

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  08/14/2012
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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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K0000	<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: 08/14/12</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)</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>construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has the capacity for 38 and had a census of 25 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 doors to hazardous areas, such as the kitchen, was held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors and 14 residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/14/12 at 1:15 p.m., the self closing door between the kitchen and exit corridor would not close unless it was pulled closed. The maintenance director said at the</p>	K0021	<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><b>K 021 - NFPA 101 Life Safety Code Standard – Smoke Zones</b></p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>The self-closing door between the kitchen and exit corridor has been adjusted to close and latch properly and excess paint has been removed from the door.</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:</p> <p>A facility wide audit was completed to</p>	09/13/2012			

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	time of observation the door had too much paint which interfered with self closing.  3.1-19		<p>ensure that smoke compartment doors closed and latched properly.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>The Maintenance Director has been in-serviced as to the required components of this tag. The Facility Preventative Maintenance Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p><b>(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:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months as they review the proper closing of smoke compartment doors at the facility. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended. date of compliance: 9-13-12</p>		

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K0025 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 wall openings in 1 of 3 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 14 residents in the center smoke compartment.</p>	K0025	<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><b>K 025 - NFPA 101 Life Safety Code Standard – Smoke Barriers</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>The two inch gap sealed with expandable foam at the sprinkler riser and rood storage room was has been cleared of the expanding foam and replaced with the proper fire/smoke rated caulking.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>A facility wide audit was completed to ensure that smoke compartment penetrations were sealed properly with fire/smoke rated caulking.</p>	09/13/2012			

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/14/12 at 1:50 p.m., the two inch gap at the sprinkler riser and food storage room wall was sealed with expandable foam The maintenance director said at the time of observation, he did not know expandable foam was not permitted to seal gaps.</p> <p>3.1-19(b)</p>		<p>(c) <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>The Maintenance Director has been in-serviced as to the required components of this tag. The Facility Preventative Maintenance Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p>(d) <b>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:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months as they review the proper caulking of penetrations to smoke compartment zones through out the facility. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended.</p> <p>(e) <b>Date of compliance:</b> 9/13/12</p>		

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K0029 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 provide automatic door closers on 1 of 5 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff, and 10 residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/14/12 at 1:40 p.m., the door between the physical therapy</p>	K0029	<p><b>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. K 029 - NFPA 101 Life Safety Code Standard – Fire Door Closure (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: The fire-rated door between Physical Therapy and the Kitchen has been modified by installing a self closing device. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility wide audit was completed to ensure that</b></p>	09/13/2012
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	room and kitchen had no self closer. The maintenance supervisor acknowledged at the time of observation, the door was not self closing.  3.1-19(b)		fire-rated doors between compartments were self-closing and released and closed properly when the fire alarm was activated. (c) <b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Maintenance Director has been in-serviced as to the required components of this tag. The Facility Preventative Maintenance Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. (d) <b>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:</b> The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months as they review that the automatic closures on fire doors are in place and release upon fire alarm activation. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended. (e) <b>Date of compliance:</b> 9/13/12		

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan which includes the procedures for the use of all types of fire extinguishers in the facility for the protection 25 of 25 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire</p>			K0048	<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><b>K 048 - NFPA 101 Life Safety Code Standard – Fire Plan (Extinguishers)</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>The Fire Plan has been updated listing the quantity, type and how to operate each Class of Fire Extinguishers present at the facility including the relationship of the Class K extinguisher and the installed Hood System. An in-service was performed with the Food and Nutrition staff on Class K extinguishers and the Hood System</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>Staff has been in-serviced on the Fire Plan as to the location and class of fire extinguishers, how to use each class of extinguisher on which type of fire, including the Class K extinguisher located in the Kitchen.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p>		09/13/2012

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	<p>plan should be immediately available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 08/14/12 at 3:25 p.m., the written Fire Plan failed to identify the types of extinguishers in the facility, the fires they are to be used for and the procedures on how to use each type of extinguisher. The manual did not address the relationship of the use of the Class K extinguisher with the hood suppression system. At the time of record review the maintenance director said, he was unaware of the requirement for the fire plan to include extinguisher availability and procedures.</p> <p>3.1-19(b)</p>		<p>The Maintenance Director has been in-serviced as to the required components of this tag. A review of the Fire Plan was conducted and no other issues were identified.</p> <p><b>(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:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months and ensure facility personnel know how to operate each type of extinguisher and know which type to use in an emergency. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended.</p> <p><b>(e) Date of compliance: 9/13/12</b></p>		

