

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGewater	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
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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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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: 10/20/14</p> <p>Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Bridgewater 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 18, New 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 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</p>	K010000	<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. The facility respectfully requests a desk review for this plan of correction.</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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K010050 SS=F	<p>detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 88 at the time of this visit.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building for medical gas storage and the generator transfer switch which was sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills on the second and third shift for 1 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include: Based on review of "Fire/Disaster Drill</p>	K010050	This deficient practice has the potential to affect all residents and the Maintenance Director has been educated on the facility policy related to fire drills and to ensure drills are conducted monthly on each shift during varying times. The Executive Director or designee will audit all fire drills monthly x 3 months and report findings to the Performance Improvement	11/10/2014			

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	<p>Report" and "Fire Drills Summary Sheet" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:50 a.m. on 10/20/14, documentation of fire drills conducted on the second and third shift in the fourth quarter (October, November, December) of 2013 were not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged fire drill records for the second and third shift in the fourth quarter of 2013 were not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>committee for 100% compliance.Date of Compliance: 11/10/14</p>		