

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
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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: 02/12/14</p> <p>Facility Number: 000166 Provider Number: 155265 AIM Number: 100267080</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Wedgewood 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the</p>	K010000	<p>Please accept this plan of correction as 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. Please note this facility respectfully requests paper compliance review for this survey. Sincerely, Tina Martin 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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	<p>corridors, with hard wired smoke detectors in resident rooms 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, and battery operated smoke detectors in the remaining resident rooms. The facility has a capacity of 124 and had a census of 103 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled. The facility has a detached wooden storage garage and detached wooden storage shed which were not sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=C	<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> <p>Based on observation and interview, the facility failed to ensure 3 of 10 Service Hall room wall smoke barriers and 1 of 1 Service Hall corridor smoke barrier were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice affects staff only who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 02/12/14 during a tour of the Service Hall from 10:30 a.m. to 11:35 a.m., the following Service Hall wall smoke barriers were not maintained:</p> <p>a. The Service Hall corridor west wall behind the ice cooler had a four inch circular area of drywall missing near the</p>	K010025	<p>This facility respectfully requests paper compliance for this survey. No specific resident was identified as being affected. All ice coolers, mechanical/sprinkler rooms were assessed for penetrations on 2-21-14. a. Wall behind ice cooler will be repaired by 2-26-14. b. Service Hall Mechanical Room identified drywall will be repaired by 2-26-14. c. Identified wall by sprinkler riser will be framed in with 5/8 drywall to prevent smoke penetration by 2-26-14. Fire/Smoke Wall PM will be completed on a weekly basis for one month, then quarterly thereafter with results being reviewed/reported to ED and facility Safety Committee as an ongoing practice. Date of Completion 2-26-14</p>	02/26/2014			

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K010062 SS=E	<p>floor/wall juncture.</p> <p>b. The Service Hall mechanical room west wall had a six inch by four inch area of drywall missing in the center of the wall.</p> <p>c. The Service Hall mechanical room/sprinkler riser room north wall next to the sprinkler riser had a three foot by four foot area of drywall missing where the sprinkler contractor removed the drywall to install sprinkler equipment that was recessed into the wall.</p> <p>The missing drywall in the Service Hall corridor, mechanical room and mechanical room/sprinkler riser room areas were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/12/14 at 1:55 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 Based on observation and interview, the facility failed to replace 2 of over 300 sprinklers in facility covered in corrosion. LSC 9.7.5 requires all</p>	K010062	There was no specific resident identified as being affected. Residents residing on 500 hall have the potential to be	03/12/2014			

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	<p>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 practice could affect 24 residents who reside on the 500 Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/12/14 during a tour of the facility from 9:30 a.m. to 1:40 p.m. with the maintenance supervisor, the 500 Hall assisted dining room outside porch overhang sprinkler and the 500 Hall boiler room each had a sprinkler completely 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 02/12/14 at 1:55 p.m.</p> <p>3.1-19(b)</p>		<p>affected.A 100% facility review of sprinkler heads has been conducted to ensure compliance.Identified Sprinkler Heads will be replaced by 3-12-14.All sprinkler heads will be monitored weekly for 30 days by facility Maintenance Director/designee, then quarterly monitoring thereafter by facility Maintenance Director/designee and contracted sprinkler company as an ongoing practice. Maintenance Director and Executive director will review quarterly inspection reports and immediately correct any deficiency.Date of Completion 3-12-14</p>		