STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	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: 04/27/12 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Sebo's 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. This facility was surveyed as three separate buildings due to the construction types of three sections of the building: Building 0102 originally built in 1951 as a house is of Type V (000) construction and is fully sprinklered; Building 0202	K0000	**K000** Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.	

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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	renovated in 1972 and 1999 was determined to be of Type II (111) construction and is now sprinklered; and Building 0302 built in 1999 was determined to be of Type V (111) construction and fully sprinklered, encompasses the north and southeast sections of the facility. The facility has one fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and a census of 110 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/10/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 2 of 99 smoke detectors was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, National Fire Alarm Code, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 28 residents in building 0202 north hall as well as visitors or staff. This deficient practice could also affect 8 residents in building 0302 north hall as well as visitors or staff. Findings include: Based on observation on 04/27/12 at 1:13 p.m. with the Maintenance Supervisor, the smoke detector next to the nurse's station in building 0202 north hall was within two feet of an air supply duct. Based on interview on 04/27/12 at 1:15 p.m., it was acknowledged by the Maintenance Supervisor the	K0052	K052 It is the practice of this facility to ensure that smoke detectors are installed in a location which will allow the smoke detector to function to its fullest capability. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The smoke detector next to the nurse's station has been relocated to an area greater than two feet from an air duct supply. · The smoke detector in the environmental office has been relocated to an area greater than two feet from an air duct supply. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents of this facility have the potential to be affected by this alleged deficient practice. An inspection of all smoke detectors in the facility was completed to insure their location is not closer than 2 feet from an air duct supply. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee will	05/25/2012

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	aforementioned smoke detector was installed within two feet of an air supply duct in the ceiling which would not allow the smoke detector to detect smoke to its fullest capability. Based on observation on 04/27/12 at 2:15 p.m. with the Maintenance Supervisor, the smoke detector in the environmental office in building 0302 north hall was within two feet of an air supply duct. Based on interview on 04/27/12 at 2:17 p.m., it was acknowledged by the Maintenance Supervisor the aforementioned smoke detector was installed within two feet of an air supply duct in the ceiling which would not allow the smoke detector to detect smoke to its fullest capability. 3.1-19(b)		inspect any contracted work that may involve the replacement/repair/ or addition of smoke detectors in this facility to assure they are located properly. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Any smoke detector not in compliance will be corrected and the Administrator will be notified. The Maintenance Director/designee will present a summary of this work to the Quality Assurance Committee. **Compliance Date: 5/25/2012**	

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K0064 SS=E	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 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 04/27/12 at 2:38	K0064	K064 It is the practice of this facility to ensure that portable fire extinguishers in the kitchen are in accordance with the requirements of NFPA 10. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · A sign has been placed by the Class K extinguisher stating "To be used only as a secondary device. This Extinguisher only used after hood suppression system is activated." · All dietary staff were in-serviced on activation on the hood suppression system and use of the Class K extinguisher. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All residents have the potential to be affected by this alleged deficient practice. · Dietary staff have been in-serviced on the activation of the hood suppression system and use of the Class K extinguisher. · All new dietary staff will be educated on the activation of hood suppression system and use of the Class K extinguisher as a part of their orientation.	05/25/2012

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	p.m. with the Maintenance Supervisor, there was a K class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 04/27/12 at 2:40 p.m. with the Maintenance Supervisor, it was acknowledged the K class portable fire extinguisher was not provided with a placard. 3.1-19(b)		**How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will make monthly observations to assure that the sign is placed in a conspicuous place near the Class K extinguisher. Any non-compliance of this practice will be corrected immediately and reported to the Administrator. A summary report of any negative findings will be presented to the Quality Assurance Committee by the Maintenance Director. **Compliance Date 5/25/2012**	

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K0067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 28 of 28 resident rooms in building 0202 were not using the corridor as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all resident rooms in building 0202 as well as visitors and staff. Findings include: Based on observations on 04/27/12 during a tour of the facility between 11:00 a.m. and 4:14 p.m. with the Maintenance Supervisor, all resident rooms in building 0202 were using the egress corridors as a return air system. Based on interview on 04/27/12 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air ducts for all the resident rooms were in the corridors	K0067	K067 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident rooms 44-70 have the adjoining bathroom exhaust fans wired to run constantly to meet the CMS guidelines for K67 HVAC Requirements in 2011. The facility had a balancing and testing contractor verify the amount of air supplied to the rooms and the air exhausted did not allow for the corridor to be used as a plenum. This facility has contracted an Architect to assist in a design study for this facility to assure compliance of this alleged deficiency is met. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents, visitors and staff have the potential to be affected by the alleged deficient practice. · This facility has contracted an Architect to assist in a design study for this facility to assure compliance of this alleged deficiency is met. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The Architect, and their engineer(s), will visit the facility and confirm the existing conditions within 30 days.	04/30/2013

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	3.1-19(b)		· Construction documents will be prepared within 45 days thereafter. · The constructions documents will be submitted to ISDH for plan review within 10 days thereafter. · Plan review period, comment and responses estimated to be 45-60 days following submittal · Release construction documents for bidding, 10 days following receipt approved documents from all agencies having jurisdiction. · Receipt of bids, 30 days thereafter · Review bids and hire contractor within 30 to 45 days thereafter How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Upon compliance of this deficiency, the Maintenance Director/designee will monitor this system to assure it is full working order. · Any findings of system not working will be corrected immediately and reported to the Administrator/designee. The Maintenance Director will report to the Quality Assurance Committee any finding on non compliance and resolution for review. **Compliance Date: 4/30/2013**	