

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(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
--------------------	--	---------------	---	----------------------

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: 03/18/14</p> <p>Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Greenfield 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 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</p>	K010000	<p>March 25, 2014</p> <p>Indiana State Department of Health 2 N. Meridian Indianapolis, IN 46204</p> <p>RE: Kindred Transitional Care and Rehabilitation-Greenfield Plan of Correction Credible Allegation of Compliance, and</p> <p>Dear Kim Rhodes,</p> <p>On March 18, 2014 a Life Safety Code Survey was completed at the above facility by the Division of Long Term Care, Indiana State Department of Health. As a result of the inspection, the surveyor alleged that the Center was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the HCFA-2567L with the Center's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Center of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.</p> <p>Please also consider this letter and the Plan of Correction to be the Center's credible allegation of compliance. The center will achieve substantial compliance with the</p>	
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/18/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140		
(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	
K010070 SS=B	<p>corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 197 and had a census of 147 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has four 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 03/20/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on record review, observation and interview; the facility failed to ensure portable space heaters were not used in health care occupancies. This deficient practice could affect 16 residents, staff</p>	K010070	<p>applicable certification requirements on March 19, 2014. Please notify me immediately if you do not find the Plan of Correction to be written credible evidence of the Center's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with additional evidence of compliance so you may certify that the center is in substantial compliance with the applicable requirements.</p> <p>Thank you for your assistance with this matter. Please call me if you have any questions.</p> <p>Sincerely, Monica J Pearson, HFA Administrator (317) 462-3311</p> <p>.What corrective action will be accomplished for those resident found to have been affected by the deficient practice? The decorative fire place in reflections 2 unit was removed from dining area. 2. How other resident</p>	03/19/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/18/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(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			
	<p>and visitors in the vicinity of the Reflections II Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Director from 9:50 a.m. to 11:30 a.m. on 03/18/14, the facility does not have a written portable space heater use policy. Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:50 p.m. on 03/18/14, an electric space heater inside a portable decorative fireplace was observed in operation in the Reflection II Dining Room which was open to the corridor in the D Wing. Based on review of the "Twin Star Electric Fireplace Homeowner's Operating Manual" during the exit interview with the Executive Director at 3:00 p.m., documentation of the space heater's operating temperature was not available for review. Based on the exit interview and at the time of observation, the Executive Director and the Maintenance Director acknowledged a portable space heater was in use in a health care occupancy.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the same deficient practice will be identified? Maintenance Director completed a facility audit on 3-18-2014 and found no other space heaters or decorative fire places in the facility. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance director and or designee will complete weekly rounds in facility x 4 weeks, monthly times 2 months, then quarterly through the facility Preventative Maintenance program to ensure no other space heaters or decorative fire places are brought into the facility. How the corrective actions will be monitored to ensure the deficient practice will not recur? Maintenance director and or designee will complete weekly rounds in facility x 4 weeks, monthly times 2 month, then quarterly through the facility Preventative Maintenance Program to ensure no other space heaters or decorative fire places are brought into the facility. Compliance Date: 3-19-2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
--	---

(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