STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155218		ĺ	LDING	ONSTRUCTION 01	(X3) DATE COMPL 08/09/	ETED	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION-DYE		•	2300 G	ADDRESS, CITY, STATE, ZIP CODE REAT LAKES DR IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0000	was conducted by Department of Facility Number: Survey Date: 05 Facility Number Provider Number AIM Number: Surveyor: W. C. Code Specialist At this Quality Assurvey, Kindred Rehabilitation compliance with This one story for the of Type V (1) fully sprinklered canopies and away building was consouth wing added has a fire alarm smoke detection open to the correspensive of 180 the time of this story of the corresponding to the c	r: 000123 er: 155218 100266720 Chris Greeney, Life Safety  Assurance Walk-thru Transitional Care and Dyer was found not in 1410 IAC 16.2-3.1-19(ff).  acility was determined to 11) construction and was d except for attached rnings. The original Instructed in 1974 with the ed in 1985. The facility system with hard-wired in the corridors, spaces idors and resident The facility has a and had a census of 129 at	K00	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155218		MULTIPLE CO JILDING ING	01	COMP	ESURVEY LETED 9/2012		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION-DYE			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR						
	SUMMARY S' (EACH DEFICIEN REGULATORY OR with state law in coverage. It was with state law re coverage.  All areas where customary acces for 8 of 9 canopi entrance/exits. A facility services for a detached m  Quality Review by Code Specialist-Me	CARE AND REHABILITATION-DY TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) regard to sprinkler found in compliance garding smoke detector  the residents have s were sprinklered except	/ER	2300 GI	REAT LAKES DR	RRECTION SHOULD BE	(X5) COMPLETION DATE		
	with the aforeme	entioned regulatory evidenced by the							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TC3321

Facility ID: 000123

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
	155218		A. BUII B. WIN			08/09/	2012	
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYE			2300 GREAT LAKES DR 'ER DYER, IN 46311					
KINDKEL	J TRANSITIONAL C	CARE AND REHABILITATION-DTE	-11	DIEK,	111 403 1 1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K9999								
	State Findings		K99	99	All areas where the residents		09/08/2012	
	_				have customary access will be	;		
	3.1-19 ENVIRO	NMENT AND			sprinkled. The following			
	PHYSICAL STA				entrance/exit doors with canopies or awning attached to the building			
	FILL SICAL SIF	ANDARDS						
					which exceeds 4 feet in length	will		
	3.1-19(ff) A heal	Ith facility licensed under			have sprinkler coverage.			
	16-28 and this ru	le must do the following:			The entrance/exit next to room	,		
	(1) Have an auto	matic sprinkler system			206.which extends from the			
	` ′	out the facility before			entrance at the end of the hall	wav		
	July 1, 2012.	iout the facility before			around the sides of the wing	way		
					covering the windows of a lour	nge		
	` ′	tic sprinkler system is not			area on one side and room 20			
	installed through	out the health care			on the other side will have			
	facility before Ju	ıly 1, 2010, submit before			sprinkler coverage.			
	July 1, 2010 a pl	an to the department for						
	completing the in	_			The entrance/exit next to room			
		eler system before July 1,			215 with a six foot awning which			
	•	ilei system before July 1,			extends from the entrance at the	he		
	2012.				end of the hallway around the			
	* /	ry operated or hard-wired			sides of the wing covering the	ا ما م		
	smoke detector is	n each resident's room			windows of room 215 on one s and room 216 on the other side			
	before July 1, 20	012.			will have sprinkler coverage.	E		
	•				wiii nave sprinker coverage.			
	This State Rule b	nas not been met as			The entrance/exit next to room	1		
	evidenced by:	not been met as			227 with a six foot awning which			
		and the second			extends from the entrance at the			
		ation and interview, the			end of the hallway around the			
	•	install a sprinkler system			sides of the wing covering the			
	under 9 of 10 car	nopies or awnings			windows of room 227 on one s			
	attached to the b	uilding and covered			and room 228 on the other side	е		
		ors located throughout the			will have sprinkler coverage.			
		eficiency could affect all			The entrance/cuit mout to me			
	_	-			The entrance/exit next to room			
	*	nd visitors in rooms			118 with a six foot awning which extends from the entrance at the			
	adjacent to the ca	-			end of the hallway around the	i i <del>C</del>		
	described below.				sides of the wing covering the			
					Sign of the thing covering the			

