

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/13/2016
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NAME OF PROVIDER OR SUPPLIER  ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/13/16</p> <p>Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870</p> <p>At this Life Safety Code survey, Especially Kidz Health &amp; Rehab 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 for the original building.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. 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 sleeping rooms in the original building. The facility has a capacity of</p>	K 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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.

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K 0018 SS=E Bldg. 01	<p>130 and had a census of 120 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility had a detached garage used for storage which was not sprinklered, plus a small area in the kitchen which was not provided with sprinkler coverage.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 06/16/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities.</p>			

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	<p>19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure the 9 of 125 corridor room doors in the original building were either provided with a suitable means for keeping the door closed or were capable of resisting the passage of smoke. This deficient practice affects 10 residents who reside in resident room #2, #4, #6, #7, #8, and any residents who use the East Hall and West Hall bathrooms.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/13/16 during a tour of the facility from 8:34 a.m. to 1:05 p.m., the following corridor room doors in the original building were either not resistant to the passage of smoke or failed to latch and close into the door frame;</p> <p>a. Resident room #4 corridor door had a one inch gap around the door knob where the door knob was loose fitting into the door.</p> <p>b. Resident room #2 corridor door had a one inch gap around the door knob where the door knob was loose fitting into the door.</p> <p>c. The East Hall bathroom corridor door had a three quarter inch gap along the latching side of the door in the closed</p>	K 0018	<p>K018 requires corridor room doors are either provided with a suitable means for keeping the door closed or were capable of resisting the passage of smoke. 1. No residents were harmed. The door to Resident Room #20 has been repaired to allow for proper closure. Additionally, the door to the sprinkler riser room has also been repaired to decrease the gap along the top and latching side of the door.2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all doors have been reviewed to ensure proper closure.4. As a means of quality assurance, the Maintenance Director will review all doors monthly to ensure proper closure as part of the preventative maintenance program. The preventative maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	07/13/2016

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K 0021 SS=E Bldg. 01	<p>position.</p> <p>d. The West Hall bathroom corridor door had a one half inch gap along the latching side of the door in the closed position.</p> <p>e. Resident room #6 corridor door had a one half inch gap along the latching side of the door in the closed position.</p> <p>f. Resident room #7 corridor door failed to latch into the door frame on two separate attempts.</p> <p>g. Resident room #8 corridor door failed to latch into the door frame on two separate attempts.</p> <p>h. The water softener room corridor door had a one inch gap along the top and latching side of the door in the closed position.</p> <p>i. The air compressor room corridor door had a one half inch gap along the latching side of the door in the closed position.</p> <p>The above listed corridor doors not resisting the passage of smoke or failing to latch into the door frames was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing</p>				

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	<p>and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</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 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>Based on observation and interview, the facility failed to ensure 4 of 12 combustable storage rooms over 50 square feet were only held open by releasing devices that automatically close the doors upon activation of the fire alarm system, local smoke detectors designed to detect smoke passing through the opening or the automatic sprinkler system. This deficient practice could affect 12 residents who reside on the South Front Hall, 9 residents who reside on the Ventilator #2 Unit Hall and any number of residents who use the kitchen and Administration Hall.</p> <p>Findings include:</p>	K 0021	K021 requires that combustable storage rooms over 50 square feet are only held open by releasing devices that automatically close the doors upon activation of the fire alarm system. 1. No residents were harmed. The wooden wedges being utilized to prop open the South Front hall combustable storage room, the Administration Hall nurse storage room, the kitchen food storage room and the Ventilator #2 unit hall clothing storage room were all removed and discarded. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all staff will be educated regarding not propping	07/13/2016

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K 0025 SS=E Bldg. 01	<p>Based on observations on 06/13/16 during a tour of the facility with the maintenance supervisor from 8:34 a.m. to 1:05 p.m., the South Front Hall combustibile storage room door, the Administration Hall nurse storage room door, the kitchen food storage room door and the Ventilator #2 Unit Hall clothing storage room door were propped open with wooden wedges. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the smoke barriers in 2 of 4 attic smoke barrier walls in the original building were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be</p>	K 0025	<p>doors of combustibile storage areas in the open position.4. As a means of quality assurance, the facility Maintenance Director will complete rounds regularly to ensure doors are not improperly propped open. The checks will be included as part of the preventative maintenance program with the logs being reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K025 requires that smoke barriers shall be constructed to provide at least a one half hour fire resistance rating. 1. No residents were harmed. The missing drywall in the attic has been repaired or replaced. 2. All residents have the potential to be affected; thus the following corrective actions have been</p>	07/13/2016

