

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 10/22/2012
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NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268
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K0000	<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: 10/22/12</p> <p>Facility Number: 01156 Provider Number: 155505 AIM Number: 100453350</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered except for four exterior combustible canopies in the Clare Bridge Hall memory care unit. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p>	K0000	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after November 21, 2012.</p>	

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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	<p>corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 76 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for four exterior combustible canopies in the Clare Bridge Hall memory care unit. The facility has one detached maintenance building which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 4 of 4 combustible exterior canopies which were each wider than 4 feet outside the Clare Bridge Hall memory care unit. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 22 residents, staff and visitors in the Clare Bridge Hall memory care unit.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance during a tour of the facility from 10:55 a.m. to 12:45 p.m. on 10/22/12, each of four exterior canopies</p>	K0056	<p>KO56 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider to provide sprinkler coverage per NFPA 13.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Sprinkler coverage has been provided to the four of four combustible exterior canopies which were wider than 4-feet outside the Clare Bridge secured Dementia Unit.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	11/21/2012	

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	<p>for the Clare Bridge Hall memory care unit extended five feet from the building, was of wood construction and was not provided with automatic sprinklers. Based on interview at the time of the observations, the Director of Maintenance acknowledged each of the four exterior canopies for the Clare Bridge Hall memory care unit extended five feet from the building, was of wood construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action(s) will be taken:</p> <p>Sprinkler coverage has been provided to the four of four combustible exterior canopies which were wider than 4-feet outside the Clare Bridge secured Dementia Unit.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All 4 of 4 combustible exterior canopies which were wider than 4-feet outside the Clare Bridge secured Dementia Unit have sprinkler coverage. The system will be checked during our quarterly sprinkler system tests to ensure proper function.</p> <p>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:</p> <p>All 4 of 4 combustible exterior canopies which were wider than 4-feet outside the Clare Bridge secured Dementia Unit have sprinkler coverage. The system will be checked during our quarterly sprinkler system tests to ensure proper function.</p>		

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K0062 SS=C	<p>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</p> <p>Based on record review and interview, the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Sprinkler Inspection Report" documentation dated 08/10/12, 04/16/12, 01/12/12, 09/26/11 and 07/18/11 with the Director of Maintenance during record</p>	K0062	<p>K062 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider to maintain sprinkler system in reliable operating condition and are inspected and tested periodically.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The sprinkler system vendor whom does our quarterly tests have been contacted and has agreed to ensure all quarterly checks fall within the calendar quarter for which they are due.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The sprinkler system vendor whom does our quarterly tests have been contacted and has agreed to ensure all quarterly</p>	11/21/2012	

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	<p>review from 9:30 a.m. to 10:55 a.m. on 10/22/12, the fourth quarter (October, November, December) 2011 sprinkler system inspection report was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the 09/26/11 sprinkler inspection was intended to be the fourth quarter sprinkler inspection but it was not conducted in the fourth quarter and acknowledged a fourth quarter 2011 sprinkler system inspection report was not available for review.</p> <p>3.1-19(b)</p>		<p>checks fall within the calendar quarter for which they are due.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Director of Engineering or designee will monitor the quarterly sprinkler check dates to ensure the service falls within the calendar quarter in which they are due. The Director of Engineering or designee will contact the Sprinkler Testing Vendor if need be to ensure the test occurs in which the quarter they are due.</p> <p>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:</p> <p>The Director of Engineering or designee will monitor the quarterly sprinkler check dates to ensure the service falls within the calendar quarter in which they are due. The Director of Engineering or designee will contact the Sprinkler Testing Vendor if need be to ensure the test occurs in which the quarter they are due.</p>		

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K0064 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 1 of 1 portable K-class fire extinguishers in the kitchen each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 10:55 a.m. to 12:45 p.m. on 10/22/12, the annual maintenance tag attached to the K-class portable fire extinguisher located in the kitchen indicated monthly inspections were not</p>	K0064	<p>K064 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider to ensure portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The Director of Engineering or designee has checked the fire extinguisher located in the kitchen to ensure the fire extinguisher was available and in working condition. The Director of Engineering or designee will check this fire extinguisher monthly to ensure it is available and in working condition.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The Director of Engineering or designee has checked the fire extinguisher located in the kitchen to ensure the fire extinguisher</p>	11/21/2012			

