DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED B NO. 0938-0391
	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) W	OLTH LL C	01	COMPLETED	
		155243	A. BUILDING			10/09	
		100210	B. WIN			10,000	2012
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	D TRANS CARE A	ND REHAB-GREATER LAFAYET	TE		INDY HILL DR ′ETTE, IN 47905		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
K0000							
	A Life Safety C	Code Recertification	K00	000	This Plan of Correction is		
	and State Lice	nsure Survey was			submitted to meet the		
		the Indiana State			requirements established by t	he	
	Department of				state and federal regulations. Kindred Transitional Care and	4	
	-				Rehabilitation of Greater	4	
	accordance with 42 CFR 483.70(a). Survey Date: 10/09/12				Lafayette desires this Plan of		
					Correction to be considered th	ne	
					facility's allegation of Complia	nce.	
					Compliance is effective on		
	Facility Number				October 31, 2012. Kindred Transitional Care and		
	Provider Num	ber: 155243			Rehabilitation of Greater		
	AIM Number:	100266900			Lafayette respectfully request	s	
					paper compliance with this Pla		
	Surveyor: Brid	lget Brown, Life			of Correction.		
	Safety Code S	-					
	At this Life Sat	fety Code survey,					
	Kindred Trans	itional Care- Greater					
	Lafayette was						
		ith Requirements for					
	Participation in						
	Medicare/Med						
		'0(a), Life Safety					
		the 2000 Edition of					
	the National F						
		IFPA)101, Life					
		SC), Chapter 19,					
	Existing Healt	h Care Occupancies					
	and 410 IAC 1	6.2.					
	This one story	r facility was					
	determined to	be of Type V (111)					
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUR	E	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

NTERS FO	R MEDICARE & MEDIC	AID SERVICES						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/09/2012	
NAME OF	PROVIDER OR SUPPLIE	2			DDRESS, CITY, STATE, ZII	P CODE		
KINIDDE		ND REHAB-GREATER LAFAYE	TTE		NDY HILL DR			
	-			· · · · · · · · · · · · · · · · · · ·				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO)		(X5) COMPLETI	
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE	
	construction a	nd fully sprinklered.						
		s a fire alarm system						
		d smoke detection						
	in corridors an	d areas open to the						
		ery powered smoke						
		provided in resident						
	rooms. The fa							
		50 and had a census						
	of 125 at the t	ime of this visit.						
	All areas where	e residents have						
	customary acc	ess were						
	sprinklered. T	he facility has one						
	detached build	ling providing						
	storage which	was not						
	sprinklered.							
		Robert Booher, Life Safety edical Surveyor on 10/12/12.						
	The facility wa							
	compliance wit							
	aforementione							
		as evidenced by the						
	following:							

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	Ĩ,		01	COMPLETED	
		155243	A. BUI B. WIN	LDING		10/09/	/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			INDY HILL DR		
KINDRE	D TRANS CARE A	ND REHAB-GREATER LAFAY	ETTE		'ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	Doors protecting than required en- openings, exits, o substantial doors of 1¾ inch solid- capable of resist minutes. Doors only required to r smoke. There is closing of the door with a means sui closed. Dutch do permitted. 19.3 Roller latches are regulations in all Based on obse interview, the ensure doors p openings in 2 compartments door frame. T practice affect 36 or more res Hall 1, and the smoke compar Findings inclue Based on obse maintenance of administrator	facility failed to protecting corridor of 10 smoke could latch into the his deficient s staff, visitors and sidents in the C wing e Physical Therapy rtments. de: rvation with the lirector and on 10/09/12 0 a.m. and 3:05 ole door sets	KO	018	K018 What corrective actions will accomplished for those residents found to have been affected by the deficient practice? The two doors identified during the survey will repaired to ensure each door latches independently into the door frame. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All door will be inspected by the Maintenance Director or desig to ensure each door is latching properly into the door frame. What measures will be put in	n II be the e ors g	10/31/20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		(X2) MULTIPLE C A. BUILDING B. WING				
		R ND REHAB-GREATER LAFAYE STATEMENT OF DEFICIENCIES	300 W	ADDRESS, CITY, STATE, ZIP CODE NDY HILL DR ETTE, IN 47905 PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	REGULATORY OF a. from the co wing, hall 1 st double door so b. from the so laundry to the dining room (t sets); each required into the door f second door w first door and tightly into the maintenance of acknowledged observations,	et); ervice corridor and C wing assisted wo double door one door to latch frame before the yould latch into the secure them both e door frame. The lirector	PREFIX TAG	<ul> <li>CACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)</li> <li>place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director or do will check two doors week for 60 days to ensure each is latching properly. The re- of the inspection will be re- to the Performance Improv- committee.</li> <li>How the corrective action be monitored to ensure the deficient practice will not recur? The monthly Preve Maintenance program will updated to include the insp of the double doors to ensi- they latch properly.</li> <li>By what date the systemic changes will be complete 10/31/12</li> </ul>	The esignee ly M-F n door esults ported vement hs will he entative be bection ure	COMPLETI DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155243	A. BUIL B. WINC			10/09/	2012
			D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			NDY HILL DR		
KINDRE	D TRANS CARE A	ND REHAB-GREATER LAFAYE	TTE	LAFAY	ETTE, IN 47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
<0021 SS=E	Any door in an e enclosure, horizo hazardous area by devices arran all such doors by facility upon activ a) the required m b) local smoke d smoke passing t required smoke d c) the automatic installed. 19.2. Based on obset interview, the ensure 1 of 8 enclosure doo only by a devic allow it to closs of the fire alar deficient pract staff, visitors, residents in the adjacent to the Findings inclue Based on obset maintenance of administrator 2:30 p.m., the	hanual fire alarm system; etectors designed to detect brough the opening or a detection system; and sprinkler system, if 2.2.6, 7.2.1.8.2 rvation and facility failed to hazardous area rs was held open the which would e upon activation m system. This ice could affect and 20 or more e main dining room the kitchen. de: rvation with the	К00	21	K021 What corrective actions will accomplished for those residents found to have been affected by the deficient practice? The pipe was immediately removed from the window and the Dietary mana and staff has been in-serviced How other residents having potential to be affected by the same deficient practice will I identified and what corrective actions will be taken? Staff been in-serviced to allow any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardo area enclosure is held open o by devices arranged to automatically close all such do by zone or throughout the faci	n ger d. the be re has bus nly poors	10/31/20

