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 12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	377 WESTRIDGE BLVD GREENWOOD, IN 46142

(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
K010000	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: 12/11/13 Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Kindred Transitional Care and Rehab - Greenwood 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) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in	K010000	Kim Rhoades I.S.D.H. L.T.CDennis Austill State Life SafetySurvey date: 12/11/13Attached is the completed Plan of Correction for Survey Event ID DM3D21It is the Facilities Management goal to meet or exceed the intent of the regulations that protect the safetey of the residents we serve.We request that this Plan of Correction be considered for desk review. All deficiencies were corrected within one hour. If you should need any documents or have any quetions please call me.Steve Tanner H.F.A.317 888 4948	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

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	all resident sleeping rooms. The facility has a capacity of 206 and had a census of 152 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services except for one detached garage, two wood sheds and five metal storage trailers. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/17/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 9 corridor doors leading to hazardous areas such as rooms with combustible items was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 22 residents on 300 hall as well as visitors and staff. Findings include: Based on observation on 12/11/13 at 12:55 p.m. with the Maintenance Supervisor, the corridor door leading into the Medical Records Storage room on 300 hall contained twenty nine cardboard boxes and did not have a closing device on the door. Based on interview on 12/11/13 at 12:57 p.m. with the Maintenance Supervisor, it was acknowledged the Medical Records	K010029	A door closer was installed on the storage room door within 1 hour of discovery. Residents were not affected.All other areas were inspected and found to be compliant. Residents were not affected.Door closers will be inspected monthly for placement, replacement, or needed service. This will be added to the Maintenance monthly rounds.The monthly rounds will be presented to the Safety committee for review.The PI committee will monitor monthly for 6 months then quarterly there after.	12/12/2013

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	Storage room which contained combustible items was not provided with a self closing device on its corridor door to ensure the door would automatically close and latch into its frame. 3.1-19(b)			

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K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, 1999 Edition, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. This deficient practice could affect all residents as well as staff and visitors. Findings include: Based on observation on 12/11/13 at 3:00 p.m. with the Maintenance Supervisor, the primary phone line from the dialer was disconnected and within 200 seconds a signal was heard and a trouble light was observed on the fire alarm panel next to the front entrance next to the reception	K010052	The Maintenance Director notified the alarm company immediately, as soon as the problem was discovered. The Director was given instructions, over the phone, and corrected the problem. The alarm company inspected the alarm 12/12/2013 and found it to be operating properly No residents were affected. All other areas were inspected and were in working order.The alarm company was told to add the affected area to their inspection report. The affected area was added to the building monthly inspection report, and will be inspected during monthly fire drills The affected area will be tested daily for two weeks then weekly for three months by building maintenance. results of the inspection will be monitored by the Safety Committee.The PI Committee will monitor monthly for compliance,	12/12/2013

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	desk. Subsequently, the secondary phone line was disconnected and after more than five minutes there was no trouble light or signal heard from the fire alarm control panel (FACP) or elsewhere in the facility. Based on interview on 12/11/13 at 3:15 p.m. with the Maintenance Supervisor, it was acknowledged when the fire alarm system was placed into trouble when the secondary phone line from the dialer was disconnected, a visual trouble signal on the dialer was not activated and not transmitted to the (FACP) next to the reception desk by the front entrance. 3.1-19(b)			

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K010070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review; the facility failed to regulate the use of 1 of 1 portable space heaters in nonresident rooms. This deficient practice could affect 22 residents as well as visitors and staff. Findings include: Based on observation on 12/11/13 at 12:45 p.m. with the Maintenance Supervisor, a portable space heater which was plugged in for use was located in the Therapy office on center hall. Based on interview on 12/11/13 concurrent with the observation, it was acknowledged by the Maintenance Supervisor, space heaters were not allowed in the facility. Based on review of the portable space heater policy on 12/11/13 at 3:30 p.m. with the Maintenance Supervisor, the facility does not allow the use of portable space heaters anywhere in the facility. 3.1-19(b)	K010070	The space heaters were immediately removed from the building. No residents were affected.Facilty maintenance inspected the bulding, no other heaters were discovered. No residents were affected.The facility policy is "NO PORTABLE HEATERS". Notices were posted and the employees were warned. Maintenance is monitoring by inspecting the affected areas daily for 2 weeks, and weekly for 3 months. The affected area will be inspectesd during monthly maintenance rounds and added to the the Directors daily rounds. If any heaters are found they will be removed immediatly, and could result in employee termination.Results of the rounds will be monitored during the monthly Safety Committee meeting.The PI committee will monitor for compliance monthly.	12/11/2013

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