STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 01 B. WING	01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	7301 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 01/22/16 Facility Number: 000227 Provider Number: 155334 AIM Number: 100267520 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. 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 hard wired to the fire alarm system installed in Resident Rooms 1	K 0000	KindredTransitional Care and Rehabilitation –Wildwood would like to request a papercompliance review for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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 135 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 01/27/16 - DA			
K 0025 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure openings through 2 of 12 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with	K 0025	Correctiveaction was immediately corrected by maintenance director who filled in thespaces where there was penetration through two fire walls where cable had been run. Allresidents had the potential to be affected. Maintenance checked all fire walls in attic and found no otherpenetrations through fire	01/23/2016

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	a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 78 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:45 a.m. to 1:10 p.m. on 01/22/16, the following was noted: a. an open ended four inch in diameter conduit which contained twenty data cables penetrated the attic smoke barrier wall above the corridor door set by Room 113. b. an open ended four inch in diameter conduit which contained twenty data cables penetrated the attic smoke barrier wall above the corridor door set by Room 410. c. eight one inch in diameter open ended conduits each containing one data cable penetrated the smoke barrier wall above the suspended ceiling by the corridor door set by Room 410. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the two smoke barrier walls were not filled with a material to maintain the fire resistance rating of the		walls. Each timethat a vendor or maintenance causepenetrations in the fire wall maintenance will get penetration filled with fireretarding foam. Maintenance will also check all fire walls ona monthly basis to assure that no penetrations have been made and if any arefound they will be immediately correctedby maintenance staff. Date ofcorrection was January 1/3/206	

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	smoke barrier wall. 3.1-19(b)			