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	<p>protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 18 residents who reside on the 40 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/13/16 from 12:20 p.m. to 12:45 p.m., the Front Hall attic smoke barrier wall had four, three inch circular areas of drywall missing and the Back Hall attic smoke barrier wall had two, four inch circular areas of drywall missing and a four foot opening in the attic smoke barrier wall where the two spring style self closing devices had been removed. The Front Hall attic smoke barrier wall missing drywall, the Back Hall attic smoke barrier wall missing drywall and the four foot opening in the wall where the two self closing door springs were removed was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p>		<p>taken,3. As a means to ensure ongoing compliance, the facility Maintenance Director was educated regarding ensuring no penetrations or missing drywall exists within smoke barriers.4. As a means of quality assurance, all attic smoke barriers will be inspected per the preventative maintenance program with repairs occurring, as warranted. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	

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K 0027 SS=E Bldg. 01	<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 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the 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 2 of 4 sets of smoke barrier doors in the original building would restrict the movement of smoke for at least 20 minutes. 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 could affect 18 residents who reside on the South Advanced Alzheimer Care Unit Hall and 21 residents who reside on the North Advanced Alzheimer Care Unit Hall.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the facility from 8:34</p>	K 0027	<p>K027 requires that door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1-inch thick solid bonded wood core. 1. No residents were harmed. The Administration Hall and Ventilator #1 Unit Hall smoke barrier doors were both adjusted to ensure proper closure. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, an inspection of all smoke barrier doors was completed.4. As a means of quality assurance, the function and proper latching of all smoke barrier doors will be monitored monthly during facility fire drills as part of the preventative maintenance schedule. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be</p>	07/13/2016

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K 0029 SS=E Bldg. 01	<p>a.m. to 1:05 p.m. with the maintenance supervisor, the Administration Hall set of smoke barrier doors and the Ventilator #1 Unit Hall set of smoke barrier doors each had a two inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 the corridor doors to 3 of 26 rooms used to store combustible material and measured over 50 square feet in the original building were provided with self closing devices which would cause the doors to automatically close and latch into the door frames or the room doors latched</p>	K 0029	<p>completed on or before July 13, 2016.</p> <p>K029 requires rooms used to store combustible material and measuring over 50 square feet be provided with self closing devices. 1. No residents were harmed. Self closing devices were installed on the South Front hall nurse storage room and the Ventilator #1 Unit Hall storage room. The door to the Ventilator #1 Unit hall respiratory therapy</p>	07/13/2016

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	<p>into the door frames. This deficient practice could affect 12 residents who reside on the South Front Hall and 9 residents who reside on the Ventilator #1 Unit Hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the maintenance supervisor on 06/13/16 from 8:34 a.m. to 1:05 p.m., the following combustible storage rooms lacked self closing devices on the doors;</p> <p>a. The South Front Hall nurse storage room, which measured one hundred twenty square feet and stored twenty shelves of combustible cardboard boxes of paper supplies, and twelve cardboard boxes of plastic nursing supplies, lacked a self closing device on the door.</p> <p>b. The Ventilator #1 Unit Hall storage room, which measured eighty square feet and stored thirteen shelves of combustible clothing, lacked a self closing device on the door.</p> <p>c. The Ventilator #1 Unit Hall respiratory therapy storage room door failed to self close and latch into the door frame, leaving a one inch gap along the latching side of the door.</p> <p>The South Front Hall nurse storage room and Ventilator Unit Hall storage room lacking self closing devices on the doors</p>		<p>storage room was adjusted to allow for proper closure. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, an inspection was completed to ensure self closing devices were in place on all doors requiring them. Additionally, all doors already outfitted with self closing devices were reviewed to ensure proper function.</p> <p>4. As a means of quality assurance, self closing devices will be installed, as warranted. Existing self closing doors will be reviewed per the preventative maintenance program. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	

