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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 09/30/2011 |
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| NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER | STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN46311 |
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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 |
|--------------------|---|---------------|---|----------------------|
| 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: 09/30/11</p> <p>Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehabilitation-Dyer was found in substantial 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</p> | K0000 | | |

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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| K0044 SS=B | <p>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 original building was constructed in 1974 with the south wing added in 1985. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident sleeping rooms. The facility has a capacity of 180 and had a census of 139 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/07/11.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> | | | |
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| | <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets to the service corridor were arranged to automatically close and latch. LSC section 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice affects staff and visitors in and near the facility's service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/30/11 at 3:45 p.m., the fire doors to the facility's service corridor did not latch. The doors are a part of a two hour fire wall as indicated on</p> | K0044 | <p>K044</p> <p>The Maintenance director adjusted the stop located on the top horizontal section of the door frame with a space to a height that will activate the automatic locking mechanism.</p> <p>Maintenance Director and/or designee to test this door 2 times per day, 5 times per week to ensure the proper operation and positive locking .</p> <p>An audit of other positive locking doors was conducted with no further issues noted.</p> | 10/12/2011 | |

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| | <p>the facility floor plan. The maintenance supervisor stated at the time of observation, the mechanism which should latch the doors was sticking and not operational.</p> <p>3.1-19(b)</p> | | | | |