

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/12/2016
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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K 0000  Bldg. 01	<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: 07/12/16</p> <p>Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Rolling Hills 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. The facility has a capacity of 115 and had a census of 93 at the time of</p>	K 0000	<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. Attached you will find the completed Plan of Correction and attachments for Life Safety Code Survey dated July 12, 2016. We respectfully request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 948-0670. Sincerely, John Keaton, Executive Director</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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K 0052 SS=E Bldg. 01	<p>this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 07/14/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on observation and interview, the facility failed to ensure 3 of 55 smoke detectors were not installed where air flow would adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 12 residents, as well as staff and visitors in the 100B hall.</p> <p>Findings include:</p>	K 0052	<p>1.3 smoke detectors identified on 100B hall located within one foot of air supply vents and return air vent were relocated to more than 3 feet from air supply vents and return air vent.</p> <p>2.A 100% assessment of smoke detectors was completed on July 13, 2016 in the facility by the facility Maintenance Director to identify other smoke detectors located within less than 3 feet of air supply vents or return air vents. No others were identified.</p> <p>3.Facility Maintenance Director in-serviced on K052 including the need to ensure smoke detectors are located more than 3 feet from</p>	07/13/2016			

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	<p>Based on observation on 07/12/16 at 1:20 p.m. during a tour of the facility with the Maintenance Director, there were three ceiling mounted smoke detectors within one foot of two air supply vents and one air return vent in the 100B hall. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3-1.19(b)</p>		<p>air supply vents and air return vents. The facility Maintenance Director designee to audit any work completed on HVAC systems or fire alarm/ smoke detectors to ensure compliance with K 052 including proper location of smoke detectors.</p> <p>4. The facility Maintenance Director or designee to audit any work completed on HVAC systems or fire alarm/ smoke detectors to ensure compliance with K 052 including proper location of smoke detectors. The Maintenance Director or designee to log findings and report findings to facility QA committee monthly x 6 months and as indicated by the facility QA committee.</p> <p>5. The Executive Director will monitor for continued compliance.</p>		