

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER  SALEM CROSSING		STREET ADDRESS, CITY, STATE, ZIP COD 200 CONNIE AVE SALEM, IN 47167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0000  Bldg. 01	<p>An investigation of Complaint Number IN00397831 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Complaint Number IN00397831 was substantiated.</p> <p>A Federal/State deficiency related to the allegation was cited at K781.</p> <p>Survey Date: 01/11/23</p> <p>Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680</p> <p>At this Complaint survey, Salem Crossing was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 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 all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 92 and had a census of 84 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered.</p>	K 0000	<p>Please find the enclosed plan of correction for the survey ending January 11, 2023.</p> <p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find sufficient documentation providing evidence of compliance with the plan of correction.</p> <p>The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.</p>	

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

TITLE

(X6) DATE

Holly Thompson

Executive Director

01/27/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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 <b>155330</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>01/11/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>SALEM CROSSING</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>200 CONNIE AVE SALEM, IN 47167</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0781 SS=F Bldg. 01	<p>Quality Review completed on 01/17/23</p> <p>NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failure to ensure portable space heaters were not used in health care occupancies according to current written policy documentation for the facility which prohibited their use. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Program" documentation dated 02/15/22 with the Executive Director and the Maintenance Director during record review from 10:00 a.m. to 10:25 a.m. on 01/11/23, the use of portable space heaters in the facility is prohibited. Item #17 on page 49 of the "General Fire Information" section of the "Fire Safety Standards" section of the 02/15/22 emergency preparedness program documentation stated, "portable space heaters are prohibited in the facility". Based on interview at the time of record review, the Executive Director and the Maintenance Director stated the heating elements and the blower motor for the attic mounted air handler which services the corridor and six rooms at the end of the 300 Hall went out of service on 12/23/22. The Executive Director and the</p>	K 0781	<p>1. No residents, staff, or visitors were harmed. Residents were removed from their rooms and relocated in facility when the heating element and blow motor failed. The outside temperatures on 12-23-22 were -4 hi and -6 lo between 6:00am – 12:00pm during the hours the failure occurred. In an effort to prevent the water pipes and sprinkler pipes from freezing, space heaters were used. If temperatures were to fall below 32 degrees Fahrenheit, this places the water pipes and sprinkler pipes at risk to freeze which could cause cracking, leaking, or bursting placing the facility at risk as well. The portable space heaters that were used were placed in the hallway and monitored every 15 minutes by nursing staff. Maintenance Director also made routine checks on the heaters with no issues noted. Space heaters were removed once the heating element</p>	01/27/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER  SALEM CROSSING		STREET ADDRESS, CITY, STATE, ZIP COD 200 CONNIE AVE SALEM, IN 47167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Director stated residents in the six rooms were moved to other open bed locations within the facility at the time of heat loss for the end of the 300 Hall. The Maintenance Director stated the heat loss event may have been due to the extreme cold at the time of heat loss but knowing now what eventually failed with the air handling unit it was likely to occur at some point anyway. The Maintenance Director stated the air handling unit was repaired by an HVAC contractor and was back on line 12/27/22. The Maintenance Director provided "Invoice" documentation dated 01/11/23 for the repairs which stated, "replaced heat kit in furnace, installed fan switch, checked operations on heat pump" for the air handling unit which services "end unit on 300 Hall". Based on observations with the Executive Director and the Maintenance Director 9:25 a.m. to 10:00 a.m., three separate portable space heaters were observed not in use but being stored in the Maintenance Office. The Executive Director and the Maintenance Director stated their Corporate Office provided the three portable space heaters from a rental company to provide heat to the corridor and the six rooms during the heat loss event for the end of the 300 Hall until heat was restored. Each of the three portable space heaters were identified as a "Patron E 1.5 Electric Construction Heater". Based on Internet review of the heater specifications, the heaters were stated as an electrical heater with one heat setting and achieving 5000 Btu heat output. The thermostat near the end of the 300 Hall indicated it was 74 degrees Fahrenheit at the time of the survey on 01/11/23. Based on interview at the time of record review, the Executive Director agreed the current written policy for space heaters is to prohibit their use in the facility.		<p>and blow motor were repaired. There are currently no portable space heaters being utilized within the facility.</p> <p>2. All residents, staff, and visitors have the potential to be affected. All space heaters were removed from resident areas. No further areas of concern noted.</p> <p>3. Policy was updated to reflect the regulation. Life Safety Code Standard for K781 and Emergency Operations Plan Section E.1.e #17 reviewed with Maintenance Director by 1-27-23 by Executive Director (See Attachment A and B). Maintenance Director will inspect facility during daily walk thru to ensure no portable space heaters are in use.</p> <p>4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment C) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.</p> <p>5. The above plan of correction will be completed on or before 1-27-23.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155330</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>01/11/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>SALEM CROSSING</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>200 CONNIE AVE SALEM, IN 47167</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>This federal tag relates to complaint number IN00397831.</p>			