

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
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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: 11/30/15</p> <p>Facility Number: 000166 Provider Number: 155265 AIM Number: 100267080</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab-Wedgewood 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in resident rooms 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, and battery</p>	K 0000	<p>Please accept this plan of correction as the center's credible allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely executed because it is required by the provisions of federal and state law. PLEASE NOTE: FACILITY RESPECTFULLY REQUESTS PAPER COMPLIANCE REVIEW FOR THIS SURVEY.</p>	
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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 0025 SS=E Bldg. 01	<p>operated smoke detectors in the remaining resident rooms. The facility has a capacity of 124 and had a census of 106 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled. The facility has a detached wooden storage garage and detached wooden storage shed which were not sprinkled.</p> <p>Quality Review completed 12/02/15 - DA</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, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 11 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice affects 10 residents who reside on the 500 Hall and any residents who use the Administration Hall.</p>	K 0025	K25- It is the practice of this center to assure that all fire/smoke barriers remain within compliance at all times to include: Smoke Barriers were repaired on 12-09-2015 using the appropriate fire rated caulk that was designed specifically for this purpose. All smoke barrier walls was inspected/sealed on 12-09-2015 to ensure compliance	12/09/2015

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	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 11/30/15 during a tour of the attic smoke barriers from 12:30 p.m. to 1:15 p.m., the following attic smoke barriers were not fire stopped or had a non rated fire stopping material used to seal penetrations;</p> <p>a. The 500 Hall attic smoke barrier had a two inch gap around a cable bundle penetration in the center of the smoke barrier wall not fire stopped.</p> <p>b. The Administration Hall attic smoke barrier had three, one inch to two inch gaps seals with a gray colored fire stopping material. Based on an interview with the maintenance supervisor on 11/30/15 at 1:20 p.m. and observation of an empty tube of fire rated caulk, the fire rated caulk used to seal the Administration Hall attic smoke barrier penetrations did not have a fire rating on the empty tube, and was labeled as its use for residential use only.</p> <p>The 500 Hall attic smoke barrier penetration not fire stopped and the Administration Hall attic smoke barrier penetrations sealed with a residential use only fire stopping caulk was verified by the maintenance supervisor at the time of observations and interview and acknowledged by the administrator at the</p>		<p>throughout the center. All smoke/fire barrier walls will be inspected on a quarterly basis and documented in preventative maintenance logs. Preventative Maintenance logs will be reviewed by the PI committee quarterly to ensure continued compliance as an ongoing practice.</p>				

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K 0027 SS=E Bldg. 01	<p>exit conference on 11/30/15 at 1:40 p.m.</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 1 of 11 smoke barrier doors 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 affects 17 residents who reside on the 100 Hall and 21 residents who reside on the 300 Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/30/15 at 12:20 p.m. with the maintenance</p>	K 0027	<p>K27</p> <p>It is the practice of this center to assure that all dooropenings in smoke barrier walls are within compliance at all times to include: Identified 100 hall doors have been ordered and will beinstalled by Jan. 15th, 2016. (see attached quote) All other Smoke barrier doors have been inspected to ensurecompliance throughout center. All doors will be inspected weekly with results documentedin preventative maintenance logs. Preventative maintenance logs will be reviewed by Plcommittee monthly for 3 months then quarterly thereafter as an ongoingpractice.</p>	01/15/2016

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	<p>supervisor, the set of smoke barrier doors at the 100 Hall leading to the 300 Hall had a one inch gap where the set of doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/30/15 at 1:40 p.m.</p> <p>3.1-19(b)</p>						