

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 01/07/2016
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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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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: 01/07/16</p> <p>Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110</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 sleeping rooms. The facility has a capacity of 128 and had a census of 112</p>	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review desk review in lieu of post survey revisit on or after January 18, 2016.	

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>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 completed on 01/11/16 - DA</p> <p>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 1¼ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 75 corridor doors were provided with a 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 28 residents, staff and visitors in the vicinity of Room 135.</p>	K 0018	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · A new latch plate and door knob was ordered and replaced on 1/15/16 for the corridor door in the vicinity of Room135. How other residents have the potential to be affected by the same deficient</p>	01/18/2016

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K 0025 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 01/07/16, the latching mechanism in the corridor door to Room 135 did not protrude into the latching plate on the door frame which provided an impediment to closing and latching the door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door had an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p> <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</p>		<p>practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the alleged deficient practice. · A new latch plate and door knob was ordered and replaced on 1/15/16 for the corridor door in the vicinity of Room135. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur: · The Maintenance Director/designee will inspect the corridor doors weekly How 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 · The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and DNS. If threshold of 95% is not achieved a naction plan will be developed. By what date the systemic change will be completed. · January 18th, 2016</p>	

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	<p>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>1. Based on observation and interview, the facility failed to ensure openings through 1 of 10 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 22 residents, staff and visitors in the vicinity of the smoke barrier wall by Room 122.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 01/07/16, an eight inch in diameter hole for the passage of a two inch in diameter sprinkler pipe was noted in the attic smoke barrier wall above the cross corridor door set by Room 122. Based on</p>	K 0025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The opening in the smoke barrier wall by Room 122 will be patched and repaired by Maintenance Director by 1/18/2016 to maintain smoke resistance. · The two inch diameter hole noted in the ceiling smoke barrier in the sprinkler room was patched and repaired by Maintenance Director on 1/07/2016. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The opening in the smoke barrier wall by Room 122 will be patched and repaired by Maintenance Director by 1/18/2016 to maintain smoke resistance. · The two inch diameter hole noted in the ceiling smoke barrier in the sprinkler room was patched and repaired by Maintenance Director on 1/07/2016. What measures will be put into place or what systemic changes will be made</p>	01/18/2016

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	<p>interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the attic smoke barrier wall did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to 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 in the vicinity of the sprinkler riser room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 01/07/16, a two inch in diameter hole was noted in the ceiling smoke barrier in the sprinkler riser room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the sprinkler riser room ceiling smoke barrier failed to maintain at least a one half hour fire resistance rating for the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>to ensure that the deficient practice does not occur: · The Maintenance Director/designee will inspect the smoke barrier walls and ceiling smoke barriers weekly. How 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 and · The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and DNS. If threshold of 95% is not achieved an action plan will be developed. By what date the systemic change will be completed. · January 18th, 2016</p>	

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K 0062 SS=E Bldg. 01	<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 observation and interview, the facility failed to replace 2 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 28 residents, staff and visitors in the vicinity of Room 127.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 01/07/16, the pendent sprinkler installed in each of two closets in Room 127 were covered with masking tape. Based on interview at the time of the observations, the Maintenance Director stated the sprinklers had been covered with</p>	K 0062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · Masking tape was removed from the two sprinklers on 1/8/2016 by Maintenance Director. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the alleged deficient practice. · Masking tape was removed from the two sprinklers on 1/8/2016 by Maintenance Director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur: · The Maintenance Director/designee will check sprinklers weekly to ensure sprinklers are free of foreign materials. How 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 and · The Maintenance Director/designee</p>	01/18/2016

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K 0147 SS=E Bldg. 01	<p>masking tape to prevent them from being painted and acknowledged the aforementioned two sprinkler locations had foreign materials on them.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 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. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the</p>	K 0147	<p>will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed. By what date the systemic change will be completed. · January 18, 2015</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The refrigerator and coffee maker in the Admissions Office were unplugged on 1/07/2016 by Maintenance Director · The "Side Socket" power strip was removed in Room 14 on 1/7/2016 by Maintenance Director. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The refrigerator and coffee maker in the Admissions Office were unplugged on 1/07/2016 by Maintenance Director · The "Side Socket"</p>	01/18/2016

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	<p>examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 30 residents, staff and visitors in the vicinity of Room 14.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 01/07/16, the following was noted:</p> <p>a. a refrigerator and a coffee pot were plugged into a power strip in the Admissions Office.</p> <p>b. each of two resident beds and an oxygen concentrator were plugged into a "Side Socket" power strip within one foot of the resident bed nearest the corridor door in Room 14.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the</p>		<p>power strip was removed in Room 14 on 1/7/2016 by Maintenance Director. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur: · All Staff will be in-serviced on the non use of power strips in offices and resident rooms by 1/18/2016. · A full house audit of every office and resident room will be conducted to ensure power strips are not in use. · Maintenance Director/Designee will check each room and office weekly to ensure the non use of power strips, weekly x 4weeks, monthly times 6 and quarterly thereafter for one year. How 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 and · The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and DNS. If threshold of 95% is not achieved an action plan will be developed. By what date the systemic change will be completed. · January 18th, 2016</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

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	aforementioned two locations. 3.1-19(b)				