STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155730	A. BUILDING -- B. WING	09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/18/23 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 At this Emergency Preparedness survey, Ripley Crossing was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 85. Quality Review completed on 09/22/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Trina Johnson	Administrator	10/04/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period did not indicate the load percent achieved during each monthly load test. In addition, loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer was not documented for any of the monthly load tests documented for the most recent twelve month period. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for the most recent twelve month period did not indicate the load percent achieved during each monthly load test. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the diesel fired emergency	E 0041	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Moving forward we do our monthly test and document on the Emergency Generator Testing Log all the required information. No residents, staff or visitors were affected by the alleged deficient practice. Administrator and Maintenance will review the Emergency Generator Monthly Test Log monthly. To further prevent any deficiency from reoccurring the Emergency Generator Monthly Test Log will be used and filled out with all the required information. ="" p="">	10/04/2023

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	generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/18/23 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 At this Life Safety Code survey, Ripley Crossing was found not in compliance with Requirements for Participation in 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 85 at the time of this visit.	K 0000		

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	All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 09/22/23			
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised			

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	automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation and interview; the facility failed to maintain the building construction type for Type V(111) construction in 4 of 6 fire walls. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of facility blueprint documentation with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, 2-hour fire resistance rated fire walls are located at the entrance to Wing 1, Wing 2, Wing 3, Wing 4, Wing 5 and at the entrance to the Seasons Assisted Living wing. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the entrance doors to Wing 1, Wing 2, Wing 3, Wing 4, Wing 5 and at the entrance to the Seasons wing were each equipped with a 90-minute fire resistance rating label affixed to the hinge side of door. However, the entrance doors at Wing 1, Wing 2, Wing 3 and Wing 5 were not equipped with latching hardware to latch each fire door into the door frame. In addition, the attic access panel in the 2-hour fire resistance rated fire wall in the attic above the 300 Wing entrance door set was not in place which caused a two foot by two foot square opening in the fire rated wall. Based on interview at the time of the	K 0161	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Contractors were in on October 2, 2023 to quote the latching hardware to be installed on the entrance doors of Wing 1, Wing 2, Wing 3, and Wing 5. Once hardware is received the contractor will install. No residents, staff or visitors were affected by the alleged deficient practice. To further prevent any deficiency from reoccurring the latching hardware will be permanently installed on all 4 doors. /p>	12/31/2023

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	observations, the Maintenance Supervisor agreed the aforementioned fire door locations did not latch into the door frame and the hole in the attic fire barrier wall above the corridor door set at the entrance to the 300 Wing did not maintain the building construction type for Type V(111) construction. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors in Wing 5 if needing to exit the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, a folding plastic table for isolation supply storage on top of the table was stored in the corridor outside Room 502	K 0211	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The folding plastic tables were replaced with wheeled over the bed tables. No residents, staff or visitors were affected by the alleged deficient practice. Infection Preventionist was informed to only use the wheeled over the bed tables for isolation rooms in the hallways. The maintenance director will complete audits of all aisles,	09/19/2023

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	and Room 518 in Wing 5. Each plastic table was not affixed to the floor or to the wall, was not wheeled and projected 18 inches into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		passageways, corridors, and exits locations when completing his environmental rounds. /p>	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 therapy room exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over five residents, staff and visitors if needing to exit the "Healthy Hoosiers" Club therapy room in Wing 5. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the door handle on the corridor door to the "Healthy Hoosiers" Club therapy room in Wing 5 was equipped with a lock which required a key to unlock the door on the therapy room side of the door. When the door was closed and latched into the door frame the door was locked and could not be opened. Neither the therapy room staff or the Maintenance Supervisor had a key to unlock the door. Facility staff at the Wing 5 nurse's station had to open the door from the corridor side of the room as the door handle locking mechanism was not locking on the corridor side of the door. The therapy room had two additional exit doors from the room to the outside of the facility which did not provide an impediment to exit the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the corridor door to the "Healthy Hoosiers" Club therapy room was equipped with a latch or lock that requires the use	K 0222	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The locking door knob was removed and replaced with a non-locking door knob. No residents, staff or visitors were affected by the alleged deficient practice. To further prevent any deficiency from reoccurring the new door knob was permanently installed. /p>	10/02/2023

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	of a tool or key from the egress side of the door. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.	K 0291	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The monthly Emergency and Exit Light Testing Form will now be itemized by Wing. We will use the Emergency and Exit Light Testing Form for the annual 90-minute testing and it will be itemized by Wing. Maintenance has replaced the non-working lights on the exit light at the front entrance, (not the Maintenance Office) and in the kitchen. No residents, staff or visitors were affected by the alleged deficient practice. Administrator and Maintenance will review the Emergency and Exit Light Testing Form monthly. To further prevent any deficiency from reoccurring the Emergency and Exit Light Testing Form will be used and filled out with all the	10/02/2023

