

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  02/03/2015
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	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: 02/03/15</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-Allison Pointe 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</p>	K010000	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.	
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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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K010018 SS=E	<p>detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 160 and had a census of 110 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 Dennis Austill, Life Safety Code Specialist on 02/05/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 80 resident sleeping room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 16 residents, staff and visitors in the vicinity of Room 219.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, the latching mechanism on the corridor door to Room 219 failed to protrude into the door frame which prevented the door from closing and latching into the door frame. In addition, the door traveled past the door stop for the frame on the latching side of the door which prevented it from proper closure. Based on interview at the time of observation, the Maintenance Director stated the door frame was out of alignment on the latching side and acknowledged the corridor door to Room 219 had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>	K010018	<p>1. Sixteen residents, staff and visitors in the vicinity of Room 219 had the potential to be affected. No specific resident was identified.</p> <p>2. Sixteen residents had the potential to be affected. The room door in 219 was fixed by Underwood Construction Company on 2-10-2015.</p> <p>3. The room 219 door was fixed to allow the door to close and latch into the door frame.</p> <p>4. The Maintenance Director or designee will check the door as part of the Preventative Maintenance Program. The Maintenance Director will report to the Performance Improvement Committee of the results on a monthly basis</p>	03/05/2015

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K010020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 attic access vertical openings were protected as appropriate for the fire resistance rating of the barrier. LSC 19.3.1.2 states doors in a stair enclosure shall be self closing and shall normally be kept in the closed position. This deficient practice could affect 58 residents, staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, the following was noted:</p> <p>a. the attic access door for the retractable stair assembly in the ceiling of the soiled linen room by the Brookshire Hall was not fully closed leaving a twelve inch opening between the door and the door stop. In addition, the aforementioned ceiling access door was not provided with a positive latching device to latch the access door into the door frame.</p>	K010020	<p>1. Fifty eight residents, staff and visitors had the potential to be affected. No specific resident was identified.2. Fifty eight residents had the potential to be affected. The center will have underwood Construction Company adjust 2 doors in the attic that will provide the appropriate fire resistance rating of the barrier.3. The attic doors will be adjusted to ensure that they are self closing and shall normally be kept in the closed position.4.The Maintenance Director or designee will check the attic doors as part of the Preventative Maintenance Program. The Maintenance Director will report to the Performance Improvement Committee the results on a monthly basis.</p>	03/05/2015			

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K010029 SS=E	<p>b. the attic access door for the retractable stair assembly in the ceiling of the Cambridge Hall Social Services Office was not provided with a positive latching device to latch the access door into the door frame.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned attic access vertical openings were not protected as appropriate for the fire resistance rating of the barrier when allowed to remain open when not in use and not provided with a positive latching device to latch the access door into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas such as soiled linen rooms were</p>	K010029	<p>1. Twenty four residents, staff, and visitors had the potential to be affected. No specific resident was identified.2. Twenty four</p>	03/05/2015			

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K010038 SS=E	<p>separated from other spaces by smoke resistant partitions. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, a twelve inch by one half inch gap was noted in between the ceiling access door and the ceiling access door frame in the soiled linen room by the Brookshire Hall nurses station which did not separate this hazardous area from the mechanical room above. Based on interview at the time of observation, the Maintenance Director acknowledged the soiled linen room by the Brookshire Hall nurses station was not separated from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <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 2 of 14 delayed egress</p>	K010038	<p>residents had the potential to be affected. The center will have Underwood Construction Company adjust the ceiling door and ceiling door frame so that the soiled utility room will be seperated from other spaces by smoke resistant partitions.3. Underwood Construction Company will correct the twelve by one inch gap between the ceiling access door and the ceiling access door frame in the soiled utility room by the Brookshire Hall nurses station.4. The Maintenance Director or designee will monitor smoke barrier doors as part of the facility PM program and report to the Performance Improvement Committee to ensure that compliance has been met.</p> <p>1. Thirty residents, staff and visitors had the potential to be affected. No specific resident was identified.2. Thirty residents</p>	03/05/2015

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	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 delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads:		had the potential to be affected. The west exit door in the dining room and the therapy room exit door did have a delay of more than 15 seconds to open the doors. Safe care repaired the doors on February 13, 2015. The doors are working properly since the repair has taken place.3.The Maintenance Director will check the doors as part of the preventative maintenance program.4. The Maintenance Director or designee will check the west exit door in the dining room and the therapy room exit to ensure no greater than a 15 second delay to open the doors. The Maintenance Director will report to the Performance Improvement Committee on a monthly basis.				

