

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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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: 03/09/16</p> <p>Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610</p> <p>At this Life Safety Code survey, Kindred Transitional Care And Rehab-Southwood 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, consisting of the original construction and a later addition identified as Reflections and the southwest section of 2B were constructed prior to March 2003. Both areas were determined to be of Type V (000) construction and were fully sprinklered. The facility has a fire alarm system with</p>	K 0000		

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=B Bldg. 01	<p>smoke detection in the corridors and spaces open to the corridors. The Reflections and southwest section of 2B have hard wired smoke detectors in resident rooms. All other resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 149 and had a census of 98 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered except a detached garage and two wooden sheds used for maintenance and equipment supply storage.</p> <p>Quality Review by Lex Brashear, LSC Specialist on 03/17/16</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</p> <p>Based on observation and interview, the facility failed to ensure the passage of cable through 1 of 7 smoke barriers was protected to maintain the smoke resistance of each smoke barrier. LSC</p>	K 0025	Facility has photos and documentation proving all work has been completed. Gateway not accepting the upload of information to be attached to this Plan of Correction. I would be able to fax proof of completion for all	03/25/2016

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K 0046 SS=C Bldg. 01	<p>Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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 could affect at least 15 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/09/16 from 1:00 p.m. to 3:00 p.m., there was an exposed penetration through the smoke barrier above the ceiling tile near room 201 that was not firestopped. The penetration was a pipe sleeve that had a 1/2 inch gap on one side and black electrical tape over the other end. Based on interview during the times of observation, the Maintenance Supervisor acknowledged the unprotected opening through the smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour</p>		<p>KTags at your convenience. Facility respectfully requests a desk review for paper compliance. There were no residents found to have been affected by the deficient practice. In order for residents not to be affected by this practice, the Director of Maintenance sealed the exposed penetration through the smoke barrier above the ceiling tile near room 201. This was completed March 09, 2016. Director of Maintenance will conduct preventative maintenance rounds on a quarterly basis. Any findings will be presented at facility monthly Performance Improvement Meeting. Director of Maintenance is responsible for continued compliance.</p>		

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	<p>duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure exterior emergency lighting was provided in accordance with LSC 7.9 for 1 of 3 battery-operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30-day intervals and an annual test to be conducted on every required battery-powered emergency lighting system for not less than 1 ½ -hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 1:00 p.m. to 3:00 p.m. on 03/09/16, the facility has three battery-operated emergency lights and the light outside the generator failed to function when tested. Based on</p>	K 0046	<p>Facility respectfully requests a desk review. There were no residents found to have been affected by the deficient practice. Maintenance Director replaced the battery-operated emergency light on March 11, 2016. In order for residents and staff not to be affected by this practice, the facility will ensure exterior emergency lighting is provided in accordance with LCS 7.9 for battery operated emergency lights. Maintenance Director/designee will conduct weekly Preventative Maintenance checks on all battery operator lighting. Results will be reported to Performance Improvement Committee at the monthly meeting. Maintenance Director is responsible for continued compliance.</p>	03/25/2016

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K 0062 SS=C Bldg. 01	<p>interview at the time of observation, the Maintenance Supervisor confirmed the facility has battery-operated lights in the generator cabinet, one outside the generator and one at the transfer switch location.</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>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 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, staff and visitors if the</p>	K 0062	<p>Facility respectfully requests a desk review for paper compliance. There were no residents found to have been affected by the deficient practice. Maintenance director installed complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition on March 10, 2016. In order for residents and staff not to be affected by this practice, the facility has provided a complete supply of spare sprinklers for the automatic sprinkler system. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings. A minimum of two sprinklers of each type and temperature rating installed shall be provided. Maintenance Director/designee will conduct</p>	03/25/2016

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K 0067 SS=C Bldg. 01	<p>sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/09/16 from 1:00 p.m. to 3:00 p.m., there were no sidewall sprinklers in the spare sprinkler cabinet. There was a sidewall sprinkler observed in the walk in freezer. The lack of a spare sidewall sprinkler was acknowledged by the Maintenance Supervisor at the time of observation.</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 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 100 % of fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation</p>	K 0067	<p>weekly Preventative Maintenance rounds to ensure continued compliance. Results will be reported to the Facility Performance Improvement monthly meeting. Maintenance Director is responsible for continued compliance.</p> <p>Facility respectfully request a desk review for paper compliance. There were no residents found to have been affected by the deficient practice. Facility had SafeCare complete 100% inspection of fire dampers in accordance with NFPA 90A. Inspection was completed on March 18, 2016. There were no issues with any of the fire damper inspections. In order for residents and staff not to</p>	03/25/2016	

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	<p>of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 98 of 98 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Supervisor on 03/09/16 during record review from 10:00 a.m. to 12:00 p.m., the facility had fire dampers and produced a quote for an outside vendor to provide service for 230 fire dampers. Based on observations with the Maintenance Supervisor during the tour from 1:00 p.m. to 3:00 p.m., the facility has fire dampers located in the HVAC return and supply vents throughout the facility with stickers dated 03/09. Further interview with the Maintenance Supervisor revealed the fire dampers were cleaned at that time but the fusible links were not removed and the dampers were not operated to verify they close.</p> <p>3.1-19(b)</p>		<p>be affected by this practice, the facility has contracted SafeCare to automatically schedule an inspection for 100% fire damper inspection at least every 4 years. Maintenance Director is responsible for continued compliance.</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one 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 (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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 storage areas where liquid oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect 40 of 98 residents.</p> <p>Finding include:</p> <p>Based on observation on 03/09/16 from 1:00 p.m. to 3:00 p.m. with the Maintenance Supervisor, the oxygen storage/transfer room in the dining room was not provided with a mechanically operated fan/vent but with two 4" by 8'</p>	K 0143	<p>Facility respectfully request a desk review for paper compliance. There were no residents found to have been affected by the deficient practice. Facility contracted an outside contractor to install new exhaust system in the liquid storage area where liquid transferring takes place as to where continuous mechanical ventilation is present. In order for residents and staff not to be affected by this practice, a new exhaust system installed in the oxygen storage/transfer room in the dining room. System will be checked quarterly during preventative maintenance rounds. Results will be reviewed at facility monthly Performance</p>	03/25/2016	

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	natural vents to the outside. Both vents were checked for an operating fan but none were found. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the vents were not provided with continuous mechanical ventilation. 3.1-19(b)		Improvement Meeting. Maintenance Director is responsible for continued compliance.		