STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING -- B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBUS TRANSITIONAL CARE AND REHABILITATION	2100 MIDWAY ST COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/22 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Emergency Preparedness survey, Columbus Transitional Care and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 180 certified beds. At the time of the survey, the census was 0. Quality Review completed on 12/07/22	E 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.	
K 0000 Bldg. 02	A Life Safety Code Preoccupancy Survey for a replacement facility located at 540 Belmont Drive, Columbus, was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/05/22 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340	K 0000	Submission of this plan of correction does not constitute admissions or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyler Reed	Administrator	12/10/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	155133	A. BUILDING 02 B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBUS TRANSITIONAL CARE AND REHABILITATION	2100 MIDWAY ST COLUMBUS, IN 47201

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	At this Life Safety Code Preoccupancy survey for a replacement facility located at 540 Belmont Drive, Columbus, Columbus Transitional Care and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC, 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. This one story facility was determined to be of Type V (111) construction and 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 building electrical system with battery backup installed in all resident sleeping rooms. The facility has a capacity of 180 and had a census of 0 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered including the detached laundry building. The facility has one detached oxygen storage shed which was not sprinklered Quality Review completed on 12/07/22		find enclosed this plan of correction for this survey.	
K 0374 SS=F Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least			

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	155133	A. BUILDING 02 B. WING	12/05/2022

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	1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 Based on record review, observation and interview; the facility failed to ensure 10 of 10 sets of smoke barrier door sets which swing in the opposite direction were equipped with a rabbet, bevel or astragal at the meeting edges of the door set. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of facility blueprint documentation with the Maintenance Director and the Senior Project Manager for the building construction manager during record review from 9:15 a.m. to 10:20 a.m. on 12/05/22, the facility has 8 smoke barrier door sets in smoke barrier walls with a minimum fire resistance rating for the walls of 1-hour fire resistance and has 2 smoke barrier door sets in smoke barrier walls with a minimum fire resistance rating for the walls of 2-hour fire resistance. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 1:40 p.m. on 12/05/22, each of the aforementioned 10 smoke barrier door sets were not equipped with a rabbet, bevel or astragal at the meeting edges of the door set. Based on	K 0374	1. No residents, staff, or visitors were affected. 2. All residents, staff, and visitors have the potential to be affected, thus the following corrective actions have been taken; 3. The Maintenance Director installed astragals on all 10 smoke barrier door sills at meeting edges per state and federal regulations. 4. Administrator and Maintenance Director or designee will ensure all astragals are intact and functional annually per policy. 5. Corrective action will be completed on or before December 13, 2022.	12/13/2022

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	interview at the time of the observations, the Maintenance Director agreed each of the aforementioned 10 smoke barrier door sets which swing in the opposite direction were not equipped with a rabbet, bevel or astragal at the meeting edges of the door set. This finding was reviewed with the Maintenance Director and the Senior Project Manager for the building construction manager during the exit conference. 3.1-19(b)			