

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 10/16/2014
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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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K010000	<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: 10/16/14</p> <p>Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-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 (000) construction and was fully sprinkled except the corridor in the Memory Garden Hall between the nurses' station and the dining room. The facility has a</p>	K010000	<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 and/or executed solely because it is required by the provisions of federal and state law. Attached you will find the completed Plan of Correction and attachments for the recertification and state licensure and complaint survey dated October 16, 2014. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 372-8447. Sincerely, Luan Deskins, Executive Director</p>	
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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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K010025 SS=E	<p>fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 212 and had a census of 142 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the corridor in the Memory Garden Hall between the nurses' station and the dining room and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p>			

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	<p>Based on observations and interview, the facility failed to ensure the smoke barrier in 1 of 14 basement room walls was 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 maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects maintenance and laundry staff, and any other staff members using the employee break room located in the basement.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor during a tour of the basement on 10/16/14 from 9:45 a.m. to 10:50 a.m., the basement sewage lift station room east, west, and north walls had ten, six inch to eight inch openings near the top of the concrete block walls from electrical conduit and water and sewage pipe penetrations with no fire stopping material used to seal the openings. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on</p>	K010025	It is the practice of this center to assure that all fire/smoke cubicles remain within compliance at all times to include: Smoke barriers will be repaired by November 14, 2014 using materials designed specifically for this purpose. All smoke barrier walls will be inspected/sealed by November 14, 2014 to ensure compliance throughout center. All smoke/fire barrier walls will be inspected quarterly thereafter. These inspections will be documented in the center Preventive Maintenance Log Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year or until a pattern of compliance is established following the noted issue.	11/14/2014

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K010027 SS=E	<p>10/16/14 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 16 smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 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 could affects 28 residents who reside on the 500 Hall, 16 residents who reside on the 400 Hall, and 21 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/16/14</p>	K010027	It is the practice of this center to assure that all door openings in smoke barrier walls are within compliance at all times to include: Damaged door(s) will be properly repaired and adjusted on November 4, 2014. All other doors in this center will be inspected and maintained by November 14, 2014. All smoke doors will be inspected and documented quarterly during our routine Preventative Maintenance Room checks. Preventive Maintenance Logs will be reviewed by the PI committee quarterly or until a pattern of compliance is established to ensure continued compliance for one year following the noted issue.	11/14/2014			

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K010056 SS=E	<p>during a tour of the facility from 9:00 a.m. to 1:40 p.m., the 500 Hall east set of smoke barrier doors, the 400 Hall set of smoke barrier doors, and the 200 Hall set of smoke barrier doors did not close completely, leaving between a three quarter inch gap and a two inch gap where the doors met the door frames. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/16/14 at 1:45 p.m.</p> <p>3.1-19(b)</p> <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 observation and interview, the facility failed to ensure 1 of 39 rooms in the Memory Garden Hall were sprinkled. This deficient practice affects 24 residents who reside in the Memory</p>	K010056	It is the practice of this center to assure that automatic sprinklers are installed and maintained in accordance with NFPA 13 and NFPA 25 to remain in compliance at all times to include: Memory	11/06/2014			

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K010062 SS=F	<p>Garden Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/16/14 at 1:15 p.m. with the maintenance supervisor, the Memory Garden Hall corridor between the nurses' station and the dining room had a four foot area with a doorway opening on each side of the corridor opening with two, two foot bulkheads extending down from the ceiling. Furthermore, the area in the corridor between the two doorway openings was not sprinkled. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/16/14 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview,</p>	K010062	<p>Gardens corridor area will be properly sprinkled by a licensed contractor by November 6, 2014. Licensed Contractor inspected all center areas to assure all areas are covered by system. All future system alterations will be corrected by licensed contractor. Plant Operations Director will inspect sprinkler piping monthly reporting any issues immediately to Sprinkler contractor for corrections. Review of findings and corrective action will be reviewed at monthly PI meetings as needed. Licensed Contractor will inspect center Sprinkler System Quarterly thereafter to ensure continued compliance. Quarterly inspections will be completed by a Licensed Contractor. These inspections will be documented in the Preventative Maintenance Program to ensure future compliance. Life Safety Preventive Maintenance Logs will be reviewed Quarterly by the Safety Committee or until a pattern of compliance is established to ensure continued compliance for one year following the noted issue.</p> <p>It is the practice of this center to</p>	11/06/2014			

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	<p>the facility failed to ensure 1 of 1 dry pipe automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler system Quarterly Sprinkler System Inspection Reports and interview with the maintenance supervisor on 10/16/14 at 9:30 a.m., none of the Quarterly Sprinkler System Inspection Reports dating from 08/12/10 to 09/24/14 indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the maintenance supervisor indicated an internal pipe inspection was conducted in</p>		<p>assure that the sprinkler system is maintained and inspected to ensure compliance at all times to include: a. Internal pipe inspection to be completed on November 6,2014 b. Sufficient spares were provided by November 6, 2014 c. Corroded Sprinkler Heads (Administration Hall Storage Room, 500 Hall East outside overhang, 500 Hall South outside overhang) were replaced by Licensed Contractor by November 6, 2014 The Automatic Sprinkler System was inspected by a Licensed Contractor by November 6, 2014 to ensure compliance with NFPA 13 and 25. Plant Operations Director and Licensed Contractor wil linspect sprinkler system quarterly to ensure future compliance. Safety Committee will inspect Automatic Sprinkler System inspection documentation quarterly for one year following the noted issue.</p>				

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	<p>2008 or 2009 but a record of the inspection could not be found. The lack of documnetation for a five year internal pipe inspection for the dry pipe sprinkler system was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 10/16/14 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p>						

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	<p>Findings include:</p> <p>Based on observation on 10/16/14 at 10:10 a.m. with the maintenance supervisor, there were four sidewall sprinklers located in the basement laundry room. Based on observation of the basement riser room spare sprinkler cabinet and the first floor Moving Forward Hall sprinkler riser room spare sprinkler cabinet, there were no sidewall spare sprinklers in the two spare sprinkler cabinets. The lack of two spare sidewall sprinklers in the spare sprinkler cabinets was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/16/14 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to replace 3 of over 300 sprinklers in the facility covered in corrosion and rust. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient</p>			

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	<p>practice could affect 28 residents who reside on the 500 Hall, and any residents who use the Administration Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/16/14 during a tour of the facility from 9:00 a.m. to 1:45 p.m. with the maintenance supervisor, the Administration Hall storage room sprinkler was covered in brown rust, and the 500 Hall east outside overhang and the 500 Hall south outside overhang sprinklers were both covered in green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/16/14 at 1:45 p.m.</p> <p>3.1-19(b)</p>						