

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN 46219
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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: 06/12/12</p> <p>Facility Number: 000227 Provider Number: 155334 AIM Number: 100267520</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Wildwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors</p>	K0000		

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

TITLE

(X6) DATE

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

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	<p>in Resident Rooms 1 through 12 and 700 through 715 only. The facility has a capacity of 173 and had a census of 135 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/14/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p>	K0038	<p>A. All residents had the potential to be affected, no specific resident was identified.B. All residents had the potential to be affected. The front lobby door was repaired on 6-22-2012 by Safe Care. The door has worked perfectly since being repaired.C. Maintenance Director will check front lobby door daily for 2 weeks and then will put on preventative maintenance sheets to be checked weekly.D. Maintenance Director will check front lobby door weekly and will initial off on the preventative maintenance form. If door is found not to be unlocking after pushing on door for 15 seconds Safe Care will be called immediately by maintenance director or Executive Director to get repaired. Maintenance will report to the PI Committee once per month for three months and then quarterly until substantial compliance is achieved</p>	06/26/2012			

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	<p>delay not exceeding 30 seconds shall be permitted.</p> <p>This deficient practice could affect any resident, staff or visitor wanting to exit the facility using the Front Lobby exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 12:45 p.m. on 06/12/12, the Front Lobby exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force four separate times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Front Lobby exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force four separate times.</p>			

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	3.1-19(b)				

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans 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 resident, staff and visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Fire Discovery and Announcement" documentation during record review with the Maintenance Supervisor from 9:05 a.m. to 11:00 a.m. on 06/12/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the</p>	K0048	<p>A. All residents had the potential to be affected, no specific resident was identified. B. All residents had the potential to be affected. The written fire plan was updated on the use of ABC type fire extinguishers and K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. C. The written fire plan was updated on the use of ABC type fire extinguishers and K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen range extinguishing system. Inservice was held 6-20-2012 with all dietary staff regarding the fire extinguishers and the kitchen range extinguishing system. D. Fire plan was updated, inservice was help with all dietary staff explaining use of extinguishers. Copy of new fire plan that explains use of type ABC extinguishers and K-class fire extinguishers located in the kitchen in relationship with the use of the kitchen rangeextinguishing system will be added as a part of the dietary orientation. This will be monitored and reviewed by the dietary manager, maintence director and PI committee on a monthly basis for 3 months and then quarterly</p>	07/02/2012

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	<p>K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include the policy 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>until substantial compliance is achieved. Dietary staff will be inserviced annually on the dietary fire extinguisher systems.</p>	

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K0050 SS=F	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Report" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 11:00 a.m. on 06/12/12, there is no documentation available for review of a fire drill conducted on the third shift for the third quarter of 2011. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation available for review of a fire drill being conducted on the third shift for the third quarter of 2011.</p>	K0050	<p>A. All residents have the potential to be affected however no specific residents were identified. Schedule has been completed by maintenance director of when fire drills will be conducted. Maintenance will assure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. B. All residents have the potential to be affected. Schedule has been completed by maintenance director of when fire drills will be conducted. Maintenance will assure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift C. Maintenance Director Maintenance will assure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift and that the staff are famniliar with procedures and is aware that drills are part of established routine. D. Maintenance director will have the responsibility for planning and conducting drills.</p>	06/26/2012			

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	3.1-19(b)		Executive Director will review fire drill schedules to assure that drills are scheduled as required and will review fire drills monthly to assure they have been held. PI committee will review monthly for 3 months and then quarterly until substantial compliance is achieved.		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room by the Therapy Exit and by the east nurse's station.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 12:45 p.m. on 06/12/12, there is an oxygen storage room by the Therapy Exit and by the east nurse's station. Each oxygen storage room contained at least five liquid oxygen canisters and each room's ceiling consisted of one layer of five eighths inch thick drywall. Based on interview at the</p>	K0076	<p>A. All residents, staff, and visitors located in the area of the oxygen storage area have the potential to be affected. Oxygen storage rooms that had only one sheet of 5/8ths" drywall had another sheet of 5/8" drywall was added to ceilings in both of the storage rooms to make the fire rating meet the 1 hour required rating.B. All residents, staff, and visitors located in the area of the oxygen storage area have the potential to be affected. Oxygen storage rooms that had only one sheet of 5/8ths" drywall had another sheet of 5/8" drywall was added to ceilings in both of the storage rooms to make the fire rating meet the 1 hour required rating.C. The facility has no other Oxygen storage areas.D. Maintenance will check the ceilings of the oxygen storage room for any damaged ceiling drywall and will replace if needed. Maintenance Director will check monthly on his preventative maintenance form. Maintenance</p>	06/26/2012			

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	time of the observations, the Maintenance Supervisor acknowledged the ceiling in each of the aforementioned oxygen storage rooms did not provide 1 hour fire resistive construction. 3.1-19(b)		Director will report to PI committee that the ceiling now meets LSC guidelines.		

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room by the Therapy Exit and by the east nurse's station.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 12:45 p.m.</p>	K0143	<p>A. All residents, staff, and visitors located in the area of the oxygen storage area have the potential to be affected. Oxygen storage rooms that had only one sheet of 5/8ths" drywall had another sheet of 5/8" drywall was added to ceilings in both of the storage rooms to make the fire rating meet the 1 hour required rating.B. All residents, staff, and visitors located in the area of the oxygen storage area have the potential to be affected. Oxygen storage rooms that had only one sheet of 5/8ths" drywall had another sheet of 5/8" drywall was added to ceilings in both of the storage rooms to make the fire rating meet the 1 hour required rating.C. The facility has no other Oxygen storage areas.D. Maintenance will check the ceilings of the oxygen storage</p>	06/26/2012			

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	<p>on 06/12/12, there is an oxygen storage and transfilling room in each wing of the facility. Each oxygen storage and transfilling room contained at least five liquid oxygen canisters and each room's ceiling consisted of one layer of five eighths inch thick drywall. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the ceiling in each of the aforementioned oxygen storage and transfilling rooms did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>room for any damaged ceiling drywall and will replace if needed. Maintenance Director will check monthly on his preventative maintenance form. Maintenance Director will report to PI committee that the ceiling now meets LSC guidelines</p>		

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, 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 could affect any resident, staff or visitor in the vicinity resident Room 209 and Room 301.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 12:45 p.m. on 06/12/12, two refrigerators were each plugged into separate power strips in resident Room 209 and a refrigerator was plugged into a power strip in resident Room 301. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged refrigerators were plugged into power strips in the aforementioned locations.</p> <p>3.1-19(b)</p>	K0147	<p>A. Residents, staff or visitors in the vicinity of room 209 and 301 had the potential to be affected. Power strips were removed from refrigerators in rooms 209 and 301.B. Any resident having a refrigerator plugged into a power strip have the potential to be affected. Residents that have refrigerators have been informed that no power strip may be used on refrigerators. Maintenance Director checked all resident room refrigerators and assured that there were no more refrigerators with powerstrips.C. All resident with refrigerators have been informed that they cannot use power strips for refrigerator. Maintenance Director will check all resident rooms with refrigerators to assure there are no power strips. If any are found they will be immediately removed.D. All new admissions or current residents who request to get a refrigerator will be informed that refrigerators cannot be plugged into a power strip. Maintenance will do weekly checks on all resident refrigerators to assure that none have power strips for two weeks , then monthly and will remove any found during his rounds. Rounds for refrigerator checks will be placed on preventative</p>	06/26/2012			

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			maintenance forms and will be reviewed monthly at the PI meeting once per month for 3 months and quarterly thereafter until substantial compliance is achieved.		