

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/14/2016
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NAME OF PROVIDER OR SUPPLIER  FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/14/16</p> <p>Facility Number: 000191 Provider Number: 155294 AIM Number: NA</p> <p>At this Life Safety Code survey, Forum at the Crossing was found not in compliance with Requirements for Participation in 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered except for the furnace closet in the kitchen. 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 in all resident sleeping rooms. The facility has a</p>	K 0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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K 0018 SS=E Bldg. 01	<p>capacity of 74 and had a census of 63 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the furnace closet in the kitchen.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the facility failed to ensure 3 of over 75 corridor doors were provided with a</p>	K 0018	<b>K 018</b> <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD	04/11/2016			

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	<p>means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, the following was noted:</p> <p>a. the corridor door to Room 620 failed to latch into the door frame because the door frame on the hinge side was loose and caused the latching mechanism to not align with the latching plate.</p> <p>b. the corridor door to resident Room 425 and to Room 628 sagged below the top of the door frame when closed which left greater than a one half inch gap between the top of the door and the door frame.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor door to Room 620 had an impediment to closing and latching into the door frame and the corridor door to Room 620, Room 425 and Room 628 failed to resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p>LSC 19 &amp; 410 IAC Door closing:</p> <p><b>A)</b> Door frames on #425, #620 and #628 will be re-braced in supporting structures to prevent sagging. In addition, tension hinges will be adjusted to increase closing pressure. <b>B)</b> All residents of the SNF/Memory Care Unit are potentially affected by doors allowing smoke and/or flames to pass between designated spaces when emergencies occur. <b>C)</b> The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor proper closure of all fire-rated doors separating spaces used by residents, visitors and staff members. Any doors found to be impeded from proper closing will have adjustments or repairs as indicated. Doors impeded for utility purposes may have electromagnetic releases applied for use with the fire alarm system. These devices will be employed to allow door closures whenever fire alarms are activated. <b>D)</b> The HFA will include observations of fire/smoke barrier doors during environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. <b>E)</b> Date of Compliance with proposed actions: <b>April 11,</b></p>	

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 19 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the smoke barrier wall in the 600 Hall by the lounge exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, a four foot by two foot opening</p>	K 0025	<p><b>2016</b></p> <p><b>K 025</b> <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 19 and 410 IAC. Smoke barriers in ceilings/walls shall be maintained intact so as to prevent passage of smoke between compartments. <b>A)</b> Openings above the cross corridor door set in the 600 hall by the lounge exit will be properly filled with approved materials to preclude passage of smoke. <b>B)</b> All residents of areas where smoke barriers are not fully intact have the potential to be affected by incomplete barriers. <b>C)</b> The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include all penetrations of smoke barriers. All openings without sufficient closure will be corrected with appropriate materials to preclude smoke penetration. Visual inspections of smoke barriers and proper sealing will be conducted with monthly fire</p>	04/11/2016

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K 0029 SS=E Bldg. 01	<p>was noted in the attic smoke barrier wall above the cross corridor door set in the 600 Hall by the lounge exit. In addition, a one foot by one foot hole for the passage of a sprinkler pipe was also noted in the aforementioned attic smoke barrier wall. The attic smoke barrier wall was constructed of two layers of five-eighths inch drywall on each side of the studs and the cross corridor door set had an affixed label stating 90 minute fire resistance rating. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in the attic smoke barrier wall failed to maintain the fire resistance rating of the smoke barrier wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>		<p>extinguisher checks are performed. Any improper penetrations will be corrected within 48 hours of identification.</p> <p>D) The HFA will include observations of smoke barrier maintenance during environmental inspections for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members whofail to maintain compliance will be reprimanded.</p> <p>E) Date of compliance with proposed actions: <b>April 11, 2016</b></p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as the kitchen were separated from other spaces by smoke resistant partitions and doors. 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 Main Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, the following was noted:</p> <p>a. the entry door to the kitchen from the Main Dining Room by the rolling fire door was equipped with a deadbolt and was not equipped with a positive latching device to latch the door into the door frame.</p> <p>b. a two inch hole was noted in the ceiling of the kitchen furnace closet which exposed the attic above.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>	K 0029	<p><b>K 029</b> <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 19 &amp; 410IAC One-hour fire rated construction protects hazardous areas. <b>A)</b> A rim lock with positive latch will be added to the kitchen door. The cited ceiling hole will be utilized for a sprinkler head (see K56 below). <b>B)</b> All residents of areas where smoke barriers are not fully intact have the potential to be affected by incomplete barriers. <b>C)</b> The Maintenance Director and/or his designee will conduct a full inspection of the physical plant to include all penetrations of smoke barriers. All openings without sufficient closure will be corrected with appropriate materials to preclude smoke penetration. Visual inspections of smoke barriers and proper sealing will be conducted with monthly fire extinguisher checks are performed. Any improper penetrations will be corrected within 48 hours of identification whenever possible. <b>D)</b> The HFA will include observations of smoke barrier maintenance on his weekly environmental rounds for the next sixty (60) days. Following that he will review records on a monthly basis. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. <b>E)</b> Date</p>	04/11/2016

