

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 07/01/2013
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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
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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: 07/01/13</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 sprinklered. 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	Attached you will find the completed Plan of Correction and attachments for the recent Life Safety Survey recertification dated 07/01/2013. We assert that all corrections described on this Plan of Correction have been implemented and will continue interventions to ensure compliance with regulations are met upon survey revisit.	
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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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	<p>Hall resident rooms 116, 118, 120, 121, 122, 123, 124, 125, and 126 with 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 99 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except a detached wooden storage garage and a detached wooden storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 2 of 16 doors serving a hazardous area such as a laundry room over 100 square feet in size were held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect 68 residents who use the main dining room, located in the Service Hall near the laundry room.</p> <p>Findings include:</p> <p>Based on observation on 07/01/13 with the maintenance director at 1:10 p.m., the laundry room, which measured three hundred fifty square feet, had a south door propped open to the Service Hall corridor with a metal clothes rack, and the north</p>	K010021	<p>K-21</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure shall be permitted to be held open only by devices arranged to automatically release upon activation of Fire Alarm:</p> <p>I. The laundry room door identified has had a fire alarm door magnet added.</p> <p>II. Maintenance Director, Environmental Services Supervisor or designee will audit laundry doors daily to ensure doors are held open only by approved devices.</p> <p>III. The Maintenance Director and Environmental Services staff has been inserviced by the Executive Director on K-21 on 7/22/13.</p> <p>IV. Monitoring by the Maintenance Director or designee will occur monthly during Life Safety rounds and be reported through the Safety Committee to the Performance Improvement Committee.</p> <p>V. Completion date will be</p>	07/25/2013

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	door propped open with two one half gallon plastic containers of floor degreaser. This was verified by the maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 07/01/13 at 1:15 p.m. 3.1-19(b)		07/25/2013.		

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect any residents in the event of a power outage and battery lighting was needed at the emergency generator.</p> <p>Findings include:</p>	K010046	<p>K-46 Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9 I. The emergency backup generator battery lighting indicated was tested and documentation completed.II. Maintenance Director or designee will conduct backup battery light testing monthly for thirty seconds and annually for ninety minutes to ensure system is functioning and operating according to code. III. Functional test will be completed monthly on battery powered lighting system and documentation kept on site as well as annual inspection by Fesco Fire Detection Company to ensure lights will provide lighting during periods of power outages. The Maintenance Director and staff was inserviced on K-46 by the Executive Director on 07/23/2013.IV. Monitoring by the Maintenance Director or designee will occur monthly during Life Safety rounds and be reported through the Safety Committee to the Performance Improvement Committee.I. Completion date will be 07/25/2013.</p>	07/25/2013

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	<p>Based on record review on 07/01/13 at 10:30 a.m. with the maintenance director, when asked if the facility had any battery backup lights and a monthly and annual testing log, it was stated there are two battery backup lights mounted outside the emergency generator and the facility does not have a monthly or annual testing log. The lack of a monthly and annual battery testing log for the two battery backup lights at the emergency generator was acknowledged by the administrator at the exit conference on 07/01/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating 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 provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all occupants if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 07/01/13 at 1:00 p.m. with the maintenance director, there were ten spare pendant style metal fuseable link sprinklers with a one</p>	K010062	<p>K62</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>I. The 100 hall soiled linen room had a metal sidewall sprinkler with a one hundred sixty five degree temperature rating and the kitchen had quick response liquid filled sprinklers with a one hundred fifty five degree temperature rating. Spare Sprinklers heads on site and sprinkler system tested, repairs complete and sprinkler system in operating condition and inspection by licensed individual scheduled.</p> <p>II. Maintenance Director or designee will audit sprinkled heads monthly and quarterly inspection by licensed individual to ensure sprinklers are functioning and operating properly.</p> <p>III. The Maintenance Director and staff was inserviced on K62 by the Executive Director on 07/23/2013</p> <p>IV. Monitoring by the Maintenance Director or designee will occur monthly during Life Safety rounds and be reported through the Safety Committee to the Performance Improvement Committee.</p> <p>V. Completion date will be 7/25/13.</p>	07/25/2013			

