

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  09/06/2013
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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: 09/06/13</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 operated</p>	K010000	Preparation or execution of this plan of correction does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required under law. By this response, Sheridan Rehabilitation and Healthcare Center acknowledges receipt of the statement of deficiencies and alleges that it is in compliance as of 09/18/13.	

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>smoke detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 67 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. The facility has one detached building providing storage services which is not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 48 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:30 a.m. to 12:40 p.m. on 09/06/13, the following openings in the ceiling smoke barrier were noted:</p> <p>a. the annular space surrounding a two inch in diameter pipe penetrating the ceiling in the "Sprinkler Valve" room.</p> <p>b. the annular space surrounding a one inch in diameter sprinkler head pipe in the ceiling of the emergency generator room.</p> <p>Based on interview at the time of the observations, the Maintenance Director</p>	K010025	K-0251. Maintenance Director immediately sealed the smoke barrier around sprinkler system pipe using Fire, smoke and draft Stop OSI Flame seal caulk. 2. Maintenance Director checked all other sprinkler system pipes to ensure smoke barriers intact. 3. Maintenance Director to check areas around pipes in generator and sprinkler system room weekly x 4 weeks and then monthly thereafter. 4. Results of findings will be brought to the QA meeting monthly for review Completed 09/18/13	09/18/2013			

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	<p>acknowledged the aforementioned openings in the ceiling smoke barrier did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<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> <p>Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as soiled linen rooms were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 24 residents, staff and visitors in vicinity of the soiled linen room by Room 211.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:30 a.m. to 12:40 p.m. on 09/06/13, the corridor entry door to the soiled linen room by Room 211 had a one half inch in diameter hole in the door above the door handle. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the corridor entry door to the soiled linen room by</p>	K010029	<p>K-029 1.Maintenance Director immediately sealed the ½ ' area above door handle using Fire, smoke and draft Stop OSI Flame seal caulk. 2. Maintenance Director checked all doors throughout facility. No other deficiencies found. 3. Maintenance Director will check doors daily and complete a weekly checklist x 4 weeks and then monthly thereafter. 4. Results of findings will be brought to the QA meeting monthly for review. Completed 09/18/13</p>	09/18/2013			

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	Room 211 failed to separate the area from other spaces by smoke resistant partitions and doors.  3.1-19(b)			

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K010038 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 32 residents, staff and visitors if needing to exit the facility by the Main Dining Room, the exit by Room 119 and the exit by the ambulance driveway.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:30 a.m. to 12:40 p.m. on 09/06/13, the Main Dining Room exit, the exit by Room 119 and the exit by the</p>	K010038	<p>K-038 1. Maintenance Director posted "code" above each key pad on the exit doors so alert residents, staff and visitors can identify and use to exit the facility. 2. All residents could be affected. A "code" posted at each door that is understandable by alert residents, visitors and staff. 3. Each time the exit code is changed a new code will be posted on the door. Maintenance Director will check weekly x 4 weeks and then monthly thereafter. 4. Results of findings will be brought to the QA meeting monthly for review. Completed 09/18/13</p>	09/18/2013

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	<p>ambulance driveway are each marked as a facility exit and each exit door was magnetically locked and could be opened by entering a four digit code, but the code was not posted at the exit by the ambulance driveway. In addition, the code which was posted at the Main Dining Room exit and at the exit by Room 119 was not the correct code to release the magnetically locked exit door based on one attempt to open each door with the posted code. Based on interview with the Director of Nursing (DON) at 11:00 a.m. on 09/06/13, the DON stated the facility houses residents mostly without a clinical diagnosis to be in a secure building. Based on interview at the time of the observations, the Maintenance Director stated the four digit exit code was changed on the previous day, 09/05/13, the posted code at the exit by Room 119 and the Main Dining Room had not yet been updated and acknowledged the code was not posted at the exit by the ambulance driveway.</p> <p>3.1-19(b)</p>				

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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 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 16 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:30 a.m. to 12:40 p.m. on 09/06/13, a refrigerator was plugged into a power strip in Room 205 and a refrigerator was plugged into a power strip in the Medical Records office. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned locations each had a refrigerator plugged into a power strip.</p> <p>3.1-19(b)</p>	K010147	<p>K-147 1. Maintenance Director removed power strip in room 205 2. Maintenance Director checked all rooms in the facility to ensure no other deficiencies were noted. 3. Maintenance Director will check rooms at least weekly x 4 weeks and then monthly thereafter, to ensure no power strips present 4. Results of findings will be brought to the QA meeting monthly for review. Completed 09/18/13</p>	09/18/2013