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155243			(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2012	
	PROVIDER OR SUPPLIE	R ND REHAB-GREATER LAFAYE	300 W	ADDRESS, CITY, STATE, ZIP CODE INDY HILL DR 'ETTE, IN 47905	
(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 APPROPRI DEFICIENCY)	ATE (X5)
	open by a leng had a notch cu allowed the pi wide open. Th supervisor was administrator observation. S was there to p	gth of pipe which ut into it which pe to hold the door ne kitchen s interviewed by the		<ul> <li>upon action of the fire alarm system.</li> <li>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or design will monitor the doors to the kitchen and main dining room ensure they close properly due ach monthly fire drill. The results of these findings will be reported to the Executive Director of 0 days.</li> <li>How the corrective actions the deficient practice will mon the doors to the kitchen and recur? The Maintenance Director or designee will mon the doors to the kitchen and recur? The Maintenance Director or designee will mon the doors to the kitchen and recur? The Maintenance Director or designee will mon the doors to the kitchen and recur? The Maintenance Director of do the Execut Director for 60 days and ongot if necessary.</li> <li>By what date the systemic changes will be completed 10/31/2012</li> </ul>	n to

	T OF HEALTH AND HU R MEDICARE & MEDI						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/09/2012		
	PROVIDER OR SUPPLIE D TRANS CARE A	R ND REHAB-GREATER LAFAYET	300 W	ADDRESS, CITY, STATE, ZIP CODE INDY HILL DR 'ETTE, IN 47905			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
K0147 SS=E	Electrical wiring accordance with Electrical Code. Based on obse	ervation and	K0147	K147		10/31/2012	
	ensure 2 of 2 not used as a wiring. NFPA Electrical Cod Article 400-8 specifically pe cords and cab as a substitute a structure. T could affect 4 and visitors in compartment	e, 1999 Edition, requires that, unless rmitted, flexible les shall not be used e for fixed wiring of This deficient practice 7 residents, staff, the central smoke on C and the south compartment.		What corrective actions will accomplished for those residents found to have been affected by the deficient practice? The power strips the were identified during the surve were immediately removed by Maintenance Director. How other residents having potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The Maintenance Director or design will inspect each resident roor ensure power strips are not us for equipment on the bedside wall.	n nat vey / the the ne be re gnee m to		
	maintenance of 10/09/12 bet and 1:25 p.m extension cor resident beds power to misc equipment in power strip w resident's bed	ween 12:00 p.m. ., a power strip d was plugged into a ide wall to supply		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Th Maintenance Director or desig will inspect 4 resident rooms weekly M-F to ensure power strips are not used for equipm on the bedside wall. The resu of these inspections will be reviewed by the Performance Improvement committee for 60 days and ongoing if needed.	e gnee ient ults		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6QT421

Facility ID: 000147

If continuation sheet Page 7 of 8

ENTERS FOR MEDICARE & MEDICAID SERVICES          STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155243		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING			
NAME OF	PROVIDER OR SUPPLIE	R		` address, city, state, zip code /INDY HILL DR	3	
KINDRE	D TRANS CARE A	ND REHAB-GREATER LAFAYE	TTE LAFA	YETTE, IN 47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE
	time of observ unaware powe	vations, he was er strips were not to ch close proximity to		How the corrective action be monitored to ensure to deficient practice will no recur? The Maintenance Director or designee will in resident rooms weekly M- ensure power strips are no for equipment on the beds wall. The results of these inspections will be reviewed the Performance Improver committee for 60 days and ongoing if needed. By what date the system changes will be complete 10/31/2012	he t nspect 4 F to ot used side ed by ment d	