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K 0038 SS=E Bldg. 01	<p>and the Ventilator #1 Unit Hall respiratory therapy storage room door not self closing was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</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 sidewalk surface on 1 of 9 exit sidewalks in the original building was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 9 residents who reside on the Ventilator #1 Unit Hall and would use the Ventilator #1 Unit South exit during an evacuation.</p> <p>Findings include:</p>	K 0038	<p>K038 requires that exit access is arranged so that exits are readily accessible at all times. 1. No residents were harmed. The concrete sidewalk at the Ventilator #1 Unit hall exit has been repaired. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all means of egress were reviewed to ensure exit access is readily accessible at all times.4. As a means of quality assurance, all means of egress will be monitored per the preventative maintenance program with repairs completed, as warranted. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above</p>	07/13/2016

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K 0047 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor on 06/13/16 at 12:05 p.m., the Ventilator #1 Unit Hall south exit sidewalk had a six foot section of concrete sidewalk extending four feet from the exit door that was completely broken in pieces and had a three inch depression from the broken concrete to the nearest concrete slab sidewalk surface.</p> <p>This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 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 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 17 exit signs was continuously illuminated. This deficient practice affects 9 residents who reside on the Ventilator #1 Unit Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/13/16 at 12:10 p.m. with the maintenance</p>	K 0047	<p>corrective actions will be completed on or before July 13, 2016.</p> <p>K047 requires that exit and directional signs are displayed continuous illumination. 1. No residents were harmed. The light bulb in the Ventilator #1 Unit Hall nursing exit sign light was replaced. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all exit and directional signs have</p>	07/13/2016

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NAME OF PROVIDER OR SUPPLIER  ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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K 0056 SS=E Bldg. 01	<p>supervisor, the Ventilator #1 Unit Hall nursing exit sign light was not illuminated. Based on an interview with the maintenance supervisor on 06/13/16 at 12:10 p.m., the light bulb is burned out. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen was fully sprinkled. This deficient practice could affect any number of residents who use the Administration Hall near the kitchen.</p> <p>Findings include:</p>	K 0056	<p>been reviewed to ensure they are continuously illuminated.4. As a means of quality assurance, the function of all exit and directional signs will be reviewed as part of the preventative maintenance schedule. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K056 requires that the facility shall be protected throughout by an approved, supervised automatic sprinkler system. 1. No residents were harmed. Appropriate sprinkler coverage was added in the kitchen area. 2. All residents have the potential to be affected; thus the following corrective actions have been</p>	07/13/2016

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K 0062 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor on 06/13/16 at 11:45 a.m., the kitchen had a twenty square foot area next to the double door entrance enclosed with bulkheads on all sides extending down from the ceiling two feet which was not provided with sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 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>1. Based on observation and interview, the facility failed to ensure 2 of 6 corridors in the original building were provided with sprinklers with similar temperature classification which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and</p>	K 0062	<p>taken,3. As a means to ensure ongoing compliance, the facility Maintenance Director was educated on recognizing the need for additional sprinkler coverage, as warranted.4. As a means of quality assurance, the sprinkler system will continue to be reviewed as part of the preventative maintenance schedule. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K062 requires that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 1. No residents were harmed. The sprinkler heads on Ventilator 1 Hall and Ventilator 2 Hall have been replaced to ensure the areas are provided with sprinklers with similar temperature classification. Additionally, the sprinkler heads in the kitchen covered with corrosion have been replaced.</p>	07/13/2016

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	<p>located so as to provide satisfactory performance with respect to activation time and distribution. NFPA 13, Table 5-2.5.1 describes Ordinary sprinklers as having a temperature rating of 135 to 170 degrees Fahrenheit (F) and Intermediate sprinklers as having a temperature rating of 175 to 225 degrees F. This deficient practice could affect 18 residents who reside on the Ventilator 1 and Ventilator 2 Halls.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the Ventilator 1 Hall and Ventilator 2 Hall from 11:50 a.m. to 12:45 p.m. with the maintenance supervisor, the Ventilator 1 Hall corridor had six intermediate sprinklers with a temperature rating of two hundred twelve degrees and two ordinary response sprinklers with a temperature rating of one hundred fifty five degrees in the same corridor and the Ventilator 2 Hall corridor had three intermediate sprinklers with a temperature rating of two hundred twelve degrees and one ordinary sprinkler with a temperature rating of one hundred fifty five degrees in the same corridor. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p>		<p>Lastly, the escutcheons were replaced in Resident Room #17, on the corridor sprinkler by the Administration Hall set of smoke barrier doors, and on the Ventilator #2 Hall electric room sprinkler.</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all sprinkler heads were reviewed to ensure all areas of the facility are provided with sprinklers with similar temperature classification, are free of corrosion and are equipped with a proper fitting escutcheon.4. As a means of quality assurance, the sprinkler system will continue to be reviewed as part of the preventative maintenance schedule. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 6 of over 12 kitchen sprinklers in the original portion of the facility covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect any number of residents who use the Administration Hall near the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the kitchen from 11:15 a.m. to 11:35 a.m. with the maintenance supervisor, the kitchen had six sprinklers completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p>						

