STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 01 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANS CARE AND REHAB-GREATER LAFAYETTE	300 WINDY HILL DR LAFAYETTE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	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). Survey Date: 10/09/12 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Kindred Transitional Care- Greater Lafayette 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. This one story facility was determined to be of Type V (111)	K0000	This Plan of Correction is submitted to meet the requirements established by the state and federal regulations. Kindred Transitional Care and Rehabilitation of Greater Lafayette desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective on October 31, 2012. Kindred Transitional Care and Rehabilitation of Greater Lafayette respectfully requests paper compliance with this Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and areas open to the corridor. Battery powered smoke detectors are provided in resident rooms. The facility has the capacity for 160 and had a census of 125 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/12/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 10 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 36 or more residents in the C wing Hall 1, and the Physical Therapy smoke compartments. Findings include: Based on observation with the maintenance director and administrator on 10/09/12 between 11:30 a.m. and 3:05 p.m., the double door sets providing access:	K0018	**K018** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The two doors identified during the survey will be 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 doors will be inspected by the Maintenance Director or designee to ensure each door is latching properly into the door frame. **What measures will be put in to**	10/31/2012

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	a. from the corridor to the C wing, hall 1 storage room (1 double door set); b. from the service corridor and laundry to the C wing assisted dining room (two double door sets); each required one door to latch into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch independently into the door frame. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director or designee will check two doors weekly M-F for 60 days to ensure each door is latching properly. The results of the inspection will be reported to the Performance Improvement committee. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** The monthly Preventative Maintenance program will be updated to include the inspection of the double doors to ensure they latch properly. **By what date the systemic changes will be completed** 10/31/12	

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 8 hazardous area enclosure doors was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 20 or more residents in the main dining room adjacent to the kitchen. Findings include: Based on observation with the maintenance director and administrator on 10/09/12 at 2:30 p.m., the rolling fire door separating the kitchen from the adjacent service corridor was held	K0021	**K021** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The pipe was immediately removed from the window and the Dietary manager and staff has been in-serviced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Staff has been in-serviced to allow any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility	10/31/2012

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	open by a length of pipe which had a notch cut into it which allowed the pipe to hold the door wide open. The kitchen supervisor was interviewed by the administrator at the time of observation. She said the pipe was there to prevent the door from closing if the fire alarm went off. 3.1-19(b)		upon action of the fire alarm system. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director or designee will monitor the doors to the kitchen and main dining room to ensure they close properly during each monthly fire drill. The results of these findings will be reported to the Executive Director for 60 days. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** The Maintenance Director or designee will monitor the doors to the kitchen and main dining room to ensure they close properly during each monthly fire drill. The results of these findings will be reported to the Executive Director for 60 days and ongoing if necessary. **By what date the systemic changes will be completed** 10/31/2012	

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K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 47 residents, staff, and visitors in the central smoke compartment on C and the south B wing smoke compartment. Findings include: Based on observation with the maintenance director on 10/09/12 between 12:00 p.m. and 1:25 p.m., a power strip extension cord was plugged into a resident bedside wall to supply power to miscellaneous equipment in room 135 and a power strip was located under the resident's bed in room 226. The maintenance director said at the	K0147	**K147** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The power strips that were identified during the survey were immediately removed by the Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The Maintenance Director or designee will inspect each resident room to ensure power strips are not used for equipment on the bedside wall. **What measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director or designee will inspect 4 resident rooms weekly M-F to ensure power strips are not used for equipment on the bedside wall. The results of these inspections will be reviewed by the Performance Improvement committee for 60 days and ongoing if needed.	10/31/2012

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	time of observations, he was unaware power strips were not to be used in such close proximity to the resident's bed. 3.1-19(b)		**How the corrective actions will be monitored to ensure the deficient practice will not recur?** The Maintenance Director or designee will inspect 4 resident rooms weekly M-F to ensure power strips are not used for equipment on the bedside wall. The results of these inspections will be reviewed by the Performance Improvement committee for 60 days and ongoing if needed. **By what date the systemic changes will be completed** 10/31/2012	