

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
---	--

(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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/25/14</p> <p>Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Rolling Hills was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in the 100 B</p>	K010000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150			
(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			
K010038 SS=E	<p>Hall resident rooms 116, 118, 120, 121, 122, 123, 124, 125, 126, and battery operated smoke detectors in the remaining resident rooms on the 100 A Hall, the 200 Hall, the 300 Hall and the 400 Hall. The facility has a capacity of 115 and had a census of 92 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden storage shed which were not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/01/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 Based on observation and interview, the facility failed to ensure 1 of 11 exit door electromagnetic lock remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every</p>	K010038	I. No residents were found to be affected by the alleged deficient practice. II. All residents have a potential to be affected. Electromagnetic Locks were adjusted and are working	09/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 42 residents who use the main dining room and could use the employee exit as a secondary means of egress during an emergency.</p> <p>Findings include:</p> <p>Based on observation during a test of the fire alarm system on 09/25/14 with the maintenance supervisor at 1:00 p.m., the electromagnetic lock on the employee exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on</p>		<p>properly.iii. Electromagnetic Locks were adjusted and are working properly. Audits will be conducted on all doors with electromagnetic locks 5 times a week for 2 weeks, then weekly to ensure doors work properly. Iv. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee. Please allow this POC to be desk reviewed.</p>				

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150		
(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	
	09/25/14 at 1:15 p.m. 3.1-19(b)				