

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155241	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2013
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NAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 525 E THOMPSON RD INDIANAPOLIS, IN 46227
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/03/13</p> <p>Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Forest Creek Village 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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The facility has battery operated smoke detectors in all resident</p>	K010000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Forest Creek Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 23, 2013. We would like to respectfully request a desk review if at all possible</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>sleeping rooms. The facility has a capacity of 128 and had a census of 113 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached wooden storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:20 a.m. to 12:20 p.m. on 10/03/13, a twelve inch by one inch rectangular opening in the ceiling of the west Med Room which did not provide at least a one half hour fire resistance rating was noted. Based on interview at the time of observation, the Maintenance Supervisor stated a water leak in the attic above the west Med Room caused the aforementioned opening in the ceiling smoke barrier and acknowledged the</p>	K010025	<p>K025 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff members, or visitors were affected by the deficient practice. The hole measuring 12 inches by 1 inch in the ceiling of the west med room was repaired and the entire ceiling now provides at least a one half hour fire resistance rating. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents were affected. Any resident, staff member, or visitor would have potential to be affected by a similar deficient practice. A complete inspection of the building yielded no further deficiencies. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? The Maintenance</p>	10/23/2013			

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	<p>opening did not provide at least a one half hour fire resistance rating for the west Med Room ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>Director or designee will make routine inspection audits. A written record of visual inspections was put into the preventative maintenance monitoring log (see attachment A). How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The maintenance director will make routine inspection audits one time each week for two weeks and then monthly for 2 months then quarterly thereafter of all areas in the facility to ensure the smoke barriers in all areas are intact and functioning to ensure compliance. The Maintenance Supervisor or designee will report findings to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any noncompliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 10/23/13</p>	

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K010062 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 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, 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.</p> <p>Findings include:</p> <p>Based on review of P.I.P.E. Inc. "Hydrant Flow Test Report" documentation dated 07/17/12 with the Maintenance Supervisor during record review from 9:00 a.m. to 10:20 a.m. on 10/03/13, an inspection of the facility's two fire hydrants was not performed within the last twelve months. Based on interview at the time of record review, the Maintenance Supervisor stated no other fire hydrant inspection documentation</p>	K010062	<p>K062 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff, or visitors were affected by this deficient practice. The fire hydrants were tested to ensure reliable operating condition(see attachment C). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents have been affected; all residents had the potential to have been affected. All fire hydrants were checked and tested to ensure reliable operational condition. What measure will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? A preventative maintenance audit tool has been initiated (see attachment B) to ensure the fire hydrants are tested annually. The Maintenance Director or designee will make routine inspection audits. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? A</p>	10/23/2013
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	<p>was available for review, the two fire hydrants are not owned by the City of Indianapolis and acknowledged it has been more than twelve months since the last annual inspection for each of the two fire hydrants.</p> <p>3.1-19(b)</p>		<p>preventative maintenance audit tool has been initiated (see attachment B) to ensure the fire hydrants are tested annually. The Maintenance Director or designee will report findings to the Executive Director or designee for review. The Executive Director or designee will forward the results to the Safety Committee for further review and recommendation. In the event any noncompliance is noted, an action plan will be developed to ensure compliance. Date of Compliance: 10/23/13</p>	