

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/03/2015
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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: 06/03/15</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, the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building consisting of everything but the south hall was surveyed with Chapter 19, Existing Health Care Occupancies.</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, in all areas open to the corridor and in resident sleeping rooms 17 through 30. Battery operated smoke</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 0021 SS=E Bldg. 01	<p>detectors are installed in all other resident sleeping rooms. The facility has a capacity of 130 and had a census of 124 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</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 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 3 of 13 hazardous area doors were held open only by devices arranged to automatically close upon activation of the fire alarm system.</p>	K 0021	<p>1. All wedges were removed from all the doors in facility that was holding the doors open.</p> <p>2. All doors were checked to ensure wedges were not holding the doors open. See corrective</p>	06/18/2015

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K 0025 SS=E Bldg. 01	<p>This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 06/03/15, the corridor door set to the kitchen and the corridor door to the Laundry were each propped in the fully open position with a wedge on the floor. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hazardous area doors were held open by devices not arranged to automatically close upon activation of the fire alarm system.</p> <p>3.1-19(b)</p> <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,</p>		<p>measures below:</p> <p>3. Administrator inserviced the director of maintenance to remove the wedges and reviewed the guidance as to why wedges are a safety hazard in regards to the citation.</p> <p>4. Daily rounds will be conducted to ensure that the doors are not being propped open by wedges.</p>				

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	<p>19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 3 of 16 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 32 residents, staff and visitors in the Vent 1 and Vent 2 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 06/03/15, one six inch in diameter hole for the passage of electrical cables was noted in each of three attic smoke barrier walls above the Vent 1 and Vent 2 smoke compartments which were not filled with a material capable of maintaining the smoke resistance of the attic smoke barrier walls. Each of the aforementioned attic smoke barrier walls were above the corridor door sets in the Vent 1 and Vent 2 smoke compartments</p>	K 0025	<p>1. All openings were re-filled and packed with fire proof material around openings to ensure smoke barrier wall is sealed</p> <p>2 All openings were checked to ensure proper packing of fire proof material around openings are present See corrective below:</p> <p>3 Administrator inserviced the director of maintenance on how to properly ensure openings are packed with fire proof materials to ensure smoke barrier wall is sealed</p> <p>4 The director of maintenance will complete daily rounds to ensure that the openings are properly sealed for smoke barriers</p>	06/18/2015			

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K 0027 SS=E Bldg. 01	<p>and consisted of two layers of five eighths inch thick dry wall. Based on interview at the time of the observations, the Maintenance Director acknowledged the openings in the aforementioned attic smoke barrier walls did not maintain the fire resistance rating of the attic smoke barrier wall.</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 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 Based on observation and interview, the facility failed to ensure 2 of 3 sets of Vent 1 and Vent 2 smoke barrier door sets would close to form a smoke resistant barrier. Centers for Medicare &amp; Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure</p>	K 0027	<p>1. Doors to vent 1 and 2 were adjusted to ensure the proper closing of the doors per guidance 2. All doors were inspected and noted to properly close. See corrective measures below: 3. Administrator inserviced the director of maintenance on how to inspect the doors to ensure proper closing for smoke barrier door sets 4. The doors will be</p>	06/18/2015

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	<p>the door which must close first always closes first. This deficient practice could affect 32 residents, staff and visitors in the Vent 1 and Vent 2 smoke compartments if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 06/03/15, the following was noted:</p> <p>a. the set of smoke barrier doors in the corridor in the Vent 1 Wing swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed three times which did not ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. In addition, the south door in the aforementioned door set dragged on the floor and was prevented from closing without continually being pushed until it contacted the door closing coordinator.</p> <p>b. the set of smoke barrier doors in the corridor in the Vent 2 Wing swing in the same direction, are equipped with an astragal and a door closing coordinator. The north door in the aforementioned</p>		<p>monitored for proper closing of set doors during monthly fire drills by the administrator and the director of maintenance</p>	

