

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
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: 09/28/15</p> <p>Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Columbus 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 with a basement was determined to be of Type V (000) construction and was fully sprinkled except the kitchen food storage room. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident</p>	K 0000	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.	

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: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0018 SS=E Bldg. 01	<p>rooms. The facility has a capacity of 212 and had a census of 136 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the kitchen food storage room.</p> <p>Quality Review completed 10/05/15 - DA</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 1¼ 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 regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 8 of 53 resident room corridor doors would resist the passage of smoke or latch into the door frame. This deficient practice affects 20 residents who reside on the Moving</p>	K 0018	K018 NFPA 101 Life Safety Code Standard It is Kindred Transitional Care and Rehab practice to maintain doors capable of resisting the passage of smoke, with no impediment to closing the door and latching devices to keep the door closed;	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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			
K 0021 SS=D Bldg. 01	<p>Forward Hall, 2 residents who reside in room 527, 52 residents who reside on the Generation Hall, and 4 residents who reside in rooms 438 and 439.</p> <p>Findings include:</p> <p>Based on observations on 09/28/15 during a tour of the facility from 10:30 a.m. to 2:50 p.m. with the maintenance supervisor, the corridor room doors to the therapy room, the Moving Forward Hall medicine room, resident room 527 and the Generation Hall restorative dining room each had a one half inch diameter hole through the doors. Furthermore, the Generation Hall nurses' station janitor closet door lacked a latching device and resident room 438, and resident room 439 room doors each had a one inch gap along the entire latching side of the doors. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/28/15 at 2:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close</p>		<p>all doors identified were adjusted to ensure latching, all holes were filled on doors identified to eliminate any potential smoke penetration. All residents have the potential to be affected by the alleged practice. All doors facility wide were inspected on 10-7-15 for appropriate latching, gaps and for door penetration; any doors deficiencies were immediately corrected. The maintenance director or designee will conduct audits to inspect all doors weekly and check for appropriate function. Any deficiencies will be corrected at the time of inspection. The results of the inspection will be provided to the Safety Committee for review. Any deficiency will be corrected immediately. Executive Director will monitor for continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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>all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure the rolling fire door in 1 of 1 laundry room, which was a two hundred twenty foot hazardous area, was arranged to automatically close. This deficient practice affect no residents but affects maintenance and laundry staff who work in the basement laundry room.</p> <p>Findings include:</p> <p>Based on observation on 09/28/15 at 10:50 a.m. with the maintenance supervisor, the laundry room rolling fire door had two full boxes of latex gloves stored under the door, which prevented the door from automatically closing in the door frame. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p>	K 0021	<p>K021 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to ensure the rolling fire door is not impeded by any objects to prevent automatically closes. No residents were affected by the alleged deficientpractice. The door was inspected on 9/28/15 to ensure it was functioning appropriately. The laundry staff were in-serviced regarding the placement of boxes and other potential obstacles to prevent the door from closing automatically. The Laundry/Housekeeping Supervisor or designee will randomly monitor the rolling door to ensure there are no items in the opening that would prevent the automatic closure of the door 4 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks. The audit results will be presented to the Safety Committee for review, any deficiency will be immediately corrected. Executive Director will monitor for continued compliance.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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			
K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 7 attic smoke barriers and 1 of 1 ceiling smoke barrier were maintained to provide a one half hour fire resistance rating. This deficient practice could affect 4 residents who reside in rooms 426 and 435, 32 residents who reside on the 400 Generations Hall, 18 residents who reside on the Harmony Hall, and 30 residents who reside on the Moving Forward Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/28/15 during a tour of the facility from 10:30 a.m. to 2:50 p.m., the following ceiling and attic smoke barriers were not fire stopped or had missing drywall;</p> <p>a. Resident room 426 closet ceiling had a three inch diameter area of drywall</p>	K 0025	<p>K025 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to maintain smoke barriers at least a one half hour fire resistance rating in accordance with 8.3. The following repairs were made: 426 Hole was patched on 9/28/15 435 Holes were patched on 10/7/15 400 Gap was patched with fire caulk on 10/2/15 Harmony attic was patched with fire caulk on 9/29/15 Moving Forward attic was patched with fire caulk on 9/29/15 426 ceiling was patched on 9/28/15 435 ceiling was patched on 10/7/15 All residents have the potential to be affected by the alleged deficient practice. Rounds through the attic and throughout the building were made on 10-2-15 to inspect for breaches in smoke barriers, Attics were inspected to ensure no cracks or openings were present. The Maintenance Director or designee will conduct</p>	10/22/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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			
