

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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K0000	<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: 12/11/12</p> <p>Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care And Rehab-Southwood 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 consisting of the original construction and a</p>	K0000	I respectfully request a desk review as follow-up for the Life Safety Survey.	

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>later addition identified as Reflections and the southwest section of 2B were constructed prior to March 2003 were determined to be of Type V (000) construction and were fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The Reflections and southwest section of 2B have hard wired smoke detectors in resident rooms. All other resident rooms were equipped with battery powered smoke detectors. The facility has the capacity for 149 and had a census of 144 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered except a detached garage and two wooden sheds used for maintenance and equipment supply storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/13/12.</p> <p>The facility was found not in</p>			

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	compliance with the aforementioned requirements as evidenced by:			

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 exit doors equipped with a delayed egress locking device complying with NFPA 101, 7.2.1.6.1(c) as permitted by NFPA 101 19.2.2.2.4 Exception No. 2 would unlock in 15 seconds. This deficient practice would affect visitors, staff and 20 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/11/12 at 1:20 p.m., the west exit door from the main dining room was equipped with a delayed egress lock and a sign indicating the door would unlock when pressure was applied to the release device for 15 seconds. The door failed to open within fifteen seconds when tested twice. The maintenance director acknowledged at the time of observation, the door release took</p>	K0038	<p>There were not any residents, staff or visitors found to have been affected by this practice. In order for residents, staff or visitors not to be affected by this practice, the delayed egress lock located on the West exit door from the main Dining Room was manually adjusted by the Maintenance Director on 12-11-2012. A second hand was utilized as a timing device to ensure door was functioning properly. Exit doors will be checked monthly using a stop watch timing device by the Maintenance Director to ensure that the deficient practice does not occur. Director of Maintenance is responsible to validate proper working condition of exit doors on a monthly basis and will report validation to facility QA meeting.</p>	12/17/2012

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	<p>30 seconds to open the door.</p> <p>3.1-19(b)</p>			

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K0130 SS=B	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to provide complete monthly documentation for testing 53 of 53 battery powered resident room smoke detectors. LSC 4.6.12.2 requires existing Life safety code features obvious to the public, if not required by the Code, shall be either removed or maintained. This deficient practice affects visitors, staff, and 119 residents on the 100, 200A, 300, 400, and 500 halls.</p> <p>Findings include:</p> <p>Based on a review of the Preventative Maintenance Task Sheet and Weekly Preventative Maintenance Program At Glance with the maintenance director on 12/11/12 at 2:30 p.m., the record noted checks of battery powered smoke detectors by listing "y" (yes) for each wing. The maintenance director said this meant all the battery powered smoke detectors had been checked and were in working order. He acknowledged at the</p>	K0130	<p>There were not any residents or staff found to have been affected by this practice. In order for residents, staff or visitors not be affected by this practice the Maintenance Director has initiated an itemized list of each battery powered smoke detector and their exact location on 12-14-2012. The Preventative Maintenance Task Sheet will be maintained by the Maintenance Director monthly to ensure that the deficient practice does not occur. Director of Maintenance is responsible for completion on a monthly basis and will report validation monthly at facility QA meeting.</p>	12/17/2012			

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	<p>time of record review, a list of each detector would provide evidence each of the detectors were checked.</p> <p>3.1-19(b)</p>			

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure decorative curtains in 1 of 7 smoke compartments were flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient</p>	K0074	There were not any residents or staff found to have been affected by this practice. In order for residents, staff or visitors not to be affected by this practice the decorative curtain hanging over a faux window in the 200A wing shower room was removed by the Maintenance Director on 12-14-2012. The Director of Maintenance will, during weekly rounds, ensure flame resistance labeling is present as demonstrated by testing in accordance with NFPA 701 to ensure that the deficient practice does not occur. Director of Maintenance is responsible to validate proper flame resistance condition is present on a monthly basis and will report validation at	12/17/2012	

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	<p>practice affects visitors, staff and 25 residents in the 200A smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/11/12 at 12:35 p.m., flame resistance labeling was not found on a decorative curtain hanging over a faux window in the 200A wing shower room. The maintenance director said at the time of observation, he had no evidence the curtain was treated to make it flame resistant.</p> <p>3.1-19(b)</p>		facility QA meeting.				