STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING 01 B. WING	11/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANS CARE AND REHAB - SOUTHPOINTE	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

(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 Certification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/29/16 Facility Number: 013126 Provider Number: 155823 AIM Number: 201256070 At this Life Safety Code survey, Kindred Trans Care and Rehab-Southpointe was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.70(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 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, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 100 and had a	K 0000	December 13, 2016 Indiana State Department of Health Kindred Transitional Care and Rehab-SouthPointe 4904 War Admiral Drive Indianapolis, IN 46237 To Whom It May Concern: **REQUEST: DESK REVIEW K711, K521 and K906** On November 29th 2016, Life Safety Code Survey was conducted at Kindred Transitional Care and Rehabilitation-SouthPointe. Enclosed is the facilities plan of corrections on the facilities deficient practices. Please accept these plans of corrections.	

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

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	census of 75 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed 12/01/16 -DA		Facility will be in substantial compliance on December 16, 2016. Documentation of corrections can be submitted upon request. Sincerely, Monica Pearson (Dirbas) Executive Director	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the	K 0521	POC SouthPointe: Fire Dampers K521 **1.Corrective action accomplished for those residents found to be affected by the alleged deficient practice** ·Facility received report on 11-29-2016 from the Indiana State Department of Health	12/16/2016

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	Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the red spiral notebook for fire damper inspections with the Executive Director and the Maintenance Director during record review from 9:00 a.m. to 12:00 p.m. on 11/29/16, documentation of facility fire		regarding the Life Safety Code Survey. Facility failed to ensure that all fire dampers in facility were inspected and provide necessary maintenance at least every four years in accordance with NFPA 90A **2.How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken** ·all residents could be affected by this deficient practice. ·Safe Care completed facility assessment to identify number of fire dampers on 12-7-2016 ·SafeCare completed an inspection and testing of all 266 fire dampers according to the regulation of NFPA 90A (including but not limited to the removal of the fusible link for testing to ensure full closure and lock-in place) 12-7-2016 **3.What measures or systemic change made to ensure that the alleged deficient practice does not recur** ·SafeCare completed inspection and testing of all 266 fire dampers according to the regulation of NFPA 90A (including but not limited to the removal of the fusible link for testing to ensure full closure and lock-in place) ·SafeCare provided proper documentation to the facility on	

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	dampers within one year of installation was not available for review. Based on interview at the time of record review, the Executive Director stated the facility opened in August 2014. The Maintenance Director stated he cleaned and exercised the shutter in fire dampers in the south corridors of the facility over time recently, affixed a sticker with the date his inspection was conducted and stated those fire damper locations are listed in the red spiral notebook. The Maintenance Director stated his fire damper inspection and maintenance was not performed within the first year of installation. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 11/29/16, fire dampers were located in the HVAC system throughout the facility and in resident sleeping room bathroom vents. In addition, the fire damper located in the HVAC vent on the ceiling near the day room by Room 501 had an affixed sticker stating February 2013 as the manufacture date. Based on interview at the time of the observations, the Maintenance Director stated fire damper inspection and maintenance documentation within the first year of installation was not available for review, he was unaware of fire dampers located in resident sleeping room bathrooms and		the inspection and testing on all 266 fire dampers that were completed ·Facility will maintain documentation from inspection and testing regarding all fire dampers ·Facility will implement required NFPA 90A frequency of maintenance for all fire dampers to the facility Preventative Maintenance program - - **4.Monitoring of corrective actions** ·Required documentation was received that all fire dampers were inspected and tested according to the NFPA 90A. (including but not limited to the removal of the fusible link for testing to ensure full closure and lock-in place) Facility will be maintained required documentation at facility. ·ED/Maintenance Director will monitor compliance through facility monthly preventative maintenance program for next scheduled required inspection and testing to ensure compliance and deficient practice does not recur.	

