

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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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: 02/19/14</p> <p>Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Kindred Transitional Care and Rehabilitation-Dyer was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety Code 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 hard wired smoke detection in the corridors, in spaces open</p>	K010000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandate submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. The facility requests a desk review for</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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	<p>to the corridors and in resident sleeping rooms. The facility has a capacity of 180 and had a census of 137 at the time of the survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for a detached equipment storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/25/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>paper with allcitations related to this survey.</p>		

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K010021 SS=E	<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 1 of 11 smoke barrier door sets were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more residents on the West wing A hall.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance director on 02/19/14 at 12:55 p.m., one door in the smoke barrier door set for the West wing A hall failed to close when tested twice. The door caught on the floor leaving the door open twelve inches. The door was observed to have failed to close again when the fire alarm was</p>	K010021	<p>We respectfully request a desk review for paper compliance for this citation K021</p> <p>The West wing A hall smoke barrier door was repaired immediately. At any time any smoke barrier door can be impaired. Nursing and housekeeping staff will be educated to immediately make maintenance aware of any barrier door failing to close when fire alarm systems are activated. All doors will be monitored weekly by the Maintenance Director/designee</p> <p>E.D./designee will review weekly. Completed February 21, 2014</p>	03/21/2014			

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K010025 SS=E	<p>activated on 02/19/14 at 2:20 p.m. The maintenance director acknowledged at the time of observation, the door was not maintaining the smoke resistance of the smoke barrier.</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, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 openings in smoke partitions such as walls and ceilings were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and and 10 or more resident on the East wing and service corridor.</p>	K010025	<p>We respectfully request a desk review for paper compliance for this citation K025 . The hole in the ceiling tile of the East Wing A hall exit egress foyer was immediately replaced. The electrical room ceiling was immediately repaired. The wall in the control panel room was repaired and all boxes removed. All areas can affect the residents at any</p>	03/21/2014			

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	<p>Findings include:</p> <p>a. Based on observation with the the administrator on 02/19/14 at 12:05 p.m., an irregular two by six inch hole was noted in the lay in ceiling tile of the East wing A hall exit egress foyer. The administer acknowledged at the time of observation, the tile should provide a smoke tight seal.</p> <p>b. Based on observation with the the maintenance director on 02/19/14 at 1:35 p.m., the main electrical switch room housing the electrical transfer switches and boilers had a ceiling penetration by a four inch pipe. The penetration was unsealed where a four inch section of the ceiling drywall was missing. The maintenance director said at the time of observation, he was unaware of the opening into the attic above.</p> <p>c. Based on observation with the the maintenance director on 02/19/14 at 1:50 p.m., an 18 by 36 inch section of the HVAC and fire alarm control panel room located above the main electrical switch room was cut out of one wall leaving the room open to the the attic. The room was being used for the storage of eight combustible cardboard cartons which the maintenance director identified at the time of observation as</p>		<p>time. · The maintenance director will be educated on focusing on the noted areas during rounds. · The E.D./designee and the maintenance director will make weekly facility rounds noting and repairing any deficiencies. · Completed March 1, 2014</p>				

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K010044 SS=E	<p>Christmas storage. The maintenance director said the hole in the wall was used by sprinkler contractors to access an area of the attic adjacent to the HVAC room. The maintenance director acknowledged the wall opening spoiled the smoke resistance of the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 fire doors was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect visitors, staff, and 10 or more residents in the dining room smoke compartment.</p>	K010044	<p>We respectfully request a desk review for paper compliance for this citation K044</p> <p>The West wing A hall smoke barrier door was repaired immediately. At any time any smoke barrier door can be impaired. Nursing and housekeeping staff will be educated to immediately make maintenance aware of any barrier door failing to close when fire alarm systems are activated. All doors will be monitored weekly by the Maintenance Director/designee. E.D./designee will review weekly. Completed</p>	03/21/2014			

