STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 01 B. WING	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LN CLARKSVILLE, IN 47129

(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
K0000	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: 12/13/12 Facility Number: 000166 Provider Number: 155265 AIM Number: 100267080 Surveyor: Mark Bugni, Life Safety Code Specialist 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. 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, spaces open to the corridors, with hard wired smoke detectors in	K0000	This Plan of Correction is the center's 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 solely because it is required by the provisions of federal and state law. Please note the facility respectfully requests paper compliance for this survey.	

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

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	resident rooms 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512 and battery operated smoke detectors in the remaining resident rooms. The facility has a capacity of 124 and had a census of 103 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached garage providing storage which is not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/19/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=E	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 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon	K0038	1. No indivdual resident was identified.2. All residents using the main dining room during meals have the potential to be affected.3. Maintenance Director repaired identified door on December the 13, 2012. The facility will be upgrading and changing equipment on the identified door (Attachment # 1) which will be installed by Jan. 2, 2013 to ensure no further instances of incorrect operation occur.4. Maintenance Director/Designee will test door for for proper operation weekly for a period of 8 weeks, then will monitor monthly as a part of the facility Preventative Maintenance Program as an ongoing practice. Results will be reported to ED weekly and to the PI Committee monthly for a period of 6 months.	01/03/2013

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	application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 18 residents who use the main dining room, located near the Service Hall exit along with staff and visitors. Findings include: Based on observation on 12/13/12 at 12:40 p.m. with the maintenance director, the Service Hall exit near the main dining room was provided with a delayed egress lock along with the proper sign indicating the doors can be opened in 15 seconds by			

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	pushing on the door, however, when the door was pushed for 15 seconds, on three separate attempts on 12/13/12 from 12:40 p.m. to 12:55 p.m., the irreversible process to release the lock was not initiated. Furthermore, the maintenance director tried to adjust an adjustment mechanism and stated the doors magnetic delayed egress device needs replaced. This was acknowledged by the administrator at the 1:40 p.m. exit conference on 12/13/12. 3.1-19(b)			

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	Based on record review and interview, the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect 18 of the 103 residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on review of the facility's Range Hood Inspection Reports on 12/13/12 at 10:10 a.m. with the maintenance director,	K0069	1. No particular resident identified on 2567.2. All residents residing in the facility have the potential to be affected.3. Upon discovery that the semi-annual range hood inspection had been missed, facility Maintenance Director contacted Fesco to complete the inspection on the range hood. The inspection was completed on 12-13-12. (attachment #2).4. To prevent reoccurance of missing the semi-annual range hood inspection the Maintenance Director will complete a yearly calendar of when range hood inspection is due and will report completion of range hood inspections semi annually to administrator. Administrator will monitor calendar and ensure inspections are completed timely.	12/13/2012

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	the most recent Range Hood Fire Extinguishing Equipment Inspection Report was dated 04/24/12, more than six months ago. Based on an interview with the maintenance director, after a phone call was made to the inspection company, it was indicated a semiannual range hood inspection had not been conducted in the six month period preceding the 04/24/12 inspection date either. This was confirmed by the administrator at the 1:40 p.m. exit conference on 12/13/12. 3.1-19(b)			