

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2014
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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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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: 10/29/14</p> <p>Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has 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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K010029 SS=E	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 61 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services which were not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>			

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	<p>Based on observation and interview, the facility failed to ensure 3 of 9 hazardous areas such as soiled linen rooms were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 32 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:55 a.m. to 12:20 p.m. on 10/29/14, the following was noted:</p> <p>a. four of four 32 gallon containers filled with soiled linen were noted in the 100 Hall Shower Room and the corridor door to the room was not self closing.</p> <p>b. two of four 32 gallon containers filled with soiled linen were noted in the long hall shower room and the corridor door to the room was not self closing.</p> <p>c. three of six 32 gallon containers filled with soiled linen were noted in the south shower room and the corridor door to the room was not self closing.</p> <p>Based on interview at the time of the observations, the Maintenance Director stated the aforementioned shower rooms are utilized as soiled linen storage rooms and acknowledged the aforementioned hazardous areas were not separated from</p>	K010029	<p>Defeciency ID: K029 Completion Date: November 21, 2014</p> <p>Plan of Correction : K-029</p> <ol style="list-style-type: none"> On 10/29/14, during Life Safety visit at facility it was requested that self closing corridor doors be used in Shower Room areas where more than 32 gallons of soiled linen may be stored at one time. All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director did a house wide audit of all shower areas and 3 were identified. The Maintenance Director will order 3 new doors with self closing devices per 	11/21/2014			

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K010038 SS=D	<p>other spaces by a self closing corridor door.</p> <p>3.1-19(b)</p> <p>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 provide 1 of over 50 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states</p>	K010038	<p>recommendation. SafeCare Door was called, quote was created, doors are ordered.</p> <p>4. The self closing doors will remain on all 3 shower areas to ensure that the soiled linen bins will always be behind a closed and secure door.</p> <p>Defeciciency ID: K038 Completion Date: November 21, 2014</p> <p>Plan of Correction: K038</p> <p>1. On 10/29/14, during Life Safety visit it was observed that a</p>	11/21/2014

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K010046 SS=C	<p>examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 3 staff and visitors in the Executive Director's office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 12:20 p.m. on 10/29/14, the corridor door to the Executive Director's office has two locks on the door and a key was required to unlock each lock on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour</p>		<p>deadbolt and keyed locking mechanism were both on the Executive director door. Exit access was alleged to be challenged by the dead bolt lock.</p> <p>2. Three staff and visitors could be affected by this alleged deficient practice.</p> <p>3. The Maintenance Director disabled the deadbolt lock by removing its locking mechanism on 10/29/14.</p> <p>4. The singular lock for the Executive Director Office door will be the only locking device used here forward</p>		

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	<p>duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:55 a.m. to 10:55 a.m. on 10/29/14, documentation of monthly functional testing and annual testing for not less than 1 ½ hour duration for facility battery powered emergency lights for the most recent twelve month period was not available for review. Based on observations with the</p>	K010046	<p>Defecency ID: K-046</p> <p>Completion Date: November 21,2014</p> <p>Plan of Correction: K-046</p> <p>1. On October 29, 2104 during Life Safety visit it was observed that the emergency lighting equipment was functional on portable generator but LSC 7.9 was alleged to not be in compliance as the log for testing was not available.</p> <p>2. All residents, staff and visitors have the</p>	11/21/2014

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K010064 SS=E	<p>Maintenance Director during a tour of the facility from 10:55 a.m. to 12:20 p.m. on 10/29/14, a total of two battery powered emergency lights were located in the facility at the portable emergency generator location and each battery powered emergency light operated when their respective test button was pushed. Based on interview at the time of observation, the Maintenance Director acknowledged documentation of monthly functional testing and annual testing for not less than 1 ½ -hr duration for facility battery powered emergency lights for the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>		<p>potential to be affected by the alleged deficient practice.</p> <p>3. The Maintenance Director will test all equipment per the LSC 7.9 on a monthly basis and document the same in a written log to be kept in a binder and readily available for inspection.</p> <p>4. The Maintenance log for emergency light testing on portable generator and any emergency lighting equipment will be monitored by keeping a monthly log which will be checked by Executive Director. Maintenance Director will be responsible for bringing same log to monthly Quality Assurance meeting to insure that the testing and log are complete on a monthly basis</p>	

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	<p>Based on observation and interview, the facility failed to inspect 1 of 14 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 16 residents, staff and visitors in the vicinity of the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:55 a.m. to 12:20 p.m. on 10/29/14, the annual maintenance tag attached to the portable fire extinguisher located in the Beauty Shop indicated a monthly inspection was not documented for the seven month period of March 2014 through September 2014. Based on</p>	K010064	<p>Deficiency ID: K-064 Completion Date: November 21, 2014</p> <p>Plan of Correction: K-064</p> <ol style="list-style-type: none"> 1. On 10/29/14 during Life Safety inspection an observation of a missing signature and date in the Beauty Shop was alleged per NFPA 10, Standard for Portable Fire Extinguishers. 2. This deficient practice could affect 16 residents, staff, and visitors in the vicinity of the Beauty Shop. 3. Upon further 	11/21/2014			

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	<p>interview at the time of observation, the Maintenance Director stated no additional documentation of monthly fire extinguisher checks was available for review and acknowledged a monthly inspection for the portable fire extinguisher located in the Beauty Shop was not documented for the seven month period of March 2014 through September 2014.</p> <p>3.1-19(b)</p>		<p>inspection it was observed that the monthly inspection for the seven month period of March 2104-September 2014 was not present in the Maintenance Director monthly log.</p> <p>4. The Maintenance Director will monitor all portable fire extinguishers in building which includes dating and signaturing the fact that the units appear to be in good working condition. Maintenance Director will audit the fire extinguishers monthly, and report the same at monthly Safety</p>		

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square foot area not protected as a hazardous area for 3 of 3 shower rooms. This deficient practice could affect 32 residents, staff and visitors.</p> <p>Findings include:</p>	K010075	<p>meeting to the Executive Director. Additionally, it will be noted in monthly Quality Assurance meeting and recorded to insure safety for all residents, staff and family in the facility.</p> <p>Defeciency ID: K075 Completion Date: November 21, 2014</p> <p>Plan of Correction : K-075</p> <p>1. On 10/29/14, during</p>	11/21/2014

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	<p>Based on observations with the Maintenance Director during a tour of the facility from 10:55 a.m. to 12:20 p.m. on 10/29/14, mobile soiled linen receptacles each with 32 gallon capacity were unattended and stored next to each other in each of the three shower rooms in the facility. Each of the three shower rooms is not protected as a hazardous area. Four of four 32 gallon containers filled with soiled linen was noted in the 100 Hall Shower Room. Two of four 32 gallon containers filled with soiled linen was noted in the long hall shower room. Three of six 32 gallon containers filled with soiled linen was noted in the south shower room. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned shower rooms are utilized as soiled linen storage rooms and acknowledged the aforementioned hazardous areas were not separated from other spaces by a self closing corridor door.</p> <p>3.1-19(b)</p>		<p>Life Safety visit at facility it was requested that self closing corridor doors be used in Shower Room areas where more than 32 gallons of soiled linen may be stored at one time.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director did a house wide audit of all shower areas and 3 were identified.</p> <p>3. The Maintenance Director will order 3 new doors with self closing devices per recommendation. SafeCare Door was called, quote was created, doors are ordered.</p> <p>4. The self closing doors will remain on all 3 shower areas to ensure that the soiled linen bins</p>	

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			will always be behind a closed and secure door.		