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K010068 SS=D	<p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 02/19/14 at 1:15 p.m., the fire door providing separation between the main dining room and the service corridor was tested twice. The door failed to latch each time the door was released from the magnet and allowed to close. The door failed to latch again at 2:20 p.m. when the fire alarm was activated. The maintenance director said at the time of observations, the door latch assembly was damaged.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes</p>	K010068	<p>February 24, 2014</p> <p>We respectfully request a desk review for paper compliance for this citation K0068 We are committing to getting a quote. This can affect anyone in the facility. Executive Director/designee will review weekly. We are currently obtaining bids to add to add fresh air intake in laundry room. A contract will be awarded. Completed 3/21/2014</p>	03/21/2014			

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K010072 SS=F	<p>dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors and 2 or more staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/19/14 at 1:20 p.m., the laundry room had two, gas fueled dryers with no fresh air intake. The maintenance director said at the time of observation, the two gas fueled dryers did not have a fresh air intake.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 12 of 14 exterior exit discharges were maintained to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1</p>	K010072	<p>We respectfully request a desk review for paper compliance for this citation K072</p> <p>All walks & emergency exits were cleared and salted. The company doing the plowing was</p>	03/21/2014			

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	<p>requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect all visitors, staff and residents on the three sleeping room wings and main dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director and administrator on 02/19/14 between 11:45 p.m. and 2:45 p.m., emergency exit discharges were covered with two to eight inches of ice and snow for two south wing exits, three west wing exits, two main dining room exits two north south corridor exits between the west wing and main dining room, and three B wing exits from the east wing, east exit from the north wing, and south exit from the south wing. The maintenance director pointed out most exit discharges had been cleared but ice had melted onto the discharge surfaces outside exits and refrozen and snow had blown to accumulate onto the exit discharge paths. In addition, he noted the snow plow for the parking area had pushed a three foot high pile of snow across the</p>		<p>notified regarding where to place snow. Walkways are not to be blocked. · All of the above areas can affect any resident at anytime. · The walkways will be cleaned and salted within 1 hour of snowfall. If internally it cannot be completed the plowing company will be contacted to complete the project. · A contract has been authorized to repair the concrete when the weather is appropriate. · Contractors will repair once weather is appropriate. An extension to the correction is requested as the weather is appropriate, see attached contract.</p>				

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K010147 SS=E	<p>evacuation point for the snow covered discharge path for the East wing B hall. He acknowledged these discharges should have been available for emergency use.</p> <p>b. Based on observation with the maintenance director and administrator on 02/19/14 at 12:10 p.m., the concrete exit discharge surface for the East wing C hall had two irregular cracks across the width of the path's surface with a two by eight inch section missing in the middle of the path outside the exit door. The maintenance director agreed the time of observation, the irregular surface could interfere with safe travel in the event of an emergency.</p> <p>3.1-19(b)</p> <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>1. Based on observation and interview, the facility failed to ensure 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be</p>	K010147	<p>We respectfully request a desk review for paper compliance for this citation K147</p> <p>The repairs have been completed by an electrical contractor. The air conditioning unit, the ladder and equipment cart were removed immediately from in front of the main electrical</p>	03/21/2014			

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	<p>provided with covers compatible with the box. This deficient practice could affect visitors, staff and 10 or more residents in the adjacent service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/19/14 at 1:50 p.m., two junction boxes in the attic HVAC room were left uncovered with multiple wires exposed. The maintenance director acknowledged at the time of observation, the boxes should have had covers.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 6 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment.</p>		<p>transfer switch room. · Any of these concerns could negatively impact the residents. · The maintenance director and Housekeeping staff were in serviced about proper placement of equipment. · Weekly rounds will be completed by E.D. to note compliance. · Completed February 28, 2014</p>				

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	<p>This deficient practice affects visitors and 2 or more staff in the main electrical transfer switch room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 02/19/14 at 1:45 p.m., an air conditioning unit, ladder, and equipment cart were stored adjacent to the bank of electrical transfer switches in the main electrical transfer switch room. The maintenance director agreed the equipment would have to be moved to access the switches in an emergency or for maintenance work.</p> <p>3.1-19(b)</p>				