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Event ID: TC3321

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
		155218	B. WIN		<del></del>	08/09/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
KINDRED TRANSITIONAL CARE AND REHABILITATION-DY			2300 GREAT LAKES DR YER DYER, IN 46311				
KINDKEI	INDRED TRANSITIONAL CARE AND REHABILITATION-D			DIEK,			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					windows of room 118 on one s		
	Findings include	<b>:</b>			and room 119 on the other sid	е	
				will have sprinkler coverage.			
	During a tour of	the facility with the			The entrance/exit next to room	1	
	_	rector on 8/9/12 between			130 with a six foot awning which		
					extends from the entrance at the		
		2:45 p.m., the following			end of the hallway around the		
		ors were found to have			sides of the wing covering the		
	_	ings attached to the			windows of a lounge area on o		
	building which e	exceeded 4 feet in length			side and room 130 on the othe		
	and did not include sprinkler coverage:  a. The entrance/exit next to room 206 had a six foot awning which extended from the entrance at the end of the hallway around the sides of the wing covering the				side will have sprinkler coverage	ge.	
					The entrance/exit next to room	,	
					107 with a six foot awning which		
					extends from the entrance at the		
					end of the hallway around the		
					sides of the wing covering the		
		unge area on one side and			windows of room 107 on one s		
		other side. Additionally,			and room 108 on the other sid	е	
	a canopy covere	d with an all-weather			will have sprinkler coverage.		
	fabric extended	from the awning outward			The continue of the continue o		
	down the sidewa	alk for 24 feet. It could			The entrance/exit next to room 013 with a six foot awning which		
	not be determine	ed what type of fabric was			extends from the entrance at t		
		truction of the canopy.			end of the hallway will have		
		exit next to room 215 had			sprinkler coverage.		
		g which extended from			The entrance/exit next to room		
		he end of the hallway			013 with a six foot awning which		
		of the wing covering the			extends from the entrance at t	he	
	windows of roor	m 215 on one side and			end of the hallway will have		
	room 216 on the other side.				sprinkler coverage.		
	c. The entrance/	exit next to room 227 had			The two outside entrance/exits	s to	
	a six foot awning which extended from				the dining room located to the		
		he end of the hallway			west of the lobby with a six foo	ot	
		of the wing covering the			awning which extends from an		
		•			entrance/exit door in the		
		m 227 on one side and			southwest area of the room an		
	room 228 on the				go the length of the outside wa		
	d. The entrance/	exit next to room 118 had			of the dining area on the west,		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
		155218	B. WING 08/09/2012				
NAME OF PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUFFLIER			2300 GREAT LAKES DR				
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYE			YER DYER, IN 46311				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG		DATE	
	a six foot awning which extended from				continuing on the north side outside wall until reaching a do	oor	
		ne end of the hallway			at the northeast section of the	)	
		of the wing covering the			room will have sprinkler		
		n 118 on one side and			coverage.		
	room 119 on the				Those gross will be added to t	ho	
		exit next to room 130 had			These areas will be added to t Preventative Maintenance	ne	
	a six foot awning	g which extended from			Program as part of the		
	the entrance at the	ne end of the hallway			Preventative Maintenance		
	around the sides	of the wing covering the			program for the sprinkler syste		
	windows of a loa	unge area on one side and			and will be checked quarterly		
	room 130 on the	other side.			ensure ongoing compliance wi state law in regard to sprinkler		
	f. The entrance/e	exit next to room 107 had			coverage.		
	a six foot awning	g which extended from			3		
		ne end of the hallway					
		of the wing covering the					
		n 107 on one side and					
	room 108 on the	other side.					
		exit next to room 013 had					
	1 -	g which extended six feet					
		e at the end of the					
	hallway.						
		exit next to room 009 had					
		g which extended six feet					
		e at the end of the					
	hallway.	Tat are end of the					
		le entrance/exits to the					
		ated to the west of the					
	_	Foot unsprinklered awning					
	I	from an entrance/exit					
		nwest area of the room					
		gth of the outside wall of					
		~					
	_	on the west. It continued					
		e outside wall until it					
	reached a door a	t the northeast section of					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155218		ILDING	01	COMPI 08/09	ETED	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION-DYE		STREET ADDRESS, CITY, STATE, ZIP CODE  2300 GREAT LAKES DR					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	the room. Interview with the Maintenance Director on 08/09/12 at 12:45 p.m. indicated there was no documentation that the canopy and awnings were built from noncombustible material. He indicated the facility was aware sprinklers would be required for those locations and they were in the process of contracting with an installer.  3.1-19(ff)						

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