas where residents have access are sprinklered. Three detached storage sheds are unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings in smoke partitions were sealed to limit the transfer of smoke in 1 of 3 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and an 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 11/12/13 at 1:00 p.m., a four inch duct and conduit penetrated the ceiling of the medicine room. The one inch gap around the duct and the one fourth inch gap around the conduit opened into the interstitial space above the room. The maintenance director said at the time of observation, he hadn't known the penetrations were unsealed.</p>	K010025	<p>K025 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? We were unable to correct the alleged deficient practice. The ceiling of the medication room will be repaired and sealed on 12/9/20123. The boiler room gaps will be repaired and sealed on 12/9/2013. How will you identify other residents affected by the alleged deficient practice? All residents may be affected by the alleged deficient practice. The entire facility will be checked on 12/9/2013 to ensure there were no other breached smoke barriers. What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) The life safety round policy will be revised to include boiler rooms, medication rooms and offices and rooms. The Round audit sheet also was revised to include all of</p>	12/14/2013			

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	b. Based on observation with the maintenance director on 11/12/13 at 1:50 p.m., a one inch ceiling gap around the 24 inch boiler duct, one inch gap around a boiler room conduit wall penetration and a four inch diameter hole in the boiler room wall were all unsealed into the adjacent interstitial spaces. The maintenance director agreed at the time of observations, the openings did not maintain the integrity of the smoke barrier. 3.1-19(b)		these areas. How will the corrective action be monitored to ensure the practice will not reoccur? (QA) Life Safety Rounds of the entire building will be completed weekly for two weeks then monthly to ensure the practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013		

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the battery powered emergency lighting fixtures for 1 of 1 emergency generator sites would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect all occupants if the lighting were needed to make emergency generator repairs.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/12/13 at 1:55 p.m., both bulbs in the battery powered emergency light fixture serving the emergency generator site failed to illuminate when tested four times. The maintenance director said at the time of observation, he could not believe the light was not working because he was diligent about checking the fixture monthly.</p> <p>3.1-19 (b)</p>	K010046	<p>K046 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? We were unable to correct the alleged deficient practice for those residents affected. The light will be repaired by Safe Care on 12/5/2013How will you identify other residents affected by the alleged deficient practice? Residents who reside in the facility may be affected by the alleged deficient practice. The light will be repaired on 12/5/2013What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) The life safety round policy will be revised to include boiler rooms, medication rooms and offices and rooms. The Round audit sheet also was revised to include all of these areas.How will the corrective action be monitored to ensure the practice will not reoccur? Life Safety Rounds of the entire building will be completed weekly for two weeks then monthly to ensure the practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013</p>	12/14/2013			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill Records and interview with the maintenance director on 11/12/13 at 3:40 p.m., a record of first shift fire drills was not found for the second and third quarters of 2013. At the time of record review, the maintenance director identified disaster drill records for those time frames. He acknowledged these were done in lieu of the fire drills.</p> <p>3.1-9(b) 3.1-51(c)</p>	K010050	<p>050 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? We were able to correct the alleged deficient practice. How will you identify other residents affected by the alleged deficient practice? All residents of the facility have the potential to be affected by the alleged deficient practice. A fire drill will be conducted on 11-29-2013 and 12/10/2013 to ensure that we are current with the final quarter of the year. What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) the fire drill policy was revised to increase the frequency of drills to ensure all were done as required. Fire drill compliance was also added to the Life safety audit. The Maintenance Director was educated on the drill policy and audit. How will the corrective action be monitored to ensure the practice will not reoccur? (QA) not</p>	12/14/2013	

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			reoccur? (QA) the fire drill schedule and completion will be reviewed weekly for one month then monthly to ensure the practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013		

