

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/25/2012
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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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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/25/12</p> <p>Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this Quality Assurance Walk-thru survey, Kindred Transitional Care and Rehab-Greenwood was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and lacked smoke detectors in the resident rooms. The facility has the capacity for 206 certified beds and had a census of 155 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and not in compliance in regard to smoke detector coverage.</p>	K0000	<p>THE SAFETY OF THE RESIDENT IS MOST IMPORTANT, AS IS EVIDENT FROM PREVIOUS LIFE SAFETY CODE SURVEYS. THE FACILITY HAS AN UNLIMITED BUDGET REGARDING RESIDENT SAFETY. July 25, 2012, The facility was surveyed by L.S.C. Enforcement. The Inspector determined that 110 resident rooms in the facility lacked smoke detectors. July 25, 2012 The equipment supplier was immediately contacted. The supplier, stated that the equipment, that had been back ordered since the first of May, were enroute and could be delivered today July 25, 2012. July 26, 2012 At 7:00 a.m. the required smoke detectors arrived at the facility. The detectors were installed in 110 resident rooms. The detectors were mounted to the ceiling as recommended by the Inspector, all were tested and were found to be operational. The installation and testing was complete by 12:00 noon July 26, 2012. Policies and procedures are in place to monitor, test, maintain, replace, and response regarding smoke alarms. The Process Improvement Committee will review and advise monthly for three months, and quarterly there after unless issues arise. The the smoke detectos will be added to the resident, and</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>All areas where residents have customary access were sprinklered. The facility has a detached garage of wood frame construction, two wood sheds and five metal storage trailers used for storage of maintenance equipment which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/30/12.</p>		<p>enviromental, monthly safety committee agenda.</p>		

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice could affect at least 60 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K9999	<p>This plan of correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction does not constitute admission of 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 soley because it is required by the provisions of the federal and state law.THE SAFETY OF THE RESIDENT IS MOST IMPORTANT, AS IS EVIDENT FROM PREVIOUS LIFE SAFETY CODE SURVEYS. THE FACILITY HAS AN UNLIMITED BUDGET REGARDING RESIDENT SAFETY. July 25, 2012, The facility was surveyed by L.S.C. Enforcement. The Inspector determined that 110 resident rooms in the facility lacked smoke detectors. July 25, 2012 The equipment supplier was immediately contacted. The supplier, stated that the equipment, that had been back ordered since the first of May, were enroute and could be delivered today July 25, 2012. July 26, 2012 At 7:00 a.m. the required smoke detectors arrived at the facility. The detectors were installed in 110 resident rooms. The detectors were mounted to the ceiling as recommended by the Inspector, all were tested and</p>	07/26/2012			

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	<p>Administrator on 7/25/12 from 12:45 p.m. to 1:30 p.m., all 110 resident rooms were not provided with smoke detectors. Based on interview during the time of observations, the Administrator acknowledged all the resident rooms were not provided with smoke detectors.</p> <p>3.1-19(ff)</p>		<p>were found to be operational. The installation and testing was complete by 12:00 noon July 26, 2012. Policies and procedures are in place to monitor, test, maintain, replace, and response regarding smoke alarms. The Process Improvement Committee will review and advise monthly for three months, and quarterly there after unless issues arise. The the smoke detectos will be added to the resident, and enviromental, monthly safety committee agenda.</p>				