STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155458	A. BUILDING -- B. WING	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	A Post Survey Revisit was conducted on the Emergency Preparedness Survey conducted by the Indiana State Department of Health in on 08/30/18 accordance with 42 CFR 483.73. Survey Date: 10/09/18 Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280 At this Post Survey Revisit, Highland Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 38 certified beds. At the time of the survey, the census was 25. Quality Review completed on 10/15/18 - DA	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit was conducted on the Life Safety Code Recertification and State Licensure Survey conducted by the Indiana State Department of Health on 08/30/18 in accordance with 42 CFR 483.90(a). Survey Date: 10/09/18 Facility Number: 000367 Provider Number: 155458	K 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	AIM Number: 100289280 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 483.90(a), Life Safety from Fire and the 2012 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 one story facility was determined to be of Type II (222) 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. All areas with resident access are sprinklered. Three detached storage sheds are unsprinklered. Quality Review completed on 10/15/18 - DA			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening			

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	provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects all building occupants. Findings include: During a tour of the facility with the Administrator and Maintenance Supervisor on 10/09/18 the following conditions were found: a) At 9:37 a.m. the set of barrier doors near resident room 5 did not latch due to a faulty coordinator and left a six inch gap between door leaves. This was verified by the Administrator and Maintenance Supervisor at the time of observation. 3.1-19(b) This deficiency was cited on 08/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0374	Corrective Action: 1. (ADA) Automated Doors Inc has repaired the Fire Doors to ensure proper closure near rooms 4-5 also near rooms 12-13 that were alleged defective in the Life Safety re-visit. How others are Identified: 2. All residents have the potential to be affected by the deficient practice No resident was affected in the alleged deficient practice. Preventative Measures: 3. Administrator re-educated the maintenance director on the importance and frequency of checking the fire doors weekly to ensure proper closure (ADA) and Maintenance Director inspected all other fire doors in the building to ensure that they are working properly. Monitored: 4. To ensure compliance, administrator or maintenance director will audit fire door latching to ensure proper closure weekly for 4 weeks and monthly for 6 months thereafter. Findings will be reported by the Maintenance Director during the monthly QAPI meeting. The IDT will determine the need for continued monitoring after 6 months.	11/08/2018

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			Completion Date: 11/8/2018	