K 0027 SS=E Bldg. 01	<p>missing.</p> <p>b. Resident room 435 had three, one half inch diameter holes in the ceiling drywall next to the corridor door.</p> <p>c. The 400 Generation Hall attic smoke barrier wall had a one inch gap around two metal supply air duct penetrations not fire stopped.</p> <p>d. The Harmony Hall attic smoke barrier wall had a three inch gap around a sprinkler pipe penetration not fire stopped.</p> <p>e. The Moving Forward Hall attic smoke barrier wall had a one inch gap around an electrical conduit pipe penetration not fire stopped.</p> <p>Resident room 426 closet ceiling missing drywall, resident room 435 ceiling holes, and the 400 Generation Hall, Harmony Hall and Moving Forward Hall attic smoke barrier penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/28/15 at 2:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the</p>		<p>monthly checks in attics for 3 months, then quarterly thereafter as part of the PM program. The Maintenance Director or designee will conduct random audits of 10 rooms weekly for 4 weeks, biweekly for 4 weeks and monthly thereafter for resident room wall penetrations. The results will be presented to the Safety Committee monthly for their review; any deficiencies will be immediately corrected. The Executive Director will monitor for continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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>door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 6 of 14 smoke barrier doors would restrict the movement of smoke for at least 20 minutes or were provided with a self closing device. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 18 residents who reside on the Harmony Hall, 52 residents who reside on the Moving Forward Halls, and 12 residents who use the Therapy room.</p> <p>Findings include:</p> <p>Based on observations on 09/28/15 during a tour of the facility from 10:30 a.m. to 2:50 p.m. with the maintenance supervisor, the following smoke barrier doors either failed to resist the passage of smoke or were missing self closing devices:</p> <p>a. The Harmony Hall smoke barrier set</p>	K 0027	<p>K027 NFPA Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to maintain at least a 1 3/4 inch thick solid bonded wood core doors in smoke barriers to resist the passage of smoke, with self-closing devices where applicable. The following repairs/adjustments occurred: Harmony Hall was adjusted on 9/28/15 Moving Forward to Harmony Hall double doors have been replaced on 10/21/15 Therapy room door had a closer installed on 10/13/15 Therapy conference room door was repaired on 10/1/15 Therapy room exit doors were repaired on 10/7/15 Moving Forward hall doors were sealed on 10/1/15 All residents have the potential to be affected by the alleged deficient practice. All doors facility wide were inspected on 10-7-15 for appropriate closers and smoke breaches. The Maintenance Director or designee will conduct inspections of all doors monthly for three month, then quarterly as part of the facility PM Program. The results of the inspections will be presented to the Safety Committee for review, any deficiency will be corrected</p>	10/22/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201		
(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	
K 0038 SS=E Bldg. 01	<p>of doors had a two inch gap where the doors came together in the closed position.</p> <p>b. The Moving Forward to Harmony Hall set of smoke barrier doors had a one inch by one inch square gap in the top of the astragal where the doors came together in the closed position.</p> <p>c. The Therapy room smoke barrier door was missing a self closing device.</p> <p>d. The Therapy conference room smoke barrier door had a one half inch diameter hole through the door.</p> <p>e. The Therapy room exit set of smoke barrier doors had a three quarter inch gap where the doors came together in the closed position.</p> <p>f. The Moving Forward Hall set of smoke barrier doors had four, one quarter inch diameter holes in the doors.</p> <p>The Harmony Hall, Moving Forward Hall, and Therapy room smoke barrier doors failing to resist the passage of smoke or missing self closing devices were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are</p>		immediately. Executive Director will monitor for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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>readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 12 exits was readily accessible at all times. This deficient practice affects 20 residents who reside on the Memory Garden Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/28/15 at 1:25 p.m., the Memory Garden Hall dining room exit door access was blocked by a table and two chairs.</p> <p>This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows 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</p>	K 0038	<p>K038 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to maintain exit access so they are readily accessible at all times in accordance with section 7.1.192.1. On 9/28/15, the table and chairs were moved to allow free exit access. The seating chart for the Memory Gardens dining room was updated to reflect this change. SafeCare installed a new maglock on 10/2/15 to allow automatic egress function for 400 hall. All residents have the potential to be affected by the alleged deficient practice. All egress doors were inspected on 10-2-15 to ensure no barriers prevented egress and doors released in the appropriate time frame. The Maintenance Director or designee will conduct rounds weekly to ensure all egress doors function appropriately as part of the PM Program. The results of the audits will be forwarded to the Safety Committee monthly for review; any deficiency will be corrected immediately. Executive Director will monitor for continued compliance.