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/14/12 at 12:45 p.m., a sprinkler pipe in the janitor's closet had two half inch metal rods zip secured to it by a zip tie. The maintenance director said at the time of observation, the rods were part of the air conditioning condensation system. He agreed these should not have been attached to the sprinkler system pipe.</p>	K0062	<p><b>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. K 062 - NFPA 101 Life Safety Code Standard – Sprinkler System Maintenance</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> The metal rods zip-tied to the sprinkler pipe have been removed and the condensation line has been rerouted. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> A facility wide audit was completed to ensure that no other items or condensation lines were supported by the sprinkler piping. No other issues were identified. <b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Maintenance</p>	09/13/2012			

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	3.1-19(b)		<p>Director has been in-serviced as to the required components of this tag. The Facility Preventative Maintenance Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. (d) <b>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:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months and ensure nothing is being supported by the sprinkler piping. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended. (e) <b>Date of compliance:</b> 9/13/12</p>		

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K0130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to provide complete monthly documentation for testing 18 of 18 battery powered smoke detectors. LSC Section 4.6.12.3 states equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as directed by the authority having jurisdiction. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the Battery Check monthly inspection of battery powered smoke detectors with the maintenance director on 08/14/12 at 1:30 p.m., the record noted a date and "all in working order." The maintenance director said this meant all the battery powered smoke detectors had been checked and were in working order. He acknowledged at the time of record review, a list of each detector would provide evidence each of the detectors were checked.</p>	K0130	<p><b>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.</b></p> <p><b>K 130 - NFPA 101 Life Safety Code Standard – Miscellaneous (Smoke detectors)</b></p> <p><b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>A record of smoke detector monthly checks has been put in place with a detailed listing of smoke detectors and when the test and battery check were performed.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b></p> <p>A facility wide audit was completed to ensure that smoke detectors were tested and the batteries were checked. The verification record was completed. No other issues were identified.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>The Maintenance Director has been in-serviced as to the required components of this tag. The Facility Preventative Maintenance Checklist was modified to include the</p>	09/13/2012			

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  08/14/2012
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	3.1-19(b)		<p>verification and compliance to this standard. Any adjustments identified will be addressed immediately.</p> <p><b>(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:</b></p> <p>The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months and ensure the testing and battery check of the smoke detectors is done. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended.</p> <p><b>(e) Date of compliance:</b> 9/13/12</p>		

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K0147 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 flexible cords were not used as a substitute for fixed wiring in 1 of 3 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, 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 visitors, staff, and 12 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/14/12 between 12:00 p.m. and 3:30 p.m., an extension cord was used to supply power to a coffee pot in the business office and two surge protectors were piggybacked together at the nurses station to provide power for a copier, fax and other equipment. The maintenance</p>	K0147	<p><b>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. K 147 - NFPA 101 Life Safety Code Standard – Electrical Wiring (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> The extension cord being used in the Business Office for the coffee pot has been removed. Equipment is now plugged directly into an outlet. The piggybacked surge protector at the Nursing Station was removed and only one surge protector is plugged directly into a permanent power outlet. <b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> A facility audit was conducted to review the use of electrical outlets and ensure there are no extension cords or piggybacked surge protectors are being used. No other issues were identified. <b>(c)</b></p>	09/13/2012

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	<p>director said at the time of observations, he thought power strips were permitted and was unaware an extension cord was in use.</p> <p>3.1-(19)b</p>		<p><b>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The Maintenance Director has been in-serviced as to the required components of this tag. The Facility Maintenance Rounds Checklist has been modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. <b>(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:</b> The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 6 months and ensure no extension cords are in use and that there are no piggybacked surge protectors in use. A report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring by the Assistant Director of Plant Operations/Designee is recommended. <b>(e) Date of compliance:</b> 9/13/12</p>		