

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/13/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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K010000	<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: 12/13/13</p> <p>Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Castleton 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors</p>	K010000		
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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>hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 160 and had a census of 101 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<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 1 of 1 smoke dampers in the facility could close to maintain the one half hour fire fire resistance rating of the smoke barrier. LSC 8.3.5.2 requires dampers in smoke barriers to close upon detection of smoke. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, one fire damper was observed installed above the ceiling in the smoke barrier wall above the corridor door set in the corridor leading to the Main Dining Room. The aforementioned fire damper shutter was in the fully open position with</p>	K010025	All residents had the potential to be affected.No specific resident was identified.All residents had the potential to be affected.The data cable was removed by the main dining room to ensure that the fire damper will be able to open and close.The data cable will be removed to ensure the fire damper by the main dining room will be able to open and close.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure that compliance has been met.	01/12/2014			

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	<p>one data cable passing through the open fire damper which prevented the damper from fully closing. Based on interview at the time of observation, the Maintenance Assistant acknowledged the data cable was an impediment to fire damper closing.</p> <p>3.1-19(b)</p>						

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K010038 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 the means of egress through 1 of 14 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p>	K010038	<p>All residents had the potential to be affected.No specific resident was identified.All residents had the potential to be affected.The north exit door in the main dining room was repaired on December 23, 2013 by Safecare.The door is working properly since the repair has taken place.The Maintenance Director or designee will check on the door three times a week for the next two weeks and will check weekly as part of the preventive maintenance program.The Maintenance Director or designee will check the north dining room door and will monitor as part of the preventive maintenance program.Safe Care will be contacted if the door is not found to be unlocking after pushing on the door for 15 seconds.The maintenance director will report to the PI committee once a month for the first three months and then quarterly until substantial compliance is met.</p>	01/12/2014			

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	<p>delay not exceeding 30 seconds shall be permitted. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, the north exit door of the Main Dining Room is equipped with a delayed egress lock and provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device but the exit door failed to open when pushed with the application of force five separate times. Based on interview at the time of observation, the Maintenance Assistant acknowledged the north exit door of the Main Dining Room is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the aforementioned exit door failed to open when the door was pushed with the application of force five separate times.</p> <p>3.1-19(b)</p>						

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K010052 SS=C	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K010052	All residents, staff members and visitors had the potential to be affected.No specific resident was identified.All residents, staff members and visitors had the potential to be affected.The center will locate the location of the fire alarm system breaker.The center will also move the smoke detector in the maintenance shop to ensure that it will be at least three feet form the air supply vent.Both of these tasks will be completed before January 12, 2014.The Maintenance Director or designee will ensure the center will know the location of the fire alarm system breaker and will move the smoke detector in themaintenance shop to ensure that it is at least three feet away from the air supply vent.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure that compliance has been met	01/12/2014			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, the fire alarm system breaker could not be located or identified. Based on interview at the time of observation, the Maintenance Assistant stated he did not know the location of the fire alarm system breaker in the facility and acknowledged the fire alarm system breaker could not be located or identified.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 141 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 5 staff and visitors in the Maintenance Office near the service corridor.</p>						

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, the smoke detector in the Maintenance Office was located on the ceiling three inches from an air supply vent. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned smoke detector was located on the ceiling within three feet of an air supply vent.</p> <p>3.1-19(b)</p>				

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K010067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and 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 record review, observation, and interview; the facility failed to ensure 1 of 1 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3-4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Assistant and the Administrator from 9:20 a.m. to 11:20</p>	K010067	All residents, staff members, and visitors had the potential to be affected.No specific resident was identified.All residents, staff members and visitors had the potential to be affected.The center will have Safe Care perform a fire damper inspection before January 12, 2014.The Maintenance Director or designee will ensure the center will have a fire damper inspection.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure that compliance has been met.	01/12/2014			

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	<p>a.m. on 12/13/13, documentation of fire damper inspection and maintenance performed within the most recent four year period was not available for review. Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, one fire damper was observed installed above the ceiling in the smoke barrier wall above the corridor door set in the corridor leading to the Main Dining Room. Based on interview at the time of record review and of the observation, the Maintenance Assistant acknowledged documentation of facility fire damper inspection and maintenance performed within the most recent four year period was not available for review.</p> <p>3.1-19(b)</p>				

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K010068 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on record review, observation and interview; the facility failed to ensure 2 of 2 natural gas fired dryers in the Laundry were provided with combustion air taken directly from the outside. This deficient practice could affect five staff and visitors in the Laundry near the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, each of two natural gas fired dryers in the laundry were not provided with a combustion air supply taken directly from the outside. Based on interview at the time of observation and record review, the Maintenance Assistant and the Administrator acknowledged each of two natural gas fired dryers in the laundry were not provided with combustion air supply taken directly from the outside.</p> <p>3.1-19(b)</p>	K010068	Some staff members and visitors have the potential to be affected.No specific resident was identified.Some staff members and visitors have the potential to be affected.SafeCare was contracted by the center to ensure that natural gas fired dryers in the laundry were provided with combustion air taken directly from the outside.The work was completed on December 17, 2013.The Maintenance Director or designee will ensure the building is in compliance.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure compliance has been met.	01/12/2014			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage locations of greater than 3,000 cubic feet are vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches in total free area. This deficient practice could affect 34 residents, staff and visitors in the vicinity of the Cambridge Hall oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, the Cambridge Hall oxygen storage and transfilling room which was used to store six liquid oxygen containers was not provided with continuous mechanical</p>	K010076	Some of the resident, staff members and visitors have the potential to be affected.No specific resident was identified.Some residents, staff members and visitors have the potential to be affected.The exhaust fan was replaced in the Cambridge unit oxygen room on December 23, 2013.The Maintenance Director or designee will ensure compliance.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure compliance has been met.	01/12/2014			

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	<p>ventilation. A mechanical vent was observed in place on the ceiling in the room but the mechanical vent was inoperable. Based on interview at the time of observation, the Maintenance Assistant acknowledged the Cambridge Hall oxygen storage and transfilling room was not provided with continuous mechanical ventilation or with natural vent openings of greater than 72 square inches in total free area.</p> <p>3.1-19(b)</p>			

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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	
K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect 34 residents, staff and visitors in the vicinity of the Cambridge Hall oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant and the Administrator during a tour of the facility from 12:00 p.m. to 4:00 p.m. on 12/13/13, the Cambridge Hall oxygen storage and transfilling room which was used to store six liquid oxygen containers was not provided with continuous mechanical</p>	K010143	<p>1. Some of the resident, staff members and visitors have the potential to be affected. No specific resident was identified.2. Some of the residents, staff members and visitors have the potential to be affected. The exhaust fan was replaced in the Cambridge unit oxygen room on December 23, 2013.3.The Maintenance Director or designee will ensure compliance.4.The Maintenance Director or designee will report to the Performance Improvement Committee to ensure compliance has been met.</p>	01/12/2014	

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	<p>ventilation. A mechanical vent was observed in place on the ceiling in the room but the mechanical vent was inoperable. Based on interview at the time of observation, the Maintenance Assistant acknowledged the Cambridge Hall oxygen storage and transfilling room was not provided with continuous mechanical ventilation.</p> <p>3.1-19(b)</p>			