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	09/29/2022

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: 09/29/22 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Emergency Preparedness survey, Columbus Transitional Care and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 212 certified beds. At the time of the survey, the census was 59. Quality Review completed on 10/03/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	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. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment			

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

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	09/29/2022

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	§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.			

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	155133	A. BUILDING -- B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated	E 0006	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 Administrator updated the Hazard Vulnerability Analysis to include the Emerging Infectious Diseases hazard (Attachment A). Policy was reviewed, no changes made.	10/14/2022

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	155133	A. BUILDING -- B. WING	09/29/2022

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	Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation dated 02/08/22 with the Administrator, the Maintenance Director and the Administrator in Training (AIT) during record review from 9:10 a.m. to 11:45 a.m. on 09/29/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Hazard Vulnerability Analysis (HVA)" for the facility. Based on interview at the time of the exit conference at 1:30 p.m. on 09/29/22, the Administrator produced a written HVA that was generated as part of the Plan of Correction for the Emergency Preparedness survey conducted on 08/12/21 which included EID as a hazard but the scoring for all risks, including EID, was not listed. Based on interview at the time of the exit conference, the Administrator agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator, the Maintenance Director and the AIT during the exit conference.		4. Administrator and Maintenance Director or designee will ensure the Hazard Vulnerability is completed annually per policy. 5. Corrective action will be completed on or before October 14, 2022.	

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	155133	A. BUILDING 01 B. WING	09/29/2022

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/29/22 Facility Number: 000058 Provider Number: 155133 AIM Number: 100283340 At this Life Safety Code survey, 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 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) 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 battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 212 and had a census of 59 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/03/22	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 find enclosed this plan of correction for this survey. Due to low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to replace 3 of over 50 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:05 p.m. on 09/29/22, manufacturer's documentation affixed to the First Alert Model SA340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 7 and in Room 431 stated each unit was manufactured in November 2011. An installation date of July 2012 was written on the back of each device. Manufacturer's documentation affixed to the First Alert Model SA340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 518 stated the unit was manufactured June 12, 2012. An installation date of July 2012 was written on the back of the device. Based on interview at	K 0300	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 replaced the smoke alarms in Room 7 (Attachment B-1), Room 431 (Attachment B-2), and Room 518 (Attachment B-3) with new smoke alarms. The Maintenance Director moved the smoke alarm to be within 12 inches of the ceiling in Room 429 (Attachment B-4). The Maintenance Director inspected all battery operated smoke detectors in the facility to ensure they are in compliance (Attachment B-5). 4. The Maintenance Director and Administrator or designees will ensure all battery operated smoke detectors are in compliance monthly. The audit will be reviewed monthly during the facility's morning meeting. The plan of correction will be reviewed quarterly and adjusted accordingly.	10/14/2022

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	the time of the observations, the Maintenance Director agreed the three smoke alarms were each more than ten years old. This finding was reviewed with the Administrator, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure battery operated smoke detectors installed in 1 of over 50 resident sleeping rooms were installed in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. NFPA 72, Section 29.8.3.3 states smoke alarms or smoke detectors mounted on walls shall be located not farther than 12 inches (300 mm) from the adjoining ceiling surface. This deficient practice could affect over 15 residents, staff and visitors in the vicinity or Room 429. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:05 p.m. on 09/29/22, the wall mounted battery operated smoke detector installed in resident sleeping Room 429 was installed 16 inches below the ceiling. Based on interview at the time of record review, the Maintenance Director agreed the wall mounted smoke detector installed in Room 429 was installed more than 12 inches from the ceiling. This finding was reviewed with the Administrator, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)		5. Corrective action will be completed on or before October 14, 2022.	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the mail room by the main entrance door set. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:05 p.m. on 09/29/22, the latching mechanism on the corridor door to the mail room by the main entrance door set was taped down such that the latching mechanism would not protrude into the latching plate on the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director stated the keypad on the door handle was not operable so the latching mechanism was taped down to allow entry into the room and agreed the corridor door to the mail room would not latch into the door frame to ensure the door would resist the passage of smoke. This finding was reviewed with the Administrator, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)	K 0363	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 removed the tape from the latching mechanism on the door to the mail room and replaced the keypad to ensure door and latching mechanism work properly (Attachment C-1). 4. Administrator or Maintenance Director or designees will ensure monthly inspection of mail room door and latching mechanism (Attachment C-2). The plan of correction will be reviewed quarterly and adjusted accordingly. 5. Corrective action will be completed on or before October 14, 2022.	10/14/2022
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping			

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	complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of 1 Main Dining Rooms were properly wired and grounded in accordance with NFPA 70. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection	K 0511	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 took the plug out, put the wires inside of the box, and put a blank over the outlet so it cannot be used by anyone and no longer be an active or accessible electrical receptacle (Attachment D). 4. The Maintenance Director or Administrator or designees will inspect electrical receptacles annually per policy and life safety code. Policy reviewed, no changes made. 5. Corrective action will be completed on or before October 14, 2022.	10/14/2022

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	to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect over 20 residents, staff and visitors in the Main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:05 p.m. on 09/29/22, four of four electrical receptacles in the wall mounted outlet box in the Main Dining Room near the entrance door to the kitchen were each found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Administrator, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)			