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K 0029 SS=E Bldg. 01	<p>door set dragged on the floor and was stopped from closing without continually being pushed until it contacted the door closing coordinator.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke barrier door sets did not close completely because one door in the door set dragged on the floor and was prevented from closing and forming a smoke resistant barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 13 hazardous areas such as combustible storage rooms greater than 50 square feet in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon</p>	K 0029	<p>1 Automatic closer was installed on the housekeeping storage door by the director of maintenance</p> <p>2 All doors were inspected to determine if need for automatic closer</p> <p>3 Administrator inserviced the director of maintenance on the</p>	06/18/2015

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K 0050 SS=C Bldg. 01	<p>activation of the fire alarm system. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the former physical therapy room by the south nurse ' s station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 06/03/15, the former physical therapy room by the south nurse ' s station measured 540 square feet and had been converted to a storage room for boxes, linen and combustible supplies. The corridor entry door to the aforementioned room was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director stated the room was being utilized as a storage room, measured greater than fifty square feet and acknowledged the entry door from the corridor was not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part</p>		<p>guidance as to the need to ensure automatic door closer are present on combustible storage rooms greater than 50 feet to separate from other areas</p> <p>4 The director of maintenance will monitor daily to ensure that the automatic closer is installed on the housekeeping storage door</p>				

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	<p>of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Administrator and Maintenance Director during record review from 9:10 a.m. to 11:30 a.m. on 06/03/15, documentation for the second shift fire drill conducted on 11/26/14 at 5:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Based on interview</p>	K 0050	<p>1 The administrator reviewed with the director of maintenance documentation on all fire drills 2 The director of maintenance will ensure documentation is present regarding activation of the fire alarm system 3 The administrator inserviced the director of maintenance on documentation of the fire alarm system for fire drills 4 The administrator will monthly review all documentation on fire drills to ensure the director of maintenance is properly documenting the test that occurred, and calling it in to ensure proper functioning.</p>	06/18/2015

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K 0069 SS=D Bldg. 01	<p>at the time of record review, the Administrator and the Maintenance Director stated no additional fire drill documentation was available for review and acknowledged documentation for the aforementioned second shift fire drill did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in</p>	K 0069	<p>1 The kitchen range was inspected and cleaned on 6/6/15 by a company that specializes in this procedure</p> <p>2 The kitchen range will be inspected per guidance</p> <p>3 The administrator inserviced the director of maintenance on the guidance of how to inspect and clean the kitchen range</p> <p>4. The director of maintenance will monitor semi annually the inspection and cleaning of the kitchen range by a professional organization</p>	06/18/2015

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	<p>accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and Maintenance Director during record review from 9:10 a.m. to 11:30 a.m. on 06/03/15, documentation of semiannual kitchen exhaust systems inspections within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 06/03/15, a sticker was affixed to the kitchen range hood indicating the most recent hood inspection was performed by Grease Cutters in August 2012. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of semiannual kitchen exhaust systems inspections within the most recent twelve</p>			

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K 0000  Bldg. 02	<p>month period was not available for review.</p> <p>3.1-19(b)</p> <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: 06/03/15</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, the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The south hall consisting of rooms 17 through 30 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to</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 0050 SS=C Bldg. 02	<p>be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident sleeping rooms 17 through 30. Battery operated smoke detectors are installed in all other resident sleeping rooms. The facility has a capacity of 130 and had a census of 124 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to document activation of the fire alarm system for second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 18.7.1.2 states fire drills in health care occupancies shall include the</p>	K 0050	<p>1 The administrator reviewed with the director of maintenance documentation on all fire drills 2 The director of maintenance will ensure documentation is present regarding activation of the fire alarm system 3 The administrator inserviced the director of maintenance on documentation</p>	06/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15A011		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED  06/03/2015	
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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	<p>transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" with the Administrator and Maintenance Director during record review from 9:10 a.m. to 11:30 a.m. on 06/03/15, documentation for the second shift fire drill conducted on 11/26/14 at 5:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Based on interview at the time of record review, the Administrator and the Maintenance Director stated no additional fire drill documentation was available for review and acknowledged documentation for the aforementioned second shift fire drill did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b)</p>		<p>of the fire alarm system for fire drills 4 The administrator will monthly review all documentation on fire drills to ensure the director of maintenance is properly documenting the test that occurred, and calling it in to ensure proper functioning.</p>				