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	<p>3. 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 2 residents who reside in resident room #17, 9 residents who reside on the Ventilator #2 Hall and any number of residents who use the Administration Hall.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the facility with the maintenance supervisor from 8:34 a.m. to 1:05 p.m., the following sprinklers were either missing the escutcheon or were not tight fitting to the ceiling;</p> <p>a. Resident room #17 sprinkler, bed #2 was missing the escutcheon.</p> <p>b. The corridor sprinkler by the Administration Hall set of smoke barrier doors had a two inch gap where the escutcheon was not tight fitting to the ceiling.</p> <p>c. The Ventilator #2 Hall electric room sprinkler had a two inch gap where the escutcheon was not tight fitting to the ceiling. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p>			
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K 0064 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 22 portable fire extinguishers in the original building was maintained in accordance with NFPA 10. This deficient practice could affect any number of residents and staff who would use the Administration Hall located near the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 06/13/16 at 11:50 a.m. with the maintenance supervisor, the kitchen K class portable fire extinguisher had visible brown rust covering the nozzle. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p>	K 0064	<p>K064 requires that portable fire extinguishers shall be installed, inspected, and maintained in all healthcare occupancies.</p> <p>1. No residents were harmed. The portable fire extinguisher located near the sprinkler riser room has been remounted at the appropriate height. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, all portable fire extinguishers have been reviewed to ensure they are mounted at the appropriate height. 4. As a means of quality assurance, the Maintenance Director will ensure proper mounting of all fire extinguishers during month fire extinguisher checks as part of the preventative maintenance program. The preventative maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.</p>	07/13/2016	

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K 0066 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review, and interview; the facility failed to ensure 3 of 3 areas where smoking was permitted used a noncombustible ashtray and metal self closing containers for discarded smoking material. This deficient practice could affect all residents if a fire occurred at the outside locations where smoking is permitted.</p> <p>Findings include:</p>	K 0066	<p>5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K066 requires that smoking regulations be adopted. 1. No residents were harmed. The discarded cigarette butts have been properly disposed of from the West Administration Hall outside smoking location, the employee break room outside smoking location and the south laundry exit smoking location. Additionally, a noncombustible ashtray was added to the West Administration hall outside</p>	07/13/2016			

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K 0067 SS=F Bldg. 01	<p>Based on observation on 06/13/16 at 12:15 p.m., the West Administration Hall outside smoking location lacked a noncombustible ashtray and had thirty discarded cigarette butts on the ground surface, the employee break room outside smoking location had thirty discarded cigarette butts on the ground surface, and the south laundry exit smoking location had twenty discarded cigarette butts on the ground surface. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 egress corridors in the original building were not being used as a portion of a return air system/plenum for heating, ventilating, or</p>	K 0067	<p>smoking location.2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all staff was educated on ensuring cigarette butts are disposed of properly.4. As a means of quality assurance, the Administrator or designee will audit each outdoor smoking area to ensure a noncombustible ashtray is available and all cigarette butts are disposed of properly daily on scheduled days of work times 4 weeks, then weekly times two weeks, then twice monthly times 2 months, then monthly until compliance is maintained for 2 consecutive quarters. The audits will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K067 requires that heating, ventilating and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 1.</p>	07/13/2016	

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K 0072 SS=E Bldg. 01	<p>air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the original portion of the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the facility from 8:34 a.m. to 1:05 p.m. with the maintenance supervisor, all rooms in the original portion of the facility used the egress corridors as a return air system for the air conditioning and heating system in the facility. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or</p>		<p>No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, a request for a waiver of K067 has been completed, (See Attachment A). 4. As a means of quality assurance, the facility will continue to complete preventative maintenance on all fire prevention equipment and HVAC equipment as required by the preventative maintenance schedule. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The facility respectfully requests that an annual waiver be granted.</p>				

