

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
--	--

(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
--------------------	--	---------------	---	----------------------

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: 10/01/15</p> <p>Facility Number: 010597 Provider Number: 155657 AIM Number: 200204440</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Harrison 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms that are not connected to the facility fire alarm system</p>	K 0000	<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 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. Attached you will find the completed Plan of Correction and attachments for annual life safety survey dated October 1, 2015. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 738-0550. Sincerely, Aaron Clarke, Executive Director</p>	
------------------------	---	--------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
--	--

(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
K 0025 SS=E Bldg. 01	<p>and provide an audible and visual alarm at the central nurses' station. The facility has a capacity of 92 and had a census of 73 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled except the 200 Hall corridor by the four foot by two foot bulkhead and all areas providing facility services were sprinkled. The facility has one detached wooden building used for storage which is not sprinkled.</p> <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 2 of 5 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice could affect 32 residents who reside on the 100 Hall.</p> <p>Findings include: Based on observations with the</p>	K 0025	<p>K025 NFPA 101 LifeSafety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab -Harrison to maintain smoke barriers at least a one half hour fire resistancerating in accordance with 8.3.</p> <p>The following repairs were made: 1.ServiceHall Attic Space – attic smoke barrier was repaired to</p>	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON				STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112			
(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			
K 0056 SS=E Bldg. 01	<p>maintenance supervisor on 10/01/15 during a tour of the attic smoke barriers from 12:45 p.m. to 1:20 p.m., the following attic smoke barriers were not fire stopped or had missing drywall;</p> <p>a. The Service Hall attic smoke barrier wall had a five foot eight inch by three foot area of drywall missing in the center of the smoke barrier wall.</p> <p>b. The 100 Hall attic smoke barrier had a five foot by four inch section of drywall separating from the wooden truss exposing a six inch gap along the five foot section of drywall which was not fire stopped. The Service Hall attic smoke barrier missing drywall and the 100 Hall attic smoke barrier drywall separating and not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/01/15 at 1:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based</p>		<p>maintain one half hourbarrier resistance rating. 2.100Hall Attic Space – attic smoke barrier was repaired to maintain one half hourbarrier resistance rating.</p> <p>All residents havethe potential to be affected by the alleged deficient practice.</p> <p>Rounds through the attic were made to inspect for breachesin smoke barriers; any issues were immediately addressed.</p> <p>The Maintenance Director or designee will conduct monthlychecks in attics for 3 months, then quarterly thereafter. The resultswill be presented to the Safety Committee monthly for their review andrecommendation. Executive Director will monitor for continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON				STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112			
(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			
K 0067 SS=F Bldg. 01	<p>Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 corridors was completely sprinkled. This deficient practice could affect 32 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 10/01/15 at 11:40 a.m. with the maintenance supervisor, the 200 Hall corridor near the set of smoke barrier doors had a four foot by two foot bulkhead extending from the ceiling down which was not provided with sprinkler coverage and obstructed from full sprinkler coverage from the bulkhead. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/01/15 at 1:35 p.m.</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</p>	K 0056	<p>K056 NFPA 101 LifeSafety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab -Harrison to ensure the automatic sprinkler system is installed in accordance with NFPA 13.</p> <p>The following repair was made: The Maintenance Director removed the obstruction to allow proper sprinkler coverage.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The maintenance director inspected all sprinkler heads to ensure there were no barriers to the sprinkler head function.</p> <p>The Maintenance Director or designee will audit sprinkler heads to ensure there are no barriers to impede the function of the sprinkler heads monthly. The results of the audit will be presented to the Safety Committee monthly for review and recommendation.</p> <p>Executive Director will monitor for continued compliance.</p>	10/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
--	--

(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
	<p>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 3 of 3 resident egress corridors and 47 of 47 resident rooms were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 10/01/15 during a tour of the facility from 9:30 a.m. to 1:30 p.m. with the maintenance supervisor, all forty seven resident rooms in the facility used the egress corridors as a return air system. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 10/01/15 at 1:35 p.m.</p> <p>3.1-19(b)</p>	K 0067	<p>K067 NFPA 101 LifeSafety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab –Harrison to ensure heating, ventilating, and air conditioning comply with the provisions of section 9.2.</p> <p>See Life Safety Code Waiver Request, attached.</p>	10/16/2015