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K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. NFPA 72, 1-5.2.5.3 requires the overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could</p>	K010051	F051 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? We were unable to correct the alleged deficient practice at this time. The Breaker box will be labeled and locked on 11/27/2013. Safe Care performed a sensitivity testing on 12/5/2013 and a list was obtained of the devices checked. How will you identify other residents affected by the alleged deficient practice? All Residents who reside in the facility have the potential to be affected by the alleged deficient practice. The Breaker box will label and locked on 11/27/2013. Safe Care performed a sensitivity testing	12/14/2013
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	<p>affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/12/13 at 2:10 p.m., the fire alarm system circuit breaker located in the emergency power breaker box was not immediately identifiable. The maintenance director could not say where the fire alarm panel circuit breaker was located until he checked all the panels in the building. The circuit breaker box was mounted on a wall outside the building. There was no lock or any other means to prevent anyone from tampering with the circuits. The maintenance director acknowledged the panel should have been labeled and locked against unauthorized tampering.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system's components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and</p>		<p>on 12/5/2013 and a list was obtained of the devices checked. What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) etc.) The life safety round policy will be revised to include Breaker Box security and sensitivity testing and documents. The Round audit sheet also was revised to include all of these areas. How will the corrective action be monitored to ensure the practice will not reoccur? (QA) Life Safety audit will be completed weekly for two weeks then monthly to ensure the practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013</p>				

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	<p>serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's fire alarm system Inspection and Testing Forms dated 12/18/13 and 06/07/13 with the maintenance director on 11/12/13 at 4:10 p.m., the December report noted in "Comments: Performed annual inspection on fire alarm system. Visually inspected all devices and functionally tested all smokes and pulls. All devices working properly. See device list for details." A second comment section noted, "All devices working properly. See device list for details." There was no itemized list of the fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and manual pull stations with the locations and results of the visual and functional tests for the dates of these inspections. The maintenance director called the fire system contractor and reported on 11/12/13 at 4:40 p.m., the contractor said the device list was provided when sensitivity testing was done and did not need to be provided for the fire system test. The last record of a sensitivity test was dated 12/19/11. The</p>						

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	<p>maintenance director confirmed the sensitivity testing was conducted every two years.</p> <p>3-1.19(b)</p>			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases in 2 of 18 resident rooms were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents in the west smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/12/13 between 2:00 p.m. and 2:10 p.m., resident rooms 11 and 16 each had one oxygen e-cylinder standing without support in the rooms. The maintenance director said at</p>	K010076	F076 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? the residents in room 11 and 16 may have been affected by the alleged deficient practice. The oxygen was removed and stored safely on 11/12/2013How will you identify other residents affected by the alleged deficient practice? The resident who are on oxygen May have the potential to be affected by the alleged deficient practice. Each room who had oxygen was checked to ensure that all oxygen was stored safely on 11/12/2013 What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) the oxygen storage policy was revised to include safe storage. Safe storage was added to the environmental audit. All nursing staff was in serviced on 11/26/2013. How will the	12/14/2013	

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	the time of each observation, the cylinder should not have been left in this manner and a storage area with appropriate racks was available. 3.1-19(b)		corrective action be monitored to ensure the practice will not reoccur? (QA) Life Safety Rounds of the entire building will be completed weekly for two weeks then monthly to ensure the practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013		

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure electrical panels in 1 of 3 smoke compartments were provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more residents in the west smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/12/13 at 2:10 p.m., an electrical room housing two electrical circuit panels and a bank of emergency generator transfer switches was used for an office in the west smoke compartment. The maintenance director was trying to observe and identify circuits in one of the circuit boxes but could not do so because a file cabinet and a stack of</p>	K010147	k147 What corrective action will be accomplished for those residents who are affected by the alleged deficient practice? All residents may have the potential to be affected by the alleged deficient practice. all items were removed and a three foot clearance was obtained on 11/26/2013How will you identify other residents affected by the alleged deficient practice? All residents who reside in the facility may be affected by the alleged deficient practice. All items were removed and a three foot clearance was obtained on11/26/2013.What measures will be put in place or what systemic changes we will make to ensure that the practice does not reoccur. (Policies, training etc.) The environmental policy was revised to include checking of electrical panels and three foot required clearance. Staff in these areas were educated on the three foot requirement. The environmental audit was also revised to include the three foot clearance near panels. How will the corrective action be monitored to ensure the practice will not reoccur? (QA) Life Safety Rounds of the entire building will be completed weekly for two weeks then monthly to ensure the	12/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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(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
	card board boxes stood eight inches in front of the panels. The maintenance director said at the time of observation, he was unaware of the requirement to maintain a three foot clearance for panel access. 3.1-19(b)		practice does not reoccur. The Quality Assurance Committee and the Administrator will oversee compliance. Completion date December 14, 2013	