STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING -- B. WING	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/16/23 Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570 At this Emergency Preparedness survey, Danville Regional Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 110 certified beds. At the time of the survey, the census was 108. Quality Review completed on 03/22/23	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Survey Revisit on or after 04/16/2023.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/16/23 Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570 At this Life Safety Code survey, Danville Regional Rehabilitation was found not in compliance with	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Survey Revisit on or after 04/16/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Berry		04/07/2023

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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	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). Building 0102 built prior to March 1, 2003 was surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system for resident sleeping rooms in the Active Life Transition Unit and in Rooms 201 to 214. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 108 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has two detached building providing facility services which were not sprinklered. Quality Review completed on 03/22/23			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 8 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable	K 0291	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* The battery operated emergency	04/16/2023

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	batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observation with the Director of Maintenance at 1:03 p.m. on 03/16/23, the battery-operated emergency light identified as emergency light #10 outside the Moving Forward unit main hall failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, Director of Maintenance acknowledged the aforementioned battery-operated emergency light failed to function when its respective test button was pushed and stated that he would replace it as soon as he could. This item was discussed with the Executive Director at the exit conference on 03/16/23 at 2:00 p.m. 3.1-19(b)		light #10 was replaced and functioning. Residents had no negative outcomes. *how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* Any resident residing on Moving Forward have the potential to be affected by the deficient practice. Maintenance Director educated on battery operated emergency lighting on or before April 10, 2023. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education will be provided to Maintenance Director on or before April 10, 2023 on battery operated emergency lighting. Maintenance Director of designee will randomly audit battery operated emergency lights to ensure proper functioning. *how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as*	

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			possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Maintenance Director will monitor function of batter operated emergency lighting weekly times 4 weeks, bi-weekly times 4 weeks, monthly times 6 months, then quarterly until compliance is maintained for two consecutive quarters. Results will be discussed in QA meeting.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and			

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	results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure all electrical receptacles were tested at least annually in all resident rooms. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 gram (4 ounces). This deficient practice could affect all patients. Findings include: Based on record review with the Director of Maintenance on 03/16/23 at 9:15 a.m., there was no receptacle retention documentation of testing the physical integrity, continuity, or polarity of the resident room receptacles available for review. Based on observations made during a tour of the facility, the facility's 60 resident rooms had roughly 6 electrical receptacles in each room, and they were not hospital grade outlets. Based on interview at the time of the observation and records review, the Director of Maintenance stated there was no documentation of testing per NFPA 99, Receptacle Testing requirements because he had been extremely busy over the past	K 0914	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Receptacle testing was completed. Residents had no negative outcomes by deficient practice. *how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents have the potential to be affected by deficient practice. Education will be provided to Maintenance Director on or before April 10, 2023 on receptacle testing. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education will be provided to Maintenance Director on or before April 10, 2023 on receptacle testing. Maintenance Director will randomly audit receptacle testing. *how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will*	04/16/2023

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	several months. This item was discussed with the Executive Director at the exit conference on 03/16/23 at 2:00 p.m. 3.1-19(b)		*not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Maintenance Director or designee will completed receptacle testing monthly times 6 months, then quarterly until compliance is maintained for two consecutive quarters. Results will be discussed in QA meeting.	