

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/07/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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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: 09/07/12</p> <p>Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Fort Wayne was found in substantial 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 V (111)</p>	K0000	<p>This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Fort Wayne for the recent Life Safety survey dated 9/7/2012.</p> <p>Kindred-Fort Wayne asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action. The staff of Kindred-Fort Wayne is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Fort Wayne is in substantial compliance as set forth below, we are confident that it will be found in substantial compliance with regulations upon re-survey. The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</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>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 160 and had a census of 124 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas providing customary access to the residents were sprinklered. The facility had a detached garage providing facility services including storage of old equipment and three sheds containing storage of new beds, mattresses and maintenance supplies which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/11/12.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the</p>			

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K0048 SS=C	<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</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Director on 09/07/12 at 12:30 p.m., the "Fire,</p>	K0048	<ol style="list-style-type: none"> 1.Maintenance Director, or designee, reviewed all Policies related to the ERP manual. 2. An audit was conducted by the Maintenance Supervisor to identify and any Emergency Response Plans to ensure all are up to date. Policy and Procedure located and verified that the types of extinguishers throughout the facility are addressed in the ERP. <ol style="list-style-type: none"> 1.All ERP manuals are confirmed to have the Policy and Procedure. 2.Maintenance supervisor and Executive Director to continue to monitor ERP manuals and ensure they are up to date. 3.Completion Date: October 1, 2012 	10/01/2012

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	<p>Tornado and Disaster Policies" manual did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p>			

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K0052 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to ensure 168 of 168 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms</p>	K0052	<ol style="list-style-type: none"> Maintenance supervisor, or designee, reviewed all Policies associated with K 052. Upon referencing the Competitive Reference Manual and Invoice, it is noted that our Notifier (AFP 400 control panel) automatically meets the requirements of NFPA 72 as a calibrated test instrument. The detector will create a trouble condition when the smoke detector needs cleaning. Company invoice and regulations reviewed to ensure that test was completed within the NFPA Life Safety standards. Maintenance supervisor confirmed that test was completed and the facility's Notifier system meet the requirements of the NFPA 72 as a calibrated test instrument. Maintenance Director, or designee, to continue to ensure facility is compliant with the smoke detectors receiving a sensitivity test. Completion Date: October 1, 2012 	10/01/2012

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	<p>show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 09/07/12 at 2:45 p.m., the facility was unable to provide</p>			

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	documentation to show all smoke detectors received a sensitivity test. This was confirmed by the Maintenance Director at the time of record review. 3.1-19(b)			

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K0130 SS=B	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice was not in a resident care area but could affect any staff in the service hall.</p> <p>Findings include:</p>	K0130	<ol style="list-style-type: none"> 1. The Maintenance Supervisor had a contractor come to the facility and inspect the rolling fire door. 2. The Maintenance Supervisor repaired the rolling fire door to ensure the opening from the kitchen to the service hall was protected. 3. Maintenance Director will continue to check and ensure rolling fire doors are functional in accordance with NFPA regulations and the preventative maintenance log. 4. Maintenance Director, or designee, will ensure that rolling fire door be inspected annually. 5. Completion Date: October 1, 2012 	10/01/2012			

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	<p>Based on observation with the Maintenance Director on 09/07/12 at 3:22 p.m., there was a rolling fire door protecting the opening from the kitchen to the service hall. Based on interview with the Maintenance Director at the time of observation, he was unable to provide documentation of an inspection for the rolling fire door.</p> <p>3.1-19(b)</p>			