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	<p>visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 6 corridor means of egresses in the original building were continuously maintained free of obstructions. This deficient practice affects 72 residents in the original portion of the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 06/13/16 during a tour of the facility from 8:34 a.m. to 1:05 p.m., the following corridors were obstructed with storage:</p> <p>a. The South Front Hall corridor had seven treatment carts, two desks, and two chairs stored in the corridor.</p> <p>b. The South Front West Hall corridor exit was blocked by a child playpen and had a fan, one treatment cart, two plastic storage cabinets, a desk and a chair stored in the corridor.</p> <p>c. The Ventilator #1 Unit Hall north exit was blocked by a table and eight cardboard boxes stored in the corridor by the exit door.</p> <p>d. The Ventilator #1 Unit Hall corridor had a table and three chairs stored in the corridor by the nurses' station.</p> <p>e. The Ventilator #1 Unit Hall south exit was blocked by two chairs.</p>	K 0072	<p>K072 requires that means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 1. No residents were harmed. All hallway obstructions were removed from the South Front Hall corridor, the south front west hall corridor exit, the Ventilator #1 Unit Hall corridor, the Ventilator #1 Unit Hall south exit and the Ventilator #2 Unit Hall corridor</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all staff have been educated regarding ensuring proper storage of items so as to no block the means of egress.4. As a means of quality assurance, the Administrator or designee will monitor to ensure all means of egress remain free of obstructions daily on scheduled days of work times 4 weeks, then weekly times 2 weeks, then twice monthly times 2 months, then monthly until compliance is maintained for 2 consecutive quarters. The audits will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13,</p>	07/13/2016			

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K 0075 SS=E Bldg. 01	<p>f. The Ventilator #2 Unit Hall corridor had a desk, two chairs, a baby stroller and a baby high chair stored in the corridor. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 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 a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded in 2 of 12 areas where soiled linen and trash receptacles were stored. This deficient practice could affect 4 residents who reside in resident room #4 and 4 residents who reside in resident room F.</p> <p>Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the facility with the</p>	K 0075	<p>2016.</p> <p>K075 requires soiled linen or trash collection receptacles do not exceed 32 gallons in capacity. 1. No residents were harmed. The trash receptacles in Resident Room #4 and Ventilator #2 Hall room F have been replaced.2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all trash and soiled linen receptacles have been reviewed to ensure they are of proper size.4. As a means of quality assurance, the Housekeeping/Laundry</p>	07/13/2016

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NAME OF PROVIDER OR SUPPLIER  ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
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K 0145 SS=E Bldg. 01	<p>maintenance supervisor from 8:34 a.m. to 1:05 p.m., resident room #4 had a forty gallon trash receptacle in use and the Ventilator #2 Hall room F had a forty four gallon trash receptacle in use. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to divide a Type 1 Essential Electrical System (EES) servicing 18 of 18 residents on life support in accordance with NFPA 99, 1999 edition, Section 3-4.2.2. This deficient practice could affect all 18 residents on ventilators.</p> <p>Finding include:</p> <p>Based on observations with the Maintenance Director on 06/13/16 during a tour of the facility from 8:34 a.m. to 1:05 p.m., the TYPE 1 EES had one transfer switch with three circuit panels containing a commingling of the critical,</p>	K 0145	<p>Supervisor or Designee will review monthly to ensure all receptacles in use are of appropriate size. The audits will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p> <p>K145 requires the Type I EES is divided into the critical branch, the life safety branch and the emergency branch.</p> <p>1. No residents were harmed. A quote has been obtained from a contractor to complete the necessary work. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all necessary changes will occur per an outside contractor. The work is scheduled to begin on or before July, 13, 2016; however, due to the scope of the work it will take several weeks to complete.4. As a means of quality assurance, the</p>	10/01/2016