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	Findings include: Based on review of "Ripley Crossing Emergency/Exit Light" testing documentation for 2022 and 2023 and "Monthly Emergency Light and Exit Light Checklist" documentation with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, monthly battery operated light testing documentation for the most recent twelve month period was not itemized by the light location. In addition, annual 90-minute functional testing documentation for all battery operated lights in the facility within the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Maintenance Supervisor agreed monthly battery operated light testing documentation for the most recent twelve month period was not itemized by the light location and annual 90-minute functional testing documentation for all battery operated lights in the facility within the most recent twelve month period was also not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, thirty-one battery operated lights were noted in the facility and each battery light location operated when its respective test button was pushed except for the light located near the maintenance office exit and at the kitchen exit door to the outside of the facility. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		required information. /p>	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	2. Based on observation and interview, the facility failed to ensure 2 of 31 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, thirty-one battery operated lights were noted in the facility and each battery light location operated when its respective test button was pushed except for the light located near the maintenance office exit and at the kitchen exit door to the outside of the facility. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned two battery light locations each failed to illuminate when its respective test button was pushed. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure 1 of over 15 hazardous areas such as laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the clean side of the Laundry Room.	K 0321	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The “No Smoking Oxygen in Use” sign was removed from Laundry. Spoke with laundry and explained we cannot use the sign in the door. They stated they were having	10/03/2023

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	Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, a magnetic "No Smoking Oxygen in Use" warning label sign was placed over the latching plate on the metal door frame for the corridor door to the clean side of the Laundry which prevented the door from latching into the door frame. The door self closed and latched into the door frame when the magnetic sign was removed from the door frame. Based on interview at the time of the observations, the Maintenance Supervisor agreed the magnetic sign placed over the latching plate on the door frame would not separate the clean side of the Laundry from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 15 hazardous areas such as fuel fired heater rooms and laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry Room. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, three separate one		issue with the doorknob and lock. Maintenance made the required repairs to the doorknob on 9/19/2023 and it is working properly. Maintenance also repaired all three holes that were noted in the ceiling in the Laundry Room behind the dryers. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will check door(s) on rounds to make sure no sign is being used. To further precent any deficiency from reoccurring maintenance will continue to monitor doors ceilings on rounds. /p>	

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	inch in diameter holes were noted in the ceiling of the Laundry Room behind the dryers above the natural gas fired water heater in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the three holes in the ceiling did not separate the Laundry Room from other spaces with smoke resistant partitions. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility	K 0324	It is the intent of Ripley Crossing	10/06/2023

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	failed to ensure repair documentation was available for review to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood inspection contractor's "Pre-Engineered Restaurant Fire Suppression Systems Report" documentation dated 12/27/22 and 06/19/23 with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, semi-annual kitchen range hood inspection reports stated "exhaust fan should continue when system activates". Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility about one month ago and was not aware if any repairs had been made on or after 12/27/22 and 06/19/23 and agreed documentation of any corrections performed on or after 12/27/22 and 06/19/23 was not available for review at the time of the survey.		to provide a safe environment for all residents and staff. Corrective Action – R.C. Electric was here after last year's survey and wired the kitchen hood so that the exhaust fan will turn on when the fire suppression system shuts off and is still working correctly. When Crossman came to do their inspection, they failed to update their report. They will be coming out Friday, October 6th to get us a clean inspection on the exhaust. No residents, staff or visitors were affected by the alleged deficient practice. Administrator and Maintenance will review the Fire Suppression Systems Report for accuracy and if issues arise will follow up on. To further prevent any deficiency from reoccurring the Fire Suppression Systems Report will be reviewed once completed and issues, if any, will be addressed. /p>	

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	These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the calendar date and the time of day for the display at the main fire alarm control panel at the main entrance lobby by the reception desk was incorrect. The display read the calendar date as "7/31" and the time of day as "7:24 p.m." at 12:50 p.m. Based on interview at the time of the observations, the Maintenance Supervisor agreed the main fire	K 0345	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The Control Panel was reset so that the date and time are now correct. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will check for accurate date & time on his weekly rounds. This will be ongoing to further prevent any deficiency from reoccurring and date and time will be accurate. /p>	09/19/2023

