

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 07/24/2012
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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
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/24/12</p> <p>Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280</p> <p>Surveyor: W. Chris Greeney , Life Safety Code Specialist,</p> <p>At this Quality Assurance Walk-thru survey, Highland Nursing and Rehabilitation Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).</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 smoke detection in the corridors and spaces open to the corridors. Each resident room had a smoke detector that was not installed in accordance with NFPA requirements. The facility has a capacity of 34 and had a census of 30 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage.</p>	K0000		

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>The facility was found not in compliance with state law in regard to smoke detector coverage since smoke detectors installed on the wall in each resident room were not installed within 4 inches to 12 inches from the ceiling.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety code of the National Fire Protection Association which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date of this rule.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in accordance with National Fire Protection Association (NFPA) requirements in each resident's room before July 1, 2012. NFPA 101, Life Safety Code (LSC), Section 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall either be maintained, or removed. NFPA 72, National Fire Alarm Code, 2-3.4.3.1 requires smoke detectors mounted on the side wall be a minimum of four inches and a maximum of 12 inches from the ceiling to the top of the detector. This deficient practice could affect all residents in the facility.</p>	K9999	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 9999</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Smoke detectors in rooms 1-19 were adjusted to meet the state and National Fire Protection Association (NFPA) code to be within 4 to 12 inches from the ceiling to the top of the detector.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Facility audit was completed to ensure that smoke detectors were placed in accordance to state and NFPA guidelines.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: NHA and Maintenance Director have been in-serviced to the requirements of this smoke detector NFPA requirement.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: Monitoring of this will be a joint effort between the NHA and the Maintenance Director who will make walking rounds</p>	07/30/2012			

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/24/12 from 9:15 a.m. to 10:00 a.m., resident rooms 1 through 18 each had a smoke detector installed on the wall just above the door frame. The distance between the top of the smoke detector and the ceiling was 18 inches in each room. Based on interview during the time of observations, the Maintenance Director confirmed with a tape measure that the devices were installed 18 inches from the ceiling.</p> <p>3.1-19(b)</p>		<p>to ensure placement of smoke detectors met the HFPA requirement. These rounds will be discussed at the monthly Risk Management/QA meeting until the committee recommends quarterly oversight by the Regional Director of Plant Ops when making his facility rounds.</p> <p>(e) Date of compliance: 7/30/2012</p>		