

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<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: 11/07/11</p> <p>Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safely Code survey, Kindred Transitional Care and Rehab-Eagle Creek was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridors and in resident rooms. The facility has a</p>	K0000	<p>Enclosed, please find our plan of correction for the deficiencys as identified during the Life Safety survey on November 7, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated committment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defenciency statement ending with an asterisk (*) denotes a defeciency which the institution may be excused from correcting providing it is determined that other safegaurds 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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K0048 SS=C	<p>capacity of 120 and had a census of 95 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/09/11.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility to protect 95 of 95 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any</p>	K0048	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the Life Safety survey on November 7, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of the facility to have a written plan for the protection of all patients and for their evacuation in the event of an emergency. Dietary staff have been inserviced on the updated Fire Discovery and Announcement policy on November 09, 2011. The addendum added to the Fire Discovery and Announcement</p>	11/11/2011	

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	<p>resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Emergency Response Plan: Discovery and Announcement" for Kindred Transitional Care and Rehab - Eagle Creek during record review with the Maintenance Director from 9:20 a.m. to 10:55 a.m. on 11/07/11, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>policy includes the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The kitchen staff trained on activating the overhead hood extinguishing system to suppress a fire before using either the ABC fire extinguisher or the K class fire extinguisher. The maintenance Director has posted instructions in the kitchen to help ensure continued compliance. The maintenance Director will incorporate with his fire drills monthly to include review with the kitchen staff to ensure continued compliance. Administrator will ensure compliance by November 11, 2011.</p>		