

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 11/10/2014
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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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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: 11/10/14</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</p>	K010000	<p>November 21,2014 RE: Life Safety Code Survey 11/10/2014. Attached you will find the completed Plan of Correction for our annual survey. We request that our plan of correction be considered for a paper compliance desk review. Should you have any questions please feel free to contact me at (317) 353-1290.The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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K010018 SS=D	<p>detectors hard wired to the fire alarm system installed in Resident Rooms 1 through 12 and 700 through 715. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 160 and had a census of 143 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/17/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are</p>						

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	<p>permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 staff and visitors in the vicinity of the Unit Manager's Office at the Windsor Nurses Station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Administrator in Training during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/10/14, the latching mechanism on the corridor door to the Unit Manager's Office at the Windsor Nurses Station was taped down and failed to protrude into the door frame which provided an impediment to closing and latching. Based on interview at the time of observation, the Maintenance Director stated the door handle is of a type which is always locked from the corridor side when latched and acknowledged the latching mechanism on the corridor door to the Unit Manager's Office at the Windsor Nurses Station was taped down</p>	K010018	<p>No residents were affected by this practice. Residents in the vicinity of the Unit Managers Office at the Windsor Nurses Station had the potential to be affected but none were affected. Tape on the locking mechanism was immediately removed. This door is not required to have a lock on it, this was verified with the surveyor. Locking doorknob was replaced with regular latching doorknob that does not lock. Staff have been instructed that there are never to be any latches on any doors taped or otherwise tampered with to prevent them from closing or latching. Unit managers and department managers are to test doors at least daily to assure that they have not been taped or otherwise manipulated. Any staff member found manipulating latches will be immediately counseled. Maintenance Director as a part of his rounds will also be checking all doors as outlined in his preventative maintenance manual.</p>	11/11/2014

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K010025 SS=D	<p>which provided an impediment to closing and latching.</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 1 of 1 ceiling smoke barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 2 staff and visitors in the vicinity of the Main Electrical Room.</p> <p>Findings include:</p>	K010025	<p>There were no residents affected by this. Maintenance drywalled and sealed the ceiling to close the opening on 11/12/14There was the potential for all residents who come to the main dining room had the potential to be affected but no residents were affected.Maintenance director repaired the drywall on the ceiling to close the opening. Maintenance directed checked all ceilings in facility and any other areas that are smoke barriers to assure all were secure.Preventative maintenance schedule updated and will be followed so all smoke barriers will be checked on a quarterly basis and any repairs will be made immediately.Maintence director will bring documentation of</p>	11/12/2014

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K010038 SS=E	<p>Based on observation with the Maintenance Director and the Administrator in Training during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/10/14, a one foot by six inch opening in the ceiling of the Main Electrical Room for the passage of two electrical conduits exposed the attic above and failed to maintain the smoke resistance of the ceiling smoke barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening exposed the attic above and failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided,</p>	K010038	<p>preventative maintenance form to PI and Safety Meetings for a period of six months to assure continued compliance .</p> <p>Residents who use the main entrance door had the potential to be affected but no residents were affected. Safecare was immediately called and came to facility on 11/12/14 and made repair and tested to assure that door was operating properly when the alarm was activated. Maintenance Director will check or maintenance assistant will check front entry doors at least monthly to assure</p>	11/12/2014

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K010062 SS=C	<p>automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Administrator in Training during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/10/14, the electromagnetic lock on the facility exit to the exterior of the building at the Main Entrance did not remain unlocked when the fire alarm was activated at 1:17 p.m. After activation of the fire alarm system at 1:17 p.m. and subsequent silencing of the system, all electromagnetic locks in the building remained unlocked except at the Main Entrance. Based on interview at the time of the observations, the Maintenance Director acknowledged the electromagnetic lock on the Main Entrance did not remain unlocked while the fire alarm system was activated.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating</p>		that latch is functioning properly. Maintenance will check front entry door and other facility doors to assure that they are operating properly following the Preventative maintenance schedule. Preventative Maintenance sheets will be reviewed at monthly PI and Safety Meetings for 6 months to assure compliance.		

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	<p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 operating wrenches for the Post Indicator Valve (PIV) were secured to prevent tampering. LSC 4.6.12.2 states life safety features obvious to the public, even if not required, shall be maintained or removed. Sprinkler systems shall be maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. NFPA 25, 9-3.3.2 says the control valve inspection shall verify the valves are in the following condition: (a) in the normal open or closed position (b) properly sealed, locked or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Administrator in Training during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/10/14, the operating wrench for the PIV was not secured to the PIV to prevent the loss of the wrench or</p>	K010062	All residents had the potential to be affected but none were affected. Maintenance director replaced padlock while surveyor was still in the facility. Maintenance Director will check padlock to assure that wrench is secure on a monthly basis. This has been placed on the Preventative Maintenance Schedule. Maintenance Director will bring Preventative Maintenance form to Monthly PI and Safety Meetings to assure compliance. This will be monitored by the PI Committee for 6 months to assure continued compliance	11/11/2014

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K010130 SS=E	<p>additional tampering. A lock was attached to the wrench but the latching bolt for the lock was rusted and failed to secure the operating wrench to the PIV. The PIV was located outside of the building near the exit by the Main Dining Room. Based on interview at the time of observation, the Maintenance Director and Administrator in Training acknowledged the operating wrench for the PIV was not secured to prevent the loss of the wrench or additional tampering.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure.</p>	K010130	All residents who come to the main dining room had the potential to be affected but none were affected.Safe Care came to facility on 11/10/2014 while surveyor was still in facility and did the test on the roll down window to kitchen. The operation of the roll down door functioned properly.Administrator contacted Safe Care who does the inspections and has it now scheduled for November of each year.Inspection of Rolling Fire Doors has been placed on preventative maintenance schedule will be followed to assure that inspections are done timely.	11/11/2014

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	<p>Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:10 a.m. to 10:50 p.m. on 11/10/14, documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Administrator in Training during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/10/14, two metal rolling fire doors protecting the opening from the kitchen to the Main Dining Room were noted. The inspection tag affixed to the main rolling fire door indicated the most recent documented inspection was on 05/19/12. No inspection tag was affixed to the rolling fire door separating the Main Dining Room from the dishwashing room in the kitchen. Based on interview at the time of record review and of the observations, the Maintenance Director stated each rolling fire door should have</p>						

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	<p>had an annual inspection, no additional documentation of an annual inspection was available for review and acknowledged documentation of kitchen rolling fire door inspection and testing within the most recent twelve month period was not available for review. Based on the survey findings, SafeCare was contacted by the facility and performed an inspection for each of the aforementioned kitchen rolling fire doors as documented in SafeCare's "Service Call Report" dated 11/10/14.</p> <p>3.1-19(b)</p>				