

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155657	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/08/2016
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
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K 0000  Bldg. 01	<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: 09/08/16</p> <p>Facility Number: 010597 Provider Number: 155657 AIM Number: 200204440</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Harrison 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 V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms that are not connected to the facility fire alarm system</p>	K 0000	The facility requests a desk review for this life safety survey	
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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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K 0025 SS=C Bldg. 01	<p>and provide an audible and visual alarm at the central nurses' station. The facility has a capacity of 92 and had a census of 81 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden building used for storage which is not sprinkled.</p> <p>Quality Review completed on 09/12/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observations and interview, the facility failed to ensure the smoke barrier in 1 of 6 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of</p>	K 0025	<p>All residents have the potential to be affected by the deficient practice Rounds through the attic were made to inspect for breaches in smoke barriers; any issues were immediately addressed The Maintenance Director or designee will conduct quarterly inspections of the attic smoke barriers as part of the facility PM program.</p>	09/23/2016			

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K 0029 SS=E Bldg. 01	<p>maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects staff only who work in the Office Hall.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 09/08/16 at 11:40 a.m., the Office Hall attic smoke barrier wall had a two inch gap above a metal duct penetration not fire stopped and a one inch gap between two, two inch water pipe penetrations not fire stopped. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/08/16 at 11:55 a.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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>		The results will be presented to the Safety Committee monthly for their review and recommendations Executive Director will monitor process for continued compliance.				

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K 0067 SS=F Bldg. 01	<p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of 6 Rehabilitation Hall hazardous areas, such as a combustibile storage room over 50 square feet, were provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 12 residents who use the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/08/16 at 9:50 a.m. with the administrator and maintenance supervisor, the Rehabilitation Hall wheel chair storage room, and the mattress/mattress pad storage room, which each measured one hundred sixty square feet and stored twenty seventy metal and plastic wheel chairs and sixteen mattress pads and twelve mattresses, each had a door that lacked self closing devices. This was verified by the administrator at the time of observation and acknowledged at the exit conference on 09/08/16 at 11:55 a.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the</p>	K 0029	<p>All residents have the potential to be affected by this alleged deficient practice All applicable storage doors were audited to ensure self closing devices were in place; Any doors noted to be deficient were addressed immediately The Maintenance Director will audit all storage rooms during quarterly facility PM rounds to ensure continue compliance with this practice. Results will be reviewed monthly in Safety Meeting for their review and recommendations.</p> <p>ExecutiveDirector will monitor process for continued compliance.</p>	09/23/2016			

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K 0143 SS=C Bldg. 01	<p>manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 resident egress corridors and 47 of 47 resident rooms were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 09/08/16 during a tour of the facility from 8:45 a.m. to 11:55 a.m. with the administrator and maintenance supervisor, all forty seven resident rooms in the facility used the egress corridors as a return air system. This was verified by the administrator at the time of observations and acknowledged by the administrator at the exit conference on 09/08/16 at 11:55 a.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one</p>	K 0067	<p><b>K067 NFPA 101 LifeSafety Code Standard</b></p> <p>It is the practice of Kindred Transitional Care and Rehab -Harrison to ensure heating, ventilating, and air conditioning comply with the provisions of section 9.2.</p> <p>See Life Safety Code Waiver Request, attached.</p>	09/23/2016			

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	<p>container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen transfer area was provided with a ceramic or concrete floor. This deficient practice could affect 18 residents who reside on the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/08/16 at 11:15 a.m. with the administrator and maintenance supervisor, the 300 Hall liquid oxygen storage room, where eight full liquid oxygen containers were stored, had a concrete floor painted with gray paint. This was verified by the administrator at the time of observation and acknowledged by the administrator at the exit conference on 09/08/16 at 11:55</p>	K 0143	<p>All residents have the potential to be affected by this alleged deficient practice. This is the only oxygen storage room in the facility. The paint has been removed from the concrete floor. Maintenance Director will monitor ongoing compliance through quarterly PM rounds. Any concerns will be reviewed with the Safety Committee monthly for their recommendations. Executive Director will monitor process for continued compliance.</p>	09/23/2016

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	a.m.  3.1-19(b)				