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Critique Form" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:50 a.m. on 03/14/16, third shift fire drills conducted on 06/11/15, 09/25/15 and 12/30/15 were conducted at, respectively, 5:45 a.m., 5:10 a.m. and 5:35 a.m. Based on interview at the time of record review,</p>	K 0050	<p>of compliance with proposed actions: <b>April 11, 2016</b></p> <p><b>K 050</b> In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 9 &amp; 410 IAC Fire drills are held at unexpected times under varying conditions. <b>A)</b> Documentation of fire drills contains times, dates and other salient details. The HFA and Maintenance Director will ensure times for shift-related drills are random and will not be held in the same hour consecutively. <b>B)</b> All residents of the community have the potential to be affected if/when staff members are not familiar with drills designed to facilitate emergency responses related to fires. <b>C)</b> The Maintenance Director keeps records offire/emergency drills which indicate date/time/shift and other</p>	04/06/2016

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K 0052 SS=C Bldg. 01	<p>the Maintenance Director acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure documentation of annual functional testing for all facility fire alarm boxes was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as fire alarm boxes</p>	K 0052	<p>pertinent information. Reminders are documented via TELS and/or ancillary systems. The Maintenance Director will plan Fire Drills in conjunction with the HFA to ensure similar times are not incorporated into shifts for consecutive drills. <b>D)</b> The HFA will include observations of both fire drills and summary forms with environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. <b>E)</b> Date of compliance with proposed actions: <b>April 6, 2016</b></p> <p><b>K 052</b> <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFE SAFETY CODE STANDARD LSC 19 &amp; 410 IAC Fire alarm system inspections. A) Telgian (the vendor responsible for fire equipment maintenance) inspection reports are being revised to contain specific</p>	04/06/2016

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K 0056 SS=D Bldg. 01	<p>are tested annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Telgian Corporation "Telgian Annual Fire Alarm" documentation dated 05/20/15, 08/05/15, 11/23/15 and 02/18/16 with the Maintenance Director during record review from 9:20 a.m. to 11:50 a.m. on 03/14/16, it could not be assured all facility fire alarm boxes were documented as being functional tested annually. The aforementioned documentation states how many fire alarm boxes were tested in each quarter but does not identify the location and testing result of all facility fire alarm boxes. Based on interview at the time of record review, the Maintenance Director stated additional fire alarm box testing documentation within the most recent twelve month period was not available for review and acknowledged it could not be assured all facility fire alarm boxes were documented as being functional tested annually.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health</p>		<p>documentation on all checked fire alarm boxes (pull stations). B) All residents of the community have the potential to be affected by non-functioning fire alarm equipment. C) The Maintenance Director and/or his designee will audit Telgian inspection reports to ensure specifically identified fire boxes are listed. D) The HFA will include observations of fire box inspection reports on his compliance inspections for the next six (6) months. He will ensure the Maintenance Director addresses any related findings. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of compliance with proposed actions: <b>April 6, 2016</b></p>	

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	<p>care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen furnace closets was sprinkled. This deficient practice could affect 5 staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, the kitchen furnace closet lacked sprinkler coverage. Based on interview at the time of observation, the Maintenance Director stated a two inch in diameter hole was noted in the ceiling where it appeared a sprinkler had been removed and acknowledged the kitchen furnace closet lacked sprinkler coverage.</p> <p>3.1-19 (b)</p>	K 0056	<p><b>K 056</b> In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19 &amp; 410 IAC. Sprinkler system components in storage areas: <b>A)</b> Doors were removed from the closet to ensure sprinkler coverage from a pendant approximately 3' from the opening. This makes the "closet" part of the galley where it is located. Doors will not be replaced until a new sprinkler pendant is installed in closet area. Quotes will be secured to enlarge the water based fire suppression system by April 13, 2016. Upon final approval by ownership engineers and consultants, the water-based fire suppression system will be enlarged to include the closet area. Contracted work will be accomplished within 30 days thereafter <b>B)</b> All residents of the community have the potential to be affected by insufficient fire sprinkler coverage in</p>	04/11/2016

