STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
K010000	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). Survey Date: 01/20/15 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Robin Run Health Center 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. 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 and in all areas open to the corridor. The facility has smoke detectors hard wired to the nurses call	K010000	The following is the Plan of Correction for Robin Run Health Center regarding the Statement of Deficiencies dated 1/20/2015. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

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

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268	

(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
	system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 81 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached maintenance building which was not sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 01/26/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the	K010018	It is the practice of the provider to	02/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268	

(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
	facility failed to ensure 1 of over 50 corridor doors would close, latch and resist the passage of smoke. This deficient practice could affect 34 residents, staff and visitors. Findings include: Based on observation with the Administrator and the Director of Maintenance during a tour of the facility from 12:40 p.m. to 3:30 p.m. on 01/20/15, two one half inch in diameter holes were noted above and below the door handle in the corridor door to the Unit Manager's Office by the nurses station. Based on interview at the time of observation, the Administrator and the Director of Maintenance acknowledged the aforementioned holes in the corridor door would not resist the passage of smoke. 3.1-19(b)		ensure that all doors close, latch, and resist the passage of smoke. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The openings identified on the door to the Unit Manager's Office have been filled to ensure that the door resists the passage of smoke. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** All other doors in the Healthcare Center have been audited, and repairs made when identified, to ensure that they resist the passage of smoke. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Engineering Department has been educated on the importance of maintaining the smoke barrier when completing any work on doors in the Healthcare Center. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Quality Assurance Performance Improvement audit tool will be utilized to audit random doors weekly times 4 weeks, then bi-weekly times 4 weeks, and then quarterly ongoing. The Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155505		01/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
			Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. **By what date will the systemic changes be completed?** February 6, 2015	
K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review, observation, and interview; the facility failed to document annual functional testing of 44 of 44 single station smoke detectors installed in the facility. NFPA 72, 7-3.3 states single station smoke detectors installed in other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7. Table 7-3.2 requires all single station smoke detectors to be functional tested annually. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include:	K010052	It is the practice of the provider to conduct annual functional testing of the single station smoke detectors installed in the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** An audit was completed of all single station smoke detectors installed in the facility, and all were found to be functioning appropriately. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** An audit was completed of all single station smoke detectors installed in the facility, and all were found to be functioning appropriately. **What measures will be put into**	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268	

(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
	Based on record review with the Director of Maintenance from 9:45 a.m. to 11:50 a.m. on 01/20/15, documentation of annual testing of resident sleeping room smoke detectors was not available for review. Based on interview at the time of record review, the Director of Maintenance stated resident sleeping room smoke detectors are hard wired to the building's electrical system and the facility's nurses call system and do not contain batteries as a secondary power supply. In addition, the Director of Maintenance acknowledged documentation of annual testing of resident sleeping room smoke detectors was not available for review. Based on observations with the Administrator and the Director of Maintenance during a tour of the facility from 12:40 p.m. to 3:30 p.m. on 01/20/15, each of 44 resident sleeping rooms has a smoke detector installed which is hard wired to the building's electrical system and the facility's nurses call system and do not contain batteries as a secondary power supply. The smoke detector installed in Room 32 provided a local audible alarm and reported to the nurses call system when "Smoke Detector Tester" smoke spray was utilized at 3:00 p.m. 3.1-19(a)		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of all single station smoke detectors installed in the facility will be conducted annually to ensure appropriate functioning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** This item has been added to the preventative maintenance schedule on an annual basis. **By what date will the systemic changes be completed? January 23, 2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155505		01/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Koorsen Fire & Security "Service Work Order" documentation dated 08/03/09 during record review with the Director of	K010062	It is the practice of the provider to maintain the automatic sprinkler system in reliable operating condition and inspect and test it periodically. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The internal pipe inspection for the facility's automatic sprinkler system was inspected by an independent contractor on 1/23/15 and found to be in reliable operating condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** The internal pipe inspection for the facility's automatic sprinkler system was inspected by an independent contractor on 1/23/15 and found to be in reliable operating condition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An inspection of the internal pipe for the facility's automatic sprinkler	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268	

(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
	Maintenance from 9:45 a.m. to 11:50 a.m. on 01/20/15, documentation of an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated no other internal pipe inspection documentation was available for review and acknowledged it has been more than five years since the most recent internal pipe inspection had been performed. Based on observation with the Administrator and the Director of Maintenance during a tour of the facility from 12:40 p.m. to 3:30 p.m. on 01/20/15, no evidence of the most recent internal pipe inspection date was recorded at the sprinkler system riser. 3.1-19(b)		system will be conducted at least once every 5 years to ensure reliable operating condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** This item has been added to the preventative maintenance schedule on an at least every 5 year basis. **By what date will the systemic changes be completed?** January 23, 2015	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, 6 of 44 resident sleeping room smoke detectors hard wired to the facility's electrical system failed to function. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect 56 residents, staff and visitors.	K010130	It is the practice of the provider to ensure that the smoke detectors hard wired to the facility's electrical system function. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The independent contractor completed work on the smoke detectors in Room 21, Room 22,	01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 01/20/2015
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268	

(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
	Findings include: Based on observations with the Administrator and the Director of Maintenance during a tour of the facility from 12:40 p.m. to 3:30 p.m. on 01/20/15, smoke detectors hard wired to the facility's electrical system failed to function when its respective test button was pushed in Room 21, Room 22, Room 24, Room 25, Room 40 and Room 49. In addition, the smoke detector in Room 21 failed to function and provide a local audible alarm when "Smoke Detector Tester" smoke spray was utilized at 2:50 p.m. three separate times. Based on interview at the time of the observations, the Director of Maintenance stated each resident sleeping room smoke detector is hard wired to the facilities electrical system and acknowledged the aforementioned resident sleeping room smoke detectors failed to function when its respective test button was pushed. 3.1-19(a)		Room 24, Room 25, Room 40, and Room 49 on January 23, 2015. Upon completion of this work all detectors tested good. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?** An audit was completed on January 20, 2015 of all resident room smoke detectors in the facility to identify any additional concerns. The independent contractor addressed additional concerns on January 23, 2015, and upon completion of this work reported that all detectors tested good. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of all single station smoke detectors installed in the facility will be conducted annually to ensure appropriate functioning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** This item has been added to the preventative maintenance schedule on an annual basis. **By what date will the systemic changes be completed?** January 23, 2015	