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	10/15/2015

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: 10/15/15 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 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New 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	November 13,2015 Dennis Austill Surveyor Supervisor, Long Term Care Division Indiana State Department of Health Dear Mr. Austill: On November 02, 2015, theDivision of Long Term Care received the facility's plan of correction inresponse to the survey completed October 15, 2015. The plan of correction thatwas submitted was found to be incomplete. On November 13, 2015, the facility submittedan updated plan of correction for K-Tag-38 regarding handrails for emergencyegress ramps/sidewalks. The required rails are being built and will beinstalled by an outside contractor, Underwood Construction. The facility will obtain letter from outsidecontractor to indicate installation of rails for 700-unit atKindred-SouthPointe. The handrails forunit 700 will be installed on 11/23/2015. It is the request of thisfacility that you accept the updated plan of correction and place this facilityback in compliance to officially close the survey window. Please feel free to contact me with anyfurther	

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

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	census of 70 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 on 10/19/15 - DA		information and questions you might have regarding the plan ofcorrection. Thank you, Monica Pearson Executive Director Kindred- SouthPointe	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 12 hazardous areas such as paint and repair shops were enclosed with a one hour fire rated barrier with a 45 minute fire rated door. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Maintenance Office. Findings include: Based on observation with the Maintenance Director during a tour of the	K 0029	K029 **1.Corrective action accomplished for thoseresidents found to be affected by the alleged deficient practice** ·Facility received report on 10/20/15 from theIndiana State Department of Health regarding the Life Safety Code Survey. Concernswere found with the Maintenance Director's office door only being a 20 minutefire resistant door instead of a 45 minute fire rated door. **2.How other residents having the potentialto be affected by the alleged deficient practice**	11/10/2015

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	facility from 11:30 a.m. to 1:50 p.m. on 10/15/15, the corridor door to the Maintenance Office was equipped with a self closing device and had an affixed fire resistance label stating a 20 minute fire resistance rating. Based on interview at the time of observation, the Maintenance Director stated the Maintenance Office is also utilized as a paint storage room and maintenance repair shop and acknowledged the entry door from the corridor was not at least a 45 minute fire rated door. 3.1-19(b)		**will be identified and whatcorrective actions will be taken** ·No resident were affected by this deficientpractice. ·Maintenance Director checked all corridor doorsin the facility. Facility corridor doors were all found to be in compliancewith the standards and regulations regarding fire ratings. **3.What measures or systemic change made toensure that the alleged deficient practice does not recur** ·Facility will remove door and replace with a 45minute fire rated door ·ED/Designee will follow up to make sure thatdoor is correct and properly installed ·Any additional doors, or changes to existingdoors, that will be added to facility will be approved by ED and/or MaintenanceDirector prior to installation. **4.Monitoring of corrective actions** ·Any additional doors, or changes to existingdoors, that will be added to facility will be approved by ED and/or MaintenanceDirector prior to installation. ·ED will monitor additional doors or changesthrough facility PI committee, will monitor monthly x	

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			3 months or until PIcommittee deems compliance.	
K 0038 SS=E Bldg. 01	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. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 15 exit accesses was provided with handrails. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. This deficient practice could affect 14 residents, staff and visitors if need to exit the facility from the 700 Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 10/15/15, the 700 Hall exit discharge to the public way had a nine foot sloping sidewalk ramp with a ten inch rise over the length of the ramp which was not provided with handrails. Based on interview at the time of observation, the Maintenance Director acknowledged the 700 Hall exit discharge to the public way	K 0038	K-38--UPDATED -11-13-15 1.Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: ·Facility received report from the IndianaDepartment of Health regarding the Life Safety Code Survey. Concerns were foundwith 700 hall's exit discharge to public way that was alleged to have a ninefoot sloping sidewalk ramp with a ten inch rise over the length of the rampwhich was not provided with handrails. 1.How other residents having the potential to be affected by the alleged deficient Practice will be identified andwhat corrective actions will be taken. ·All residents on 700 hall have the potential to be affected by deficient practice. ·Ramp railing will be installed on 700 exit ramp by 11/23/15, by Underwood Construction. ·Remaining facility ramps will be assessed for needed action by Underwood Construction, and corrections implemented to comply with 7.2.5.4 guards and handrails.	11/23/2015

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	was not provided with handrails. 3.1-19(b)		1.What measures or systemic changes made to ensure that the alleged deficient practice does not recur ·Maintenance Director will monitor sidewalkegress ramps for compliance with 18.2.1 and 7.1 to insure compliance; any discrepancy will be immediatelycorrected, either with the installation of hand rails, or modification to theside walk to correct slope issue. 1.How will the corrective actions will be monitored to ensure the alleged deficient Practice will not recur ·Monitoring of side walk ramp ways will bebrought to the facility safety committee for review, any deficiency will beimmediately addressed. ·Executive Director will monitor for continuedcompliance.	
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and interview; the facility failed to ensure 2 of 2 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection,	K 0062	K062 **1.Corrective action accomplished for thoseresidents found to be affected by the alleged deficient practice** ·Facility received letter on 10/20/15 from theIndiana State	10/19/2015

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	Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of The Snider Group "Contractor's Material & Test Certificate for Underground Piping" documentation dated 06/05/14 with the Maintenance Director during record review from 9:15 a.m. to 11:30 a.m. on 10/15/15, two fire hydrants were installed and tested at the facility's address 4904 War Admiral Drive. Based on interview at the time of record review, the Maintenance Director stated Ramsey Development owns the site and the aforementioned two hydrants which were located at the west side of the building and acknowledged documentation of fire hydrant inspections within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 10/15/15, two fire hydrants were noted on the west side of the premises. Based on		Department of Health regarding the Life Safety Code Survey. Twofire hydrants on the west side of the property had no documentation of a 12month inspection. **2.How other residents having the potentialto be affected by the alleged deficient practice will be identified and whatcorrective actions will be taken** ·All residents could be affected by this ·Outside vendor completed required inspection onboth fire hydrants. **3.What measures or systemic change made toensure that the alleged deficient practice does not recur** ·Maintenance Director and/or Designee willcomplete the required yearly inspections on both fire hydrants. ·Maintenance director will complete fire hydrantpreventative maintenance schedule as required. **4.Monitoring of corrective actions** ·ED and/or designee will monitor the scheduled preventativemaintenance program for testing and inspections regarding fire hydrants. ED and/or designee will monitor testing onfire hydrants yearly x 3 years, or until PI committee deems in	

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	interview at the time of the observations, the Maintenance Director acknowledged the installed fire hydrants intended use would be for the facility in the event of a fire. 3.1-19(b)		compliance.	