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	<p>documented for August and September 2012. Based on interview at the time of observation, the the Director of Maintenance acknowledged monthly inspections for the K-class portable fire extinguisher located in the kitchen were not performed for August and September 2012.</p> <p>3.1-19(b)</p>		<p>was available and in working condition. The Director of Engineering or designee will check this fire extinguisher monthly to ensure it is available and in working condition.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Director of Engineering or designee will check all fire extinguishes located in the HealthCare Center and Kitchen to ensure they are available and that they are in working condition. These checks will take place monthly.</p> <p>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:</p> <p>The Director of Engineering or designee will check all fire extinguishes located in the HealthCare Center and Kitchen to ensure they are available and that they are in working condition. These checks will take place monthly.</p>		

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K0069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen hood self contained chemical extinguishing systems was compliant with standard UL 300. LSC 19.3.2.6 requires cooking facilities to be in compliance with LSC 9.2.3 which requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2 states automatic fire extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could affect all kitchen staff.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Restaurant Systems Work Order" documentation dated 06/06/12 and 12/21/11 with the Director of Maintenance during record review from 9:30 a.m. to 10:55 a.m. on 10/22/12, "No" was listed as the response to "Is System UL 300?" on each of the two kitchen hood extinguishing system work order documents. In addition, the "Comments"</p>	K0069	<p>K069 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider to ensure cooking facilities are protected in accordance with 9.2.3. 19.3.2.6. NFPA 96</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The kitchen hood self contained chemical extinguishing systems will be updated to be compliant with UL 300.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The kitchen hood self contained chemical extinguishing systems will be updated to be compliant with UL 300.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The sprinkler test vendor will</p>	11/21/2012			

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	<p>section of the 12/21/11 documentation stated "recommend update to UL 300 system". Based on interview at the time of record review, the Director of Maintenance acknowledged work order documentation identified the kitchen hood extinguishing system as not compliant with UL 300.</p> <p>3.1-19(b)</p>		<p>install the kitchen hood self contained chemical extinguishing systems to be compliant with UL 300. In addition the sprinkler test vendor will perform annual checks on the self contained chemical extinguishing system.</p> <p>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:</p> <p>The sprinkler test vendor will install the kitchen hood self contained chemical extinguishing systems to be compliant with UL 300. In addition the sprinkler test vendor will perform annual checks on the self contained chemical extinguishing system.</p>		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 22 residents and any staff or visitor in the vicinity of the Clare Bridge memory care unit oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 10:55 a.m. to 12:45 p.m. on 10/22/12, the entry door to the Clare Bridge memory care unit oxygen storage and transfilling room had no fire resistance rating label attached to the door. Two liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Director of Maintenance acknowledged the entry</p>	K0076	<p>K076 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider for medical gas storage and administration areas are protected in accordance with NFPA 99, standards for Health Care Facilities.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p> <p>How other residents having the potential to be affected by the</p>	11/21/2012			

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	room door to the Clare Bridge memory care unit oxygen storage and transfilling room did not provide one hour fire resistive construction. 3.1-19(b)		<p>same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p> <p>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:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a</p>		

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			separation of 1-hour fire resistive construction and has a tag stating such.	

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 22 residents and any staff or visitor in the vicinity of the Clare Bridge memory care unit oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 10:55 a.m. to 12:45 p.m. on 10/22/12, the entry door to the Clare</p>	K0143	<p>K143 NFPA 101 Life Safety Code Standard</p> <p>It is the practice of the provider to transfer oxygen in accordance with 8.6.2.5.2</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p>	11/21/2012	

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 10/22/2012
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	<p>Bridge memory care unit oxygen storage and transfilling room had no fire resistance rating label attached to the door. Two liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Director of Maintenance acknowledged the entry room door to the Clare Bridge memory care unit oxygen storage and transfilling room did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.</p> <p>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:</p>		

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			The door leading to the oxygen storage room in Clare Bridge was 1-hour rated but did not have a tag therefore the door has been updated with a door that has a separation of 1-hour fire resistive construction and has a tag stating such.	