</p>	10/22/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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>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:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(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.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0047 SS=D Bldg. 01	<p> 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: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p> This deficient practice affects 32 residents who reside on the 400 Generation Hall.</p> <p> Findings include:</p> <p> Based on observation on 09/28/15 at 1:40 p.m. with the maintenance supervisor, the 400 Generation Hall exit door was provided with a delayed egress lock and had a sign reading PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.</p> <p> Furthermore, when the door was pushed on three separate attempts, the irreversible process to release the lock was not initiated and the door remained locked. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p> 3.1-19(b)</p> <p> NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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			
K 0048 SS=F Bldg. 01	<p>continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 27 exit signs was continuously illuminated. This deficient practice does not affect any residents but affects the maintenance and laundry staff that use the basement laundry room.</p> <p>Findings include:</p> <p>Based on observation on 09/28/15 at 10:45 a.m. with the maintenance supervisor, the basement laundry room exit sign was not lit. Based on an interview with the maintenance supervisor at the time of observation, it was stated the laundry exit sign light bulbs were burned out. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that</p>	K 0047	<p>K047 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to ensure exit and directional signs are displayed in accordance with section 7.10 with continuous illumination. The basement laundry room exit bulb was replaced on 9/28/15. No residents were affected by the alleged deficient practice. All exit signs were inspected on 9-29-15 to ensure all signs were illuminated. The Maintenance Director or designee will observe the allexit signs weekly. The results ofthe audit will be forwarded to the Safety Committee monthly for review; anydeficiencies will be corrected immediately. Executive Director will monitor for continued compliance.</p>	10/22/2015			
		K 0048	<p>K048 NFPA 101 Life Safety Code Standard It is the practice of Kindred</p>	10/22/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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>incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 09/28/15 at 9:20 a.m. with the maintenance supervisor, the facility's fire safety plan labeled Kindred Disaster Plan did not address the transmission of the fire alarm to the fire department and lacked information addressing resident room battery operated smoke detectors. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p>		<p>Transitional Care and Rehab to ensure there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. The Kindred Disaster Plan policy "Fire Prevention/Life Safety Training" document was found to read under 1.a. "...one person should be directed by the squad leader to contact the fire department by phone"; our fire alarm system automatically dials monitoring station / fire department. Also, the policy "Battery Operated Smoke Detectors In Patient Rooms" addresses resident room battery operated smoke detectors. Please refer to attachments of both documents and supporting documentation.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The Maintenance Director placed copies of the policies in the Kindred Disaster Plan book on 9-29-2015.</p> <p>The Maintenance Director or designee will audit the Kindred Disaster Plan book quarterly to ensure the policies are in the book. Any missing documents will be replaced immediately. The results of the audit will be presented to the Safety Committee monthly for review and recommendation.</p> <p>Executive Director will monitor for continued compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0056 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen food storage room was completely sprinkled. This deficient practice could affect 78 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 09/28/15 at 1:00 p.m. with the maintenance supervisor, the kitchen food storage room sprinkler at the back of the room was blocked by a light fixture which extended four inches below the sprinkler, obstructing the back room sprinkler from providing coverage. This was verified by the maintenance supervisor at the time of observation and</p>	K 0056	<p>K056 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to ensure the automatic sprinkler system is installed in accordance with NFPA13. The light in the kitchen food storage room was moved out of the way of the sprinkler head on 9/28/15. All residents have the potential to be affected by the alleged deficient practice. The maintenance staff inspected all sprinkler heads on 10-6-15 to ensure there were no barriers to the sprinkler head function. The Maintenance Director or designee will audit sprinkler heads weekly to ensure there are no barriers to impede the function of the sprinkler heads monthly. The results of the audit will be presented to the Safety</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201		
(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	