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	life safety and equipment branches. The north utility room contained one circuit breaker panel where the circuit breaker labels included alarm booster control, ext. lights, telephone, south side emergency lights, vent unit, vent 1 emergency outlets fire alarm FACP, oxygen master alarm, VAC +O2 area=master alarm panel, hallway lights, outside lights, sprinkler compressor and fire alarm transformer. The main electrical room contained one transfer switch and 2 circuit breaker panels E-1 and E-2. Circuit panel labels for E-2 included PTAC units in the north and south activity rooms, and resident rooms 108, 113, 114, 121, 126, 129, 132, 140, 112, 115, 122, 130, 131, 144, furnace #1, and emergency wall pack. Circuit panel labels for E-1 included north unit bed lights, south unit bed lights, emergency lights, med room GFCI 's and nurses station receptacle., furnace #2, exhaust fan 1, nurse restroom, room 112, 115, 122,130, 131 emergency receptacles., activity room EM receptacles., room 129, 132, 140, 144, and med room fridge. On 06/13/16 at 9:45 a.m., the Administrator and the Maintenance Supervisor stated the entire facility is supplied emergency power by a 100 KW diesel powered generator and acknowledged the commingling of the critical, life safety and equipment branches.		Maintenance Director will ensure that any future electrical work is completed in an appropriate fashion. Any changes will be reviewed during the monthly Quality Assurance Meeting with the plan of action adjusted accordingly, if warranted.5. The facility respectfully requests that a temporary waiver be granted through October 1st to allow time for the work to be completed.		

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K 0147 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 9 of 42 resident rooms did not use flexible cords or multiplex outlets as a substitute for fixed wiring to provide power for medical equipment electrical devices. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 9 resident in the facility. Findings include:</p> <p>Based on observations on 06/13/16 during a tour of the facility with the maintenance supervisor from 8:34 a.m. to 1:05 p.m., the following resident rooms used power strips or multiplex outlets to power medical equipment;</p> <p>a. Resident room #26 had a multiplex outlet used to power a feeding tube and a bed side light.</p> <p>b. Infirmary Resident room #1 had three power strips plugged into one another and then plugged into a multiplex outlet to power a light, a radio and had a white extension cord used to power the clock</p>	K 0147	<p>K147 requires that electrical wiring and equipment shall be in accordance with the National Electrical Code.</p> <p>1. No residents were harmed. The power strips and multiplex outlets have been removed from powering medical equipment in Resident Room #26, Infirmary Resident room #1, Resident Room A, Resident Room C, Resident Room G, and Resident Room H.2. All residents have the potential to be affected; thus the following corrective actions have been taken,<sup>3</sup> As a means to ensure ongoing compliance, all resident rooms have been reviewed to ensure power strips and multiples outlets are not in use to power medical equipment. All staff have received education regarding not utilizing power strips and multiplex outlets to power medical equipment.<sup>4</sup> As a means of quality assurance, the Maintenance Director or Designee will review weekly to ensure all medical equipment is powered by fixed wiring outlets. The audits will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if</p>	07/13/2016	

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K 0211 SS=E Bldg. 01	<p>radio.</p> <p>c. Resident room A had three power strips used to power feeding tubes for bed #1, bed #2, and bed #3.</p> <p>d. Resident room C had two power strips plugged into one another used to power a a feeding tube for bed #1 and a power strip used to power a feeding tube for bed #3.</p> <p>e. Resident room G had a power strip used to power a feeding tube for bed #2.</p> <p>f. Resident room H had a power strip used to power a feeding tube for bed #4.</p> <p>The above listed resident rooms using pigtailed power strips, multiplex outlets, extension cords, and power strips for medical equipment was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers shall have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> </ul>		warranted.5. The above corrective actions will be completed on or before July 13, 2016.				

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K 0000  Bldg. 02	<p>o Dispensers are not installed over or adjacent to an ignition source.</p> <p>o If the floor is carpeted, the building is fully sprinklered.</p> <p>18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 2 of 13 corridor area alcohol based hand rub dispensers were not located over an ignition source. This deficient practice could affect any number of residents who would use the Administration Hall exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 06/13/16 at 8:34 a.m. with the maintenance supervisor, the Administration Hall exit foyer had two, fifteen ounce containers of alcohol based hand sanitizer mounted on each side of the outside exit door wall directly above the electric keypad entry panel box and the electric push button electric box and electric outlet. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p>	K 0211	<p>K211 requires that alcohol based hand rub dispensers not be located over an ignition source.</p> <p>1. No residents were harmed. The two alcohol based hand rub dispensers at the Administration Hall exit foyer have been relocated. 2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all alcohol based hand rub dispensers have been reviewed to ensure they are no located over an ignition source.4. As a means of quality assurance, the Maintenance Director or Designee will ensure any new dispensers added to the facility are not located over an ignition source. A review will be conducted monthly. The audits will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	07/13/2016

