

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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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: 02/04/16</p> <p>Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Greenwood 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in Room 339. The facility has battery operated smoke detectors installed in all resident sleeping rooms</p>	K 0000		
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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 0029 SS=E Bldg. 01	<p>except Room 339. The facility has a capacity of 206 and had a census of 159 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 02/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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> <p>Based on observation and interview, the facility failed to ensure 1 of 9 hazardous areas such as soiled linen rooms were separated from other areas by smoke resistant partitions and doors. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Reflections I Soiled Utility Room.</p>	K 0029	<p>Test. EVENT 48NK21 K 029</p> <p>The facility Administrator requests that this POC be accepted as our credible allegation of compliance. Date of compliance 02/12/2016 The door that was cited was repaired within 1 hour. All other doors were</p>	02/12/2016

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K 0064 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 02/04/16, the corridor door to the Reflections I Soiled Utility Room was not equipped with a latching mechanism to latch the door into the door frame. In addition, a four inch section of the door jamb was missing near the floor on the door handle side which caused a one half gap between the door and the door frame which would not resist the passage of smoke. The room contained six 32 gallon soiled linen carts and five plastic tubs for red bag waste. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned soiled linen room did not separate this hazardous area from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to document inspection of 1 of 33 portable fire extinguishers in the facility each month. NFPA 10, Standard</p>	K 0064	<p>re-inspected, immediately and found to be in compliance.</p> <p>The Maintenance Director will inspect the smoke doors weekly for 6 weeks and monthly thereafter.</p> <p>The administrator will inspect the smoke doors during monthly Life Safety Code rounds.</p> <p>The QAPI Committee will monitor for any Life Safety Code deficiency.</p> <p>The Administrator, respectfully, requests a paper compliance desk review.</p> <p>EVENT 48 NK 21 K 064 The Administrator requests that this POC be accepted as our credible allegation of compliance.</p>	02/12/2016			

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	<p>for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect three residents, staff and visitors in the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 02/04/16, the inspection tag affixed to the portable fire extinguisher in the Beauty Shop indicated a monthly inspection was not documented after November 2015. Based on interview at the time of observation, the Director of Maintenance stated additional documentation of monthly fire extinguisher checks for all portable fire extinguishers in the facility is kept in a computer database in "Direct Supply TELS Logbook Documentation"</p>		<p>Date of compliance 02/12/2016</p> <p>The fireextinguisher found to be deficient was corrected immediately.</p> <p>All of the facility fire extinguishers were re-inspected, within 1 hour, and found to be compliant.</p> <p>A mastercheck off list, with location and condition, of every extinguisher was developed.</p> <p>The Maintenance Director will inspect every extinguisher, once a week, for 6 weeks, then monthly thereafter.</p> <p>The administrator will inspect the extinguishers during monthly Life Safety Code rounds.</p> <p>The QAPI committee will monitor for any Life Safety Code deficiency.</p> <p>The Administrator, respectfully, requests a paper compliance desk review.</p>	

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	but it is not itemized by extinguisher location and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented after November 2015. 3.1-19(b)				