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	<p>hundred sixty five degree temperature rating in the spare sprinkler cabinet located in the Administration Hall sprinkler riser room. During a tour of the facility on 07/01/13 from 10:40 a.m. to 1:15 p.m. with the maintenance director, the 100 Hall soiled linen room had a metal sidewall sprinkler with a one hundred sixty five degree temperature rating and the kitchen had quick response liquid filled sprinklers with a one hundred fifty five degree temperature rating. Furthermore, there were no spare metal sidewall sprinklers or spare red liquid filled quick response sprinklers in the Administration Hall sprinkler riser room spare sprinkler cabinet. This was verified by the maintenance supervisor on 07/01/13 at 1:00 p.m. in the Administration Hall sprinkler riser room, and acknowledged by the administrator at the exit conference on 07/01/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 2 of 2 dining rooms were flame retardant. This deficient practice could affect 68 resident who use the main dining room in the Service Hall and 12 residents who use the 200 Hall restorative dining room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director during a tour of the Service Hall main dining room at 11:00 a.m., and the 200 Hall restorative dining room at 12:40 p.m., the Service Hall dining room had six window curtains and</p>	K010074	<p>K 74</p> <p>Drapes, curtains, including cubical curtains and other loosely hanging fabrics and film serving as furnishing or decorations in health care occupancies are in accordance with the methods cited</p> <p>I. Documentation regarding flame retardant for the Service Hall main dining room and 200 hall restorative dining room window curtains was not available for review. Maintenance Director notified manufacture of curtains which are now in accordance with required code.</p> <p>II. Newly introduced curtains are flame retardant and documentation on site to ensure compliance Maintenance Director or designee with audit periodically to maintain compliance</p>	07/25/2013

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	<p>the 200 Hall restorative dining room had eleven window curtains which lacked attached documentation showing they were inherently flame retardant. Based on interview at the time of observations with the maintenance director, documentation regarding flame retardance for the Service Hall main dining room and 200 Hall restorative dining room window curtains was not available for review. This was acknowledged by the administrator at the exit conference on 07/01/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>		<p>III. The Maintenance Director and staff inserviced on 07/23/2013 K74 by the Executive Director.</p> <p>IV. Monitoring by the Maintenance Director or designee will occur monthly during Life Safety rounds and be reported through the Safety Committee to the Performance Improvement Committee.</p> <p>V. Completion date will be 7/25/13.</p>	

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 53 of 62 resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility except the 100 B Hall resident rooms which have hard wired smoke detectors.</p> <p>Findings include:</p> <p>Based on an interview on 07/01/13 at 10:35 a.m. with maintenance director during record review, fifty three of the sixty two resident rooms have battery operated smoke detectors located in each of the resident rooms in the 100 A Hall, 200 Hall, 300 Hall and 400 Hall. Furthermore, there was no preventive maintenance program to document monthly testing and annual battery replacement for each of the fifty three battery operated smoke detectors. The lack of a written maintenance program to provide monthly testing and annual battery replacement for the fifty three resident room battery operated smoke</p>	K010130	<p>K 130</p> <p>Facility failed to implement and maintain a preventative maintenance program for battery operated smoke detectors installed in 53 of 62 resident rooms.</p> <p>I. Monthly testing and annual battery for 100A Hall, 200 Hall, 300 Hall and 400 hall battery operated smoke detectors complete 07/25/2013</p> <p>II. Maintenance Director completed audits on all hallways and documentation on cite to maintain compliance with code indicated. II. Maintenance Director or designee will audit battery operated smoke detectors indicated monthly and document to ensure smoke detectors are functioning and operating properly in compliance with code.</p> <p>III. Maintenance Director and staff inserviced on K 130 by the Executive Director on 07/23/2013</p> <p>IV. Monitoring by the Maintenance Director or designee will occur monthly during Life Safety rounds and be reported through the Safety Committee to the Performance Improvement Committee.</p> <p>V. Completion date will be 7/25/13.</p>	07/25/2013	

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	<p>detectors was verified by the maintenance director at the time of interview and acknowledged by the administrator at the exit conference on 07/01/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			