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	<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: 06/13/16</p> <p>Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870</p> <p>At this Life Safety Code survey, Especially Kidz Health &amp; Rehab 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 18, New Health Care Occupancies and 410 IAC 16.2 for the 2009 comprehensive care wing New Unit addition, which was located to the east of the original building.</p> <p>This one story addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in the 14 resident sleeping rooms. The facility has a capacity of 130 and had a census of 120</p>	K 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	

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K 0011 SS=F Bldg. 02	<p>at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility had a detached garage used for storage which was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 06/16/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 two hour fire rated separation wall between the 2009 New Unit Hall addition and the original building was maintained. This deficient practice could affect 28 residents who reside on the New Unit Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/13/16 at 11:15 a.m. with the maintenance</p>	K 0011	<p>K011 requires that if the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. 1. No residents were harmed. The attic fire barrier has been repaired.2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, the Maintenance Director received education</p>	07/13/2016

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K 0018 SS=E Bldg. 02	<p>supervisor, the fire barrier wall, located in the attic above the South Hall in the New Unit Hall had a three inch circular area of double drywall missing, two one inch gaps around electrical conduit penetrations not fire stopped, and a two inch gap filled with orange expandable foam. Based on an interview with the maintenance supervisor on 06/13/16 at 11:25 a.m., there was no evidence available or review to indicate the expandable foam was an acceptable fire rated material for a two hour fire wall. The missing drywall, gaps around penetrations and non-rated foam used as a fire stopping material was verified by the maintenance supervisor at the time of observations and interview and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p>		<p>regarding ensuring all penetrations in a fire barrier are stopped appropriately following any work involving a fire barrier.4. As a means of quality assurance, the Maintenance Director will review all attic fire barriers monthly as part of the preventative maintenance program. The preventative maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	

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K 0064 SS=F Bldg. 02	<p>Based on observation and interview, the facility failed to ensure 2 of 22 corridor room doors in the 2009 addition New Unit Hall were either provided with a suitable means for keeping the door closed or resisted the passage of smoke. This deficient practice affects 2 residents who reside in resident room #20 and any residents on the New Wing who reside near the sprinkler riser room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/13/16 during a tour of the New Unit Hall from 8:34 a.m. to 11:15 a.m., resident room #20 corridor door failed to latch into the door frame on two separate attempts and the sprinkler riser room corridor door had a one half inch gap along the top and latching side of the door in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care</p>	K 0018	<p>K018 requires corridor room doors are either provided with a suitable means for keeping the door closed or were capable of resisting the passage of smoke. 1. No residents were harmed. The door to Resident Room #20 has been repaired to allow for proper closure. Additionally, the door to the sprinkler riser room has also been repaired to decrease the gap along the top and latching side of the door.2. All residents have the potential to be affected; thus the following corrective actions have been taken,3. As a means to ensure ongoing compliance, all doors have been reviewed to ensure proper closure.4. As a means of quality assurance, the Maintenance Director will review all doors monthly to ensure proper closure as part of the preventative maintenance program. The preventative maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before July 13, 2016.</p>	07/13/2016			

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	<p>occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers on the New Unit Hall was installed no more than five feet above the floor. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 28 residents who reside on the New Unit Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/13/16 at 10:45 a.m. with the maintenance supervisor, the New Unit Hall portable fire extinguisher located near the sprinkler riser room measured sixty seven inches from the top of the extinguisher to the floor. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/13/16 at 1:05 p.m.</p> <p>3.1-19(b)</p>	K 0064	<p>K064 requires that portable fire extinguishers shall be installed, inspected, and maintained in all healthcare occupancies.</p> <ol style="list-style-type: none"> <li>1. No residents were harmed. The portable fire extinguisher located near the sprinkler riser room has been remounted at the appropriate height.</li> <li>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</li> <li>3. As a means to ensure ongoing compliance, all portable fire extinguishers have been reviewed to ensure they are mounted at the appropriate height.</li> <li>4. As a means of quality assurance, the Maintenance Director will ensure proper mounting of all fire extinguishers during month fire extinguisher checks as part of the preventative maintenance program. The preventative maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.</li> <li>5. The above corrective actions will be completed on or before July 13, 2016.</li> </ol>	07/13/2016