K 0062 SS=E Bldg. 01	<p>acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <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 3 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 52 residents who use the Moving Forward Hall dining room, and 4 residents who reside in resident rooms 505 and 507.</p> <p>Findings include:</p> <p>Based on observations on 09/28/15 during a tour of the facility with the maintenance supervisor from 10:30 a.m. to 2:50 p.m., the Moving Forward Hall dining room in the center of the room, resident room 505, and resident room 507 were each missing the sprinkler escutcheon. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p>	K 0062	<p>Committee monthly for review; any deficiency will be corrected immediately. Executive Director will monitor for continued compliance.</p> <p>K062 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to ensure the automatic sprinkler systems are continuously maintained in reliable operating condition. The three escutcheon rings were replaced on 9/28/15. All residents have the potential to be affected by the alleged deficient practice. The maintenance staff inspected all sprinkler heads 10-2-15 to ensure there were no barriers to the sprinkler head function. The Maintenance Director or designee will audit sprinkler heads to ensure the escutcheon rings are in place monthly. The results of the audit will be presented to the Safety Committee monthly for review and any deficiency will be immediately corrected. Executive Director will monitor for continued compliance.</p>	10/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0064 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on record review, observation and interview, the facility failed to ensure 3 of 38 portable fire extinguishers were inspected at least monthly and the inspections were documented for 4 of 4 months since the annual inspection, including the date and initials of the person performing the inspection. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect any residents in the Administration Hall, 52 residents who reside on the Moving Forward Hall, and 20 residents who reside on the Memory Garden Hall.</p> <p>Findings include:</p> <p>Based on record review on 09/28/15 at 9:15 a.m. with the maintenance</p>	K 0064	<p>K064 NFPA 101 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehab to ensure portable fire extinguishers are provided in all healthcare occupancies in accordance with 9.7.4.1 19.3.5.6 NFPA 10. Allied Safety inspected all fire extinguishers on 10/9/15 to ensure all are in compliance. The Maintenance Director has prepared a facility layout to indicate the location of each fire extinguisher in the building to ensure all extinguishers are inspected monthly. All residents have the potential to be affected by the alleged deficient practice. The maintenance staff will check all fire extinguishers to ensure they are properly charged on 10/9/15. The Maintenance Director or designee will audit all fire extinguishers monthly to ensure that all fire extinguishers' tags are dated and initialed timely. The results of the audit will be presented to the Safety Committee monthly for review; any deficiency will be immediately corrected. Executive Director will monitor for continued compliance.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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>supervisor, an annual inspection was conducted on 04/10/15 for the thirty eight portable fire extinguishers in the facility. Furthermore, the maintenance supervisor indicated monthly inspections are conducted at each extinguisher and annotated on the service and inspection tag. Based on observations during a tour of the facility with the maintenance supervisor on 09/28/15 from 10:30 a.m. to 2:50 p.m., the service and inspection tags for the portable fire extinguisher located in the Administration Hall at the top of the first floor to basement stairway door lacked a monthly inspection for May and June 2015, the Moving Forward Hall dining room portable fire extinguisher lacked a monthly inspection for May, June July, and August 2015, and the Memory Garden Hall dining room portable fire extinguisher lacked a monthly inspection for May, June, July, and August 2015. The lack of monthly inspections of the portable fire extinguishers located at the top of the first floor to basement stairway, the Moving Forward Hall dining room, and Memory Garden Hall dining room was verified by the maintenance supervisor at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0075 SS=E Bldg. 01	<p>the time of observations and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure soiled linen containers in 1 of 9 first floor corridors did not exceed 32 gallons. This deficient practice could affect 12 residents who use the Therapy room.</p> <p>Findings include:</p> <p>Based on observation on 09/28/15 at 1:45 p.m. with the maintenance supervisor, the Therapy room had a fifty five gallon soiled linen container filled with soiled linen stored in the Therapy corridor. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p>	K 0075	<p>K075 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab to ensure the soiled linen or trash receptacles do not exceed 32 gal. The 55gallon linen barrel in the Therapy gym was replaced with a 32 gallonreceptacle.</p> <p>All residents have the potential to be affected by thealleged deficient practice.</p> <p>The maintenance staff toured the building on 10-1-15 to ensure no linen/trashreceptacles exceeded 32 gallons.</p> <p>The Laundry supervisor or designee will monitor the linenreceptacles to ensure they do not exceed the 32</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0130 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 113 of 113 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 09/28/15 at 9:15 a.m. with the maintenance supervisor, there was no smoke detector maintenance log in the two life safety binders provided for record review. Based an interview with the maintenance supervisor on 09/28/15 at 9:20 a.m., the facility has one hundred thirteen resident rooms with battery operated smoke detectors located in each of the resident</p>	K 0130	<p>gallon maximum capacity weeklyfor 3 months. The results of the audit will be presented to the SafetyCommittee monthly for review; any deficiencies will be immediately corrected.</p> <p>Executive Director will monitor for continued compliance.