STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING -- B. WING	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(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: 04/23/25 Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870 At this Emergency Preparedness survey, Especially Kidz Health & Rehab was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 114. Quality Review completed on 04/25/25	E 0000	**Submission of this plan of correction does not constitute admission 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 and 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 the 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.**	
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: 04/23/25	K 0000	**Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of**	

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

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ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

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	Facility Number: 000273 Provider Number: 15A011 AIM Number: 100267870 At this Life Safety Code survey, Especially Kidz Health & Rehab was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) 2012 Edition and 410 IAC 16.2. The original building, Building 01, and the 2009 addition, Building 02, were each surveyed with Chapter 19, Existing Health Care Occupancies as one building. 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, in all areas open to the corridor and in resident sleeping rooms 17 through 30. Battery operated smoke detectors are installed in all other resident sleeping rooms. The facility has a capacity of 130 and had a census of 114 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 04/25/25		**deficiencies. The plan of correction is prepared and submitted because of requirement under and 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 the 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.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 25 hazardous areas such as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant	K 0321	1. No Residents were affected as a result of this deficient practice. 2. All Residents have the potential to be affected	05/09/2025

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	partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry Room. Findings include: Based on observations with the Assistant Administrator, the Maintenance Director, the Regional Director and the Life Safety Director at 2:32 p.m. on 04/23/25, the corridor door to the washing machine area of the Laundry Room was equipped with a self-closing device but the door failed to fully self-close and latch into the door frame when tested to close multiple times due to air flow from the room preventing closure. Based on interview at the time of the observations, the Assistant Administrator agreed the corridor door to the washing machine area of the Laundry Room failed to fully self-close and latch into the door frame when tested to close multiple times due to air flow from the room preventing closure which did not separate this hazardous areas from other spaces with smoke resistant partitions. These findings were reviewed with the Administrator, Assistant Administrator, the Maintenance Director, the Regional Director and the Life Safety Director during the exit conference. 3.1-19(b)		3. The door closure(s) for the laundry doors were replaced to ensure the doors are closing and latching into the door frame when shut. See Attachment A1 4. All other doors closures were inspected and found to be functioning. These inspections will continue in concert with the preventative maintenance program. These inspections will be submitted to the Quality Assurance and Performance Improvement committee. Should any deficient practice be identified, corrective actions will be taken immediately and hardware replaced.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors in the original building were not being used as a portion of a return air system/plenum for heating,	K 0521	**1.) Egress corridors in the original building were not being used as a portion of a return air system/plenum for**	05/09/2025

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	ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice could affect over 30 residents in the original portion of the facility. Findings include: Based on interview during the entrance conference at 9:10 a.m. on 04/23/25, the Administrator stated the original part of the facility is still using the egress corridor as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. The Administrator stated the facility applies for a waiver whenever it is cited in a Life Safety survey and there has been no changes to the HVAC system since it was last cited. Based on observations with the Assistant Administrator, the Maintenance Director, the Regional Director and the Life Safety Director at 2:02 p.m. on 04/23/25, resident sleeping Room 1 and resident sleeping Room 2 were using the egress corridor in the original building as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. Based on interview at 2:02 p.m. on 04/23/25, the Assistant Administrator, the Maintenance Director and the Life Safety Director agreed the two resident sleeping rooms only had HVAC supply in the room with the return air in the corridor for these two rooms and all resident sleeping rooms in the original building. These findings were reviewed with the Administrator, Assistant Administrator, the Maintenance Director, the Regional Director and		**heating.** **2.) Residents in the original portion of the facility have the potential to be affected. No Residents have been affected.** **3.) There have been no changes to the facility structure.** **4.) As a means of Quality Assurance, the facility will continue to complete preventative maintenance on all fire prevention equipment and HVAC equipment as required by the preventative maintenance schedule.** **5.)As a means to ensure ongoing compliance, an annual request for waiver has been completed May 2, 2025. (PLEASE SEE LIFE SAFETY CODE WAIVER REQUEST) Attachment 2**	

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	the Life Safety Director during the exit conference. 3.1-19(b)			
K 0907 SS=E Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Maintenance Pr Based on record review and interview, the facility failed to maintain the facility's piped gas systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect 30 residents should the facility's piped gas system not be operational. Findings include: Based on review of the piped gas system inspection contractor's "Medical Piped Gas Inspection" documentation dated 10/15/24 to 10/17/24 with the Assistant Administrator, the Maintenance Director and the Life Safety Director at 1:02 p.m. on 04/23/25, annual inspection documentation for the facility's piped gas systems within the most recent twelve month period indicated six inventory items were listed as "Unacceptable" for items inspected or tested and classified them as needing "Repair Orders (RO)". The October 2024 inspection documentation listed the "Repair Orders (RO)" included the Bulk Cryogenic tank, Master Alarms and a station outlet identified as "Oxygen S1 Wall". Based on interview at 1:02 p.m. on 04/23/25, the Assistant Administrator stated the inspection contractor has been awaiting parts for repair, the repair has been scheduled for 04/28/25 and agreed repair or replace documentation for the "Repair Orders (RO)" on or after 10/17/24 was not available for review at the time of the survey. These findings were reviewed with the	K 0907	1. All Residents have the potential to be affected by the deficient practice. 2. No other Residents have been affected by the deficient practice. 3. All repairs/parts identified in the October 2024 inspection report was repaired on 4/28/2025. Routine maintenance will continue to be completed by facilities piped gas vendor. Deficiencies were identified by the vendor, and repaired. Attachment 3, Attachment 4 4. Maintenance Director or designee will complete routine inspections in concert with the established preventative maintenance schedule on the facility piped gas system. Results of the inspections by the Maintenance Director/designee and vendor will be submitted to the Quality Assurance and Performance Improvement Committee for review. Any deficiencies identified will be corrected immediately.	05/09/2025

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	Administrator, Assistant Administrator, the Maintenance Director, the Regional Director and the Life Safety Director during the exit conference. 3.1-19(b)			