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	<p>PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, the west exit door in the Dining Room and the therapy room exit door by the Dining Room to the exterior of the building were each marked as a facility exit, were each equipped with a delayed egress lock and provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device but each exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observations, the Maintenance Director stated each of the aforementioned exits is a facility exit, is equipped with a delayed egress lock and the necessary signage but acknowledged each exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times.</p> <p>3.1-19(b)</p>				

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 3 of 4 shower rooms in the facility. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, 1999 edition, at 5-5.5.1 says a continuous or noncontinuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice could affect ten residents, staff and residents in shower rooms.</p> <p>Finding includes:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, the following was noted:</p> <p>a. one of two shower curtains in the Brookshire Hall shower room by Room 114 hung from the ceiling and had no mesh openings at the top of the curtain to provide a minimum 18 inch clearance below the sprinkler head deflector.</p>	K010062	<p>1. Ten residents, staff and visitors had the potential to be affected. No specific resident was identified.2. Ten residents had the potential to be affected. The center did not provide clearance of 18 inches or more below the level of the sprinkler deflectors in 3 of 4 shower rooms. The center will order and hand up shower curtains that have mesh opening on the top and that will provide a minimum of 18 inch clearance below the sprinkler head.3. The Maintenance Director or designee will check the shower curtains as part of the preventative maintenance program.4.The Maintenance Director will report to the Performance Improvement to ennnsure that compliance has been met.</p>	03/05/2015			

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K010069 SS=D	<p>b. one of two shower curtains in the Brookshire Hall shower room by Room 129 hung from the ceiling and had no mesh openings at the top of the curtain to provide a minimum 18 inch clearance below the sprinkler head deflector.</p> <p>c. one of three shower curtains in the Cambridge Hall shower room hung from the ceiling and had no mesh openings at the top of the curtain to provide a minimum 18 inch clearance below the sprinkler head deflector.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged at least 18 inches clearance was not provided for sprinklers installed in the aforementioned shower rooms due to the use of shower curtains hung from the ceiling with no openings provided in the curtains.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of</p>	K010069	<p>1. Five residents, staff members and visitors had the potential to be affected. No specific resident was identified.2. Zero residents had the potential to be affected. The center had one area underneath the kitchen range hood drip tray missing.3. The Maintenance Director or designee will check to make sure that the</p>	03/05/2015

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	<p>Commercial Cooking Operations. NFPA 96, 1998 edition, Section 3-2.6 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect five staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, one of two designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. The designated location for a grease container nearest the kitchen window to the outside had a one inch in diameter hole in the drip tray beneath the system filters and had an affixed bracket for holding a container but no container was present. Based on interview at the time of observation, the Maintenance Director acknowledged one of two designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into.</p>		<p>drip trays are in place under the kitchen range hood system as part of the preventative maintenance program.4. The Maintenance Director will report to the Performance Improvement Committee to ensure compliance has been met.</p>	

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K010147 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or</p>	K010147	<p>1. Forty two residents, staff and visitors had the potential to be affected. No specific resident was identified.2. Forty two residents had the potential to be affected. The center removed the compact disc player that was plugged into a power strip under the resident bed in room 119. The center has removed the caccum pump medical device that was plugged into resident room 236.3. The Maintenance Director had ordered quad receptacles to assist with residents who require power strips. The Maintenance Director will check for these concerns as part of the preventative maintenance program.4. The Maintenance Director will report to the Performance Improvement committee to ensure that compliance has been met.</p>	03/05/2015

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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
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	<p>office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 02/03/15, the following was noted:</p> <p>a. a compact disc player appliance was plugged into a power strip under the resident bed in Room 119.</p> <p>b. a vacuum pump medical device and an air compressor medical device were each plugged into a power strip in resident Room 236 within two feet of the resident bed. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>						