</p> <p>K130 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab toensure a preventative maintenance testing program for "Battery Operated SmokeDetectors in Patient Rooms;" that addresses resident room battery operatedsmoke detectors and inspection of the battery operated smoke detectors. PMProgram was implements on 9/29/15. Please refer to attachments of documents and supportingdocumentation. The Laundry rolling fire door that exceeded one yearinspection time frame was inspected by Safecare on 9/29/15.</p> <p>All residents have the potential to be affected by thealleged deficient practice.</p> <p>The Maintenance Director ensured the maintenance log formonitoring the smoke detectors was in place</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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>rooms. Furthermore, there was no preventive maintenance program to document monthly testing and annual battery replacement for each battery operated smoke detector. The lack of a written maintenance program to provide monthly testing and annual battery replacement for the eleven resident room battery operated smoke detectors was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation, interview and record review, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the</p>		<p>9-29-15. All battery operated detectors were inspected 9-29-15. The rolling door was placed on an annual inspection with SafeCare.</p> <p>The Maintenance Director or designee will audit all battery operated smoke detectors weekly for testing and manufactured specified maintenance, batteries are 10 year lithium installed in 2012. The rolling door was placed on an annual inspection with SafeCare. The results of the audit will be presented to the Safety Committee monthly for review; any deficiencies will be corrected immediately.</p> <p>The Executive Director will monitor for continued compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0144 SS=F	<p>manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects no residents but affects laundry and maintenance staff who work in the basement laundry room.</p> <p>Findings include:</p> <p>Based on observation on 09/28/15 at 9:15 a.m. with the maintenance supervisor, there was a rolling fire door protecting the opening from the dirty laundry room to the clean laundry room in the basement without an attached inspection tag. Based on record review and interview at 9:20 a.m. with the maintenance supervisor, the rolling laundry room fire door had an inspection conducted on 09/24/14, which was a period exceeded the annual inspection interval. The lack of a current annual rolling fire door inspection for the laundry rolling fire door was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
Bldg. 01	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on interview, the facility failed to ensure the fuel source for 1 of 1 emergency generator was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors.</p>	K 0144	<p>K144 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab to ensure Generators fuel supply is reliable, A letter from Vectren was received indicating the "...delivery of natural gas is consistent with the reasonable reliability required...". 3.4.4.1. Please see attached document.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The Maintenance Director obtained the letter from Vectren dated 9-28-2015 and added a yearly reminder to obtain this document annually.</p> <p>The Maintenance Director or designee will contact the natural gas provider one month prior to the end of the prior document to obtain a current letter. The letter will be presented to the Safety Committee for review; any deficiency will be immediately corrected.</p> <p>The Executive Director will monitor for continued compliance.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
--	---

(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
K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on interview with the maintenance supervisor on 09/28/15 at 9:30 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on interview, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. The lack of a letter from the natural gas provider indicating the natural gas was from a reliable source was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <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 1 of 122 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor</p>	K 0147	<p>K147 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of Kindred Transitional Care and Rehab to ensure that all receptacles in water areas are in accordance with NFPA 70 National Electric Code 9.1.2. The Maintenance Director replaced the receptacle with a GFCI receptacle on 10-1-15 in Therapy near the hand washing sink.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
(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>or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 12 residents who use the therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 09/28/15 at 1:50 p.m., the Therapy room hand wash sink had an electric receptacle on the wall within two feet of the handwash sink with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor at the time of observation, the circuit breakers for the Therapy room electric outlet was not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/28/15 at 2:50 p.m.</p> <p>3.1-19(b)</p>		<p>All residents/staff in the Therapy gym have the potential to be affected by the alleged deficient practice.</p> <p>The Maintenance Director inspected all hand washing sinks for GFCI protection on 10-1-15. All receptacles needing replacement were changed to meet code on 10-1-15.</p> <p>An audit tool was prepared for inspection of GFCI receptacles. The Maintenance Director or designee will inspect all GFCI protection monthly for 3 months, then quarterly as part of the PM Program. The results will be presented to the Safety Committee for review; any deficiencies will be immediately corrected.</p> <p>Executive Director will monitor for continued compliance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201		
(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	