

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219
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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: 08/22/13</p> <p>Facility Number: 000227 Provider Number: 155334 AIM Number: 100267520</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Wildwood 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 detectors</p>	K010000	The facility requests that this plan of correction be considered its 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	
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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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	<p>hard wired to the fire alarm system installed in Resident Rooms 1 through 12 and 700 through 715. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 173 and had a census of 146 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/26/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<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 openings through 1 of 9 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:50 a.m. to 2:40 p.m. on 08/22/13, there were five, four inch in diameter openings for plastic conduit, pipes and cables in the smoke barrier wall above the suspended ceiling near Room 5 which were not smoke resistant. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the aforementioned openings in the smoke barrier wall above the suspended ceiling near Room 5.</p>	K010025	<p>1. Maintenance Director removed expansion foam and replaced it with fire caulking in the smoke barrier wall above the suspended ceiling near room 5. 2. This finding could have the potential to affect 42 residents. Maintenance Director checked all 9 of the smoke barrier walls. There were no breaches in these walls after the 1 cited was repaired. 3. Maintenance Director checked all smoke barriers to assure there were no breaches and there were no others found. 4. Maintenance Director will check all smoke barriers on a monthly basis to assure there are no breaches. This is now on the preventative maintenance schedule. Maintenance Director is responsible for monitoring to assure compliance and reporting to QAPI committee at next meeting to report compliance to determine if further monitoring by committee can be discontinued.</p>	09/04/2013			

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	3.1-19(b)			

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K010029 SS=E	<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 7 of 7 soiled linen and trash receptacle carts were stored in areas separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 12 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:50 a.m. to 2:40 p.m. on 08/22/13, there were four 32 gallon mobile soiled linen carts and one 32 gallon mobile trash cart each containing soiled linen or trash unattended and stored next to each other in the corridor by the West Laundry; and two 32 gallon mobile soiled linen carts each containing soiled linen were unattended and stored next to each other in the corridor by the East</p>	K010029	<ol style="list-style-type: none"> <li>Barrels and laundry soiled linen carts were relocated from corridors by the East and the West laundry.</li> <li>Residents on both the East and West corridors had the potential to be affected.</li> <li>Barrels and soiled linen carts were moved into areas behind smoke resistant doors. Linen carts were removed from halls. Housekeeping and laundry staff and nursing staff were instructed that carts and barrels may not be left in corridors when not in use. Laundry was inserviced on storage of carts and linen containers on 9-6-2013.</li> <li>Housekeeping/Laundry manager will check on placement of barrels and carts at a minimum of 5 days per week. If any carts, linen containers or barrels are found in corridors they will be immediately removed and re-education will be done with staff member at that time. Laundry Manager will keep a</li> </ol>	09/06/2013	

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	<p>Laundry. Based on interview at the time of the observations, the Maintenance Supervisor stated each bin on the aforementioned mobile carts has a 32 gallon capacity and acknowledged mobile soiled linen and trash carts with a combined capacity of greater than 32 gallons were not stored in areas separated from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>check list showing that corridors were checked and that corridors on East and West laundry areas are kept clear. Manager will report this to the QAPI committee on a monthly basis until substantial compliance is attained.</p>		

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K010038 SS=E	<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>1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 11 delayed egress 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</p>	K010038	<p>1. SafeCare was contacted and on 9-4 and 9-5-13 technician came to facility and tested all exit doors. 2. All ambulatory residents have the potential to be affected. 3. Employee exit door timer was adjusted and tested to assure that it would open when pushed for 15 seconds. The exit door to the Physical Therapy Room and the exit door by Room 11 had new mag locks installed and tested to assure proper operation and that they could be opened by holding down handle for 15 seconds. The corridor exit by the main dining room has the code for opening the door with keypad. Door was equipped with a new delayed egress lock and was tested by Safe Care to assure that all open properly, timely and that code is posted by each door on code to open door using keypad. 4. To ensure continued compliance Maintenance will check all exit doors on a weekly basis to assure that code is in place, that key pad unlocks door, and that door unlocks if the lock bar is held down for 15 seconds. This has been placed on preventative maintenance check sheet. Results of these checks will be reviewed at QAPI meeting on a monthly basis for 3 months to</p>	09/05/2013			

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	<p>authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:50 a.m. to 2:40 p.m. on 08/22/13, the following was noted for each of three sets of exit doors equipped with a delayed egress lock and provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds:</p> <p>a. the employee exit door opened after 27 seconds each time the door was pushed with the application of force three separate times.</p> <p>b. the Physical Therapy Room exit door set and the exit door set by Room 11 each did not open when the aforementioned door sets were pushed with the application of force three separate times.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned exit doors are each equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release</p>		<p>assure substantial compliance has been achieved and maintained.</p>				

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	<p>device within 15 seconds but the aforementioned doors did not release within 15 seconds when the door was pushed with the application of force three separate times.</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 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 40 residents, staff and visitors if needing to exit the facility by the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of</p>				

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	<p>the facility from 10:50 a.m. to 2:40 p.m. on 08/22/13, the corridor exit by the Main Dining Room is marked as a facility exit and the exit door was magnetically locked and could be opened by entering a four digit code, but the code was not posted. In addition, the aforementioned exit door is not equipped with a delayed egress lock and did not open with the application of force three separate times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the four digit code was not posted at the aforementioned facility exit. Based on interview at 2:45 p.m. on 08/22/13, the Administrator stated the facility houses residents mostly without a clinical diagnosis to be in a secure building and acknowledged the exit access code should be posted at the corridor exit door by the Main Dining Room.</p> <p>3.1-19(b)</p>			

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K010075 SS=E	<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 a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 2 of 7 corridors. This deficient practice could affect 12 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 10:50 a.m. to 2:40 p.m. on 08/22/13, there were four 32 gallon mobile soiled linen and one 32 gallon trash carts each containing soiled linen, draperies or trash were unattended and stored in the corridor by the West Laundry; and two 32 gallon mobile soiled linen carts each containing soiled linen were unattended and stored in the corridor by the East Laundry.</p> <p>Based on interview at the time of the</p>	K010075	<ol style="list-style-type: none"> <li>1. Barrels and laundry soiled linen carts were relocated from corridors by the East and the West laundry.</li> <li>2. Residents on both the East and West corridors had the potential to be affected.</li> <li>3. Barrels and soiled linen carts were moved into areas behind smoke resistant doors. Linen carts were removed from halls. Housekeeping and laundry staff and nursing staff were instructed that carts and barrels may not be left in corridors when not in use. Laundry was inserviced on storage of carts and linen containers on 9-6-2013.</li> <li>4. Housekeeping/Laundry manager will check on placement of barrels and carts at a minimum of 5 days per week. If any carts, linen containers or barrels are found in corridors they will be immediately removed and re-education will be done with staff member at that time. Laundry Manager will keep a check list showing that corridors were checked and that corridors</li> </ol>	09/06/2013

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	<p>observations, the Maintenance Supervisor acknowledged each bin on each cart has a 32 gallon capacity and acknowledged mobile soiled linen receptacles with a capacity of more than 32 gallons were stored within the 64 square feet corridor area near the aforementioned laundry rooms.</p> <p>3.1-19(b)</p>		<p>on East and West laundry areas are kept clear. Manager will report this to the QAPI committee on a monthly basis until substantial compliance is attained.</p>		