

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-Thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/16/12</p> <p>Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehabilitation-Columbus 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 with a basement was determined to be of Type V (111) construction and was sprinklered except for two outside canopies. The facility has</p>	K0000	<p>This plan of correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of federal and state law.</p>	

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>a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident rooms. The facility has a capacity of 212 and had a census of 144 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, however, the facility was found in compliance with smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered except for two outside canopies. The facility does have a small shed which is used to store maintenance equipment which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/20/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p>	K0051	<p>K51 A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. I. What corrective action(s) will be accomplished for those residents found to be affected by this alleged deficient practice? The fire panel breaker was identified and marked "FIRE ALARM CIRCUIT CONTROL" in red marking and is accessible only to authorized personnel. Date of compliance was July 17, 2012. II. How other residents having the potential to be</p>	07/17/2012

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	<p>Based on observation on 07/16/12 at 1:10 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker could not be located. Based on interview on 07/16/12 at 1:15 p.m. with the Maintenance Supervisor, it was acknowledged the location of the breaker for the fire alarm panel was unknown..</p> <p>3.1-19(b)</p>		<p>affected by the alleged deficient practice will be identified and what corrective action(s) will be taken. The residents residing within the facility have the potential to be affective by this alleged deficient practice. III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur. Maintenance Director or Designee will check the fire panel breaker weekly to insure that the panel is marked and identified in red assuring compliance with life safety code standards. IV. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur. Maintenance Director / Designee will review results of fire panel breaker checks monthly x 3 in PI committee meetings and then quarterly x 3. Issues identified will be corrected immediately. Date of Compliance: July 17, 2012</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observations and interview, the facility failed to ensure 2 of 4 outside canopies, were provided with automatic sprinklers to ensure sprinkler coverage in all portions of the building. NFPA 13, Standard for the Installation of Sprinkler Systems, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs or canopies exceeding four feet in width. This deficient practice could affect 10 residents on 200 hall, 24 residents on Freedom hall east and 3 residents observed in the dining room which is adjacent to the front entrance as well as visitors or staff.</p> <p>Findings include: Based on observation on 07/16/12 during</p>	K0056	<p>K56 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. I. What corrective action(s) will be accomplished for those residents found to be affected by this alleged deficient practice? All alleged deficient areas will have sprinkler coverage by 08/10/2012 installed by Safecare. II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken. The residents residing within the facility have the potential to be affected by this alleged deficient practice. Maintenance Director/ designee will continue to review</p>	08/10/2012			

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	<p>the tour between 12:00 p.m. to 3:35 p.m. with the Maintenance Supervisor, the following canopies were not provided with sprinkler head coverage.</p> <p>a. A twenty five foot overhang outside Freedom hall exit was attached to the building and constructed of aluminum supports with a vinyl roof.</p> <p>b. A twelve foot overhang outside 200 hall exit was attached to the building and constructed of aluminum supports with a vinyl roof.</p> <p>Based on interview on 07/16/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged there were no sprinkler heads present for the aforementioned canopies to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>educational material and implement any new changes to life safety code as they occur. III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur. Safecare will complete quarterly inspections of the facility sprinkler system to ensure compliance with Life Safety Code Standards. IV. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur. Maintenance Director / Designee will review results Safecare quarterly inspections in PI committee meetings quarterly. Issues identified will be corrected immediately. Date of Compliance: August 10, 2012</p>		