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K 0074 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p>		<p>defined/contained areas. <b>C)</b> The Maintenance Director and/or his designee will perform monthly inspections of individual closets/rooms to ensure all requirements of separate sprinkler pendants are met. Any found to be lacking or improperly installed will be corrected by a licensed contractor. <b>D)</b> The HFA will include observations of sprinkler pendant placements with environmental rounds no less than once monthly. He will ensure the Maintenance Director keeps accurate and up-to-date reports of inspections. Assigned staff members who fail to maintain compliance will be reprimanded. <b>E)</b> Date of Compliance with proposed actions: <b>April 11, 2016</b></p>	

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	<p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on record review, observation and interview; the facility failed to ensure window curtains and cubicle curtains in 2 of 9 smoke compartments were flame resistant. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to 11:50 a.m. on 03/14/16, window curtain and cubicle curtain flame resistant documentation was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, window curtains in the main lobby and in the reception desk area by the Dining Room had no affixed documentation stating each curtain was inherently flame retardant. In addition, cubicle curtains in resident Room 508, Room 510 and Room 512 each had a blank tag affixed to the curtain which contained no flame resistance</p>	K 0074	<p><b>K 074</b> In response to cited findings, the following actions will be taken: NFPA 101 LIFE SAFETY CODE STANDARD LSC 19 &amp; 410 IAC Flame retardant fabric treatment. <b>A)</b> Fabrics without flame retardant documentation available will be sprayed using "Fire Stop" or similar product(s). Application will be made in accordance with manufacturer's recommendations. <b>B)</b> All residents of the community have the potential to be affected by non-fire retardant fabrics in emergency situations. <b>C)</b> The Maintenance Director and/or his designee will ensure records are maintained to demonstrate fire retardant properties of current and newly-acquired fabric products. <b>D)</b> The HFA will include observations of surface ratings, including fabrics on periodic environmental rounds. He will include observations for newly introduced fabrics. He will ensure the Maintenance Director continues to enforce prohibition of inappropriately fire-rated fabrics and keeps accurate and</p>	04/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155294	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/14/2016
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NAME OF PROVIDER OR SUPPLIER  FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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K 0147 SS=E Bldg. 01	<p>information. Based on interview at the time of record review and of the observations, the Maintenance Director stated lobby curtains and resident room cubicle curtains are not treated with a flame retardant material and acknowledged window curtain and cubicle curtain flame resistant documentation was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 10 residents, staff</p>	K 0147	<p>up-to-date records on file. Assigned staff members who fail to maintain compliance will be reprimanded. E) Date of Compliance with proposed actions: <b>April 13, 2016</b></p> <p><b>K 147</b> <i>In response to cited findings, the following actions will be taken:</i> NFPA 101 LIFESAFETY CODE STANDARD LSC 19 &amp; 410 IAC Electrical wiring. <b>A)</b> The power strip was removed and a permanent electric receptacle was installed. <b>B)</b> All residents could potentially be affected by power strips/extension cords being</p>	04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/14/2016
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NAME OF PROVIDER OR SUPPLIER  FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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	<p>and visitors in the vicinity of the 400 Hall Medication Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 2:10 p.m. on 03/14/16, a refrigerator was plugged into a power strip in the 400 Hall Medication Room. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p>		<p>utilized in the community. <b>C)</b> The Maintenance Director and/or his designee will perform monthly inspections with related documentation to monitor for improper power extension cords/strips being utilized in licensed portions of the community. Any found will be removed from the premises as indicated. Residents/family members who bring such items onto the property will be advised of prohibitions against them. <b>D)</b> The HFA will include observations for newly introduced extension cords/power strips during environmental rounds no less than once monthly. He will ensure the Maintenance Director continues to enforce prohibition of extension cords/power strips. Assigned staff members who fail to maintain compliance will be reprimanded. <b>E)</b> Date of Compliance with proposed actions: <b>April 1, 2016</b></p>	