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	acknowledged fire damper inspection and maintenance documentation within the first year of installation was not available for review. 3.1-19(b)			
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms	K 0711	POC SouthPointe: Evacuation and Relocation Plan K711 **1.Corrective action accomplished for those residents found to be affected by the alleged deficient practice** ·Facility received report on 11-29-2016 from the Indiana State Department of Health regarding the Life Safety Code Survey. Facility failed to provide a	12/16/2016

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	(5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Response Plan" documentation with the Executive Director and the Maintenance Director during record review from 9:00 a.m. to 12:00 p.m. on 11/29/16, the written fire safety plan did not address the relocation of wheeled equipment		written plan that addressed all components of 1 of 1 written fire plans. **2.How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken** ·all residents could be affected by this deficient practice. ·Addendum to the facility Fire Discovery and Announcement plan to include location of wheel equipment on 12-9-2016 was completed **3.What measures or systemic change made to ensure that the alleged deficient practice does not recur** ·Facility added addendum to the Fire Discovery and Announcement policy to indicate where the relocation of wheel equipment will be stored during fire and similar emergencies was completed on 12-9-2016 ·Facility staff in-serviced on proper relocation of wheel equipment will be placed during fire and similar drills - - **4.Monitoring of corrective actions** ·ED will monitor fire drills and similar emergencies for compliance or changes through facility PI committee, will monitor	

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	during a fire or similar emergency. Based on interview at the time of review, the Executive Director acknowledged the aforementioned written fire safety plan for the facility did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 11/29/16, crash carts were noted in the corridor in addition to wheeled blood pressure cuff stands in the corridor outside Rooms 309, 507 and 809. Based on interview at the time of the observations, the Executive Director and the Maintenance Director acknowledged wheeled equipment was stored and in use in the corridor. 3.1-19(b)		monthly x 3 months or until PI committee deems compliance and to ensure the deficient practice does not recur	
K 0906 SS=B Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Central Supply Gas and Vacuum Piped Systems - Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with			

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	cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 central supply systems enclosures was provided with a minimum of two exits. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 5.1.3.3.2(3) states locations for central supply systems and the storage of positive-pressure gases, if outdoors, shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits. This deficient practice could affect 28 residents, staff and visitors. Findings include:	K 0906	POC SouthPointe: Gas and Vacuum Piped Systems/central supply K906 **1.Corrective action accomplished for those residents found to be affected by the alleged deficient practice** ·Facility received report on 11-29-2016 from the Indiana State Department of Health regarding the Life Safety Code Survey. Facility failed to ensure 1 of 1 central supply systems enclosures was provided with a minimum of two exits. **2.How other residents having the potential to be affected by**	12/16/2016

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	Based on observation with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 11/29/16, the outdoor central supply systems and storage of positive-pressure gases location at the rear of the facility was a chain link fence enclosure and had one entry/exit. Seven liquid oxygen containers each with 160 liter capacity and ten 'E' cylinders were stored or in use for the central supply system. Based on interview at the time of observation, the Maintenance Director acknowledged the outdoor central supply systems enclosure at the rear of the facility had one entry/exit. 3.1-19(b)		**the alleged deficient practice will be identified and what corrective actions will be taken** ·all residents could be affected by this deficient practice. ·Facility has 1 of 1 outside central supply system enclosure that has does not provide a minimum of two exits. ·Facility contacted outside contractor (Bob Underwood Inc.) to install new fence with minimum of two exits **3.What measures or systemic change made to ensure that the alleged deficient practice does not recur** ·On 12-16-2016 Facility installed new fence with minimum of two exits to the Central supply system enclosure. ·Maintenance/designee will check new fence to ensure compliance for minimum of two exits are completed. 12-16-2016 - - - **4.Monitoring of corrective actions** ·Maintenance/designee will check new fence to ensure compliance for minimum of two exits are completed. ·ED/Maintenance check new fence with minimum of two exits monthly x 3 months or until PI committee deems compliance and to ensure the deficient	

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			practice does not recur	