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	alarm control panel for the facility did not display the correct date and time of day. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the "Healthy Hoosiers" Club room in Wing 5. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, a one half inch in diameter hole was noted above the door handle for the corridor door to the "Healthy Hoosiers" Club room in Wing 5 which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Supervisor agreed the corridor door to the "Healthy Hoosiers" Club room in Wing 5 would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0363	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – The hole noted above the door handle for the corridor door to the Therapy Gym was repaired by maintenance. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will monitor fire doors to ensure no holes are in the door on weekly rounds and no less than yearly with our Annual Fire Door Inspection. To further prevent any deficiency from reoccurring the hole was permanently fixed. /p>	10/02/2023

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first and second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, first shift fire drills conducted within the most recent twelve month period on 02/23/23, 06/07/23 and 08/23/23 were conducted at, respectively, 10:00 a.m., 10:30 a.m. and 10:15 a.m. In addition, second shift fire drills conducted within the most recent twelve month period on 11/17/22, 04/18/23 and on 07/19/23 were conducted at, respectively, 2:45 p.m., 2:30 p.m. and 3:30 p.m. Based on interview at the time of record review, the Maintenance Supervisor stated the facility operates three shifts per day and agreed the aforementioned first and second shift fire drills were not conducted at	K 0712	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Fire Drills will be conducted at a 2hr minimum interval from last drill conducted on each shift. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will conduct fire drills with a variance in time to simulate emergency, in that staff will not be expectant of time for each of the 3 shifts. To further prevent any deficiency from reoccurring the fire drills will be conducted at unexpected times and ongoing. /p>	10/06/2023

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	unexpected times under varying conditions. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) and 3.1-51(c)			
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Maintenance performed a complete Annual Inspection of the Fire Doors on October 2, 2023. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will perform a complete inspection of the Fire Doors yearly. To further prevent any deficiency from reoccurring the Fire Door Yearly Inspection will be completed for all fire doors annually and will be ongoing. /p>	10/02/2023

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	NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Door Yearly Inspection" documentation dated 01/12/23 with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, annual inspection documentation of fire door assemblies in the facility within the most			

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	recent twelve month period did not include all fire doors in the facility. The annual fire door inspection documentation included an itemized listing of all fire door locations inspected in Wing 1 and Wing 2 but was left blank for most fire door locations in Wing 3 and all fire door locations in Wing 4, Wing 5 and in service areas, support offices and the entrance door set to the Seasons wing which is the attached Assisted Living area of the facility. Based on review of facility blueprint documentation at the time of record review, 2-hour fire resistance rated fire walls are located at the entrance to Wing 1, Wing 2, Wing 3, Wing 4, Wing 5 and at the entrance to the Seasons wing. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility about one month ago and agreed annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the entrance doors to Wing 3, Wing 4 and Wing 5 and at the entrance to the Seasons wing were each equipped with a 90 minute fire resistance rating label affixed to the hinge side of door. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0914 SS=D Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing			

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	155730	A. BUILDING 01 B. WING	09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN 47031

(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
	Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 1 of over 50 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon	K 0914	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Hospital grade receptacles were ordered and this outlet will be replaced once it arrives. It is scheduled to be delivered on October 5, 2023. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will replace any non-working receptacle with a hospital grade receptacle. To further prevent any deficiency for reoccurring maintenance will only use hospital grade	10/06/2023

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	modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect 2 residents and staff in Room 303. Findings include: Based on review of "Ripley Crossing Electrical Receptacle Tests" documentation dated 01/12/23 with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, an electrical receptacle in resident sleeping Room 303 was replaced following receptacle testing. Based on interview at the time of record review, the Maintenance Supervisor stated he started working at the facility about one month ago and did not know if the replacement receptacle for Room 303 was hospital-grade or not. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, all receptacle locations in Room 303 were not hospital-grade. Based on interview at the time of the observations, the Maintenance Supervisor agreed all receptacle locations in Room 303 were not hospital-grade. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		receptacles when replacing receptacle(s). /p>	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the			

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	10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for 12 months of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using	K 0918	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Moving forward we use a new Emergency Generator Monthly Test Log to record all the required information. No residents, staff or visitors were affected by the alleged deficient	10/04/2023

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	one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Testing Log" documentation for the most recent twelve month period with the Administrator and the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 09/18/23, monthly load testing documentation for the facility's diesel fired emergency generator for the most recent twelve month period did not indicate the load percent achieved during each monthly load test. In addition, loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer was not documented for any of the monthly load tests documented for the most recent twelve month period. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for the most recent twelve		practice. Administrator and Maintenance will review the Emergency Generator Monthly Test Log monthly. To further prevent any deficiency from reoccurring the Emergency Generator Monthly Test Log will be used and filled out with all the required information. /p>	

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	month period did not indicate the load percent achieved during each monthly load test. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 50 kW and was manufactured in 2020. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon			

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	completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 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, 2012 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 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 10.4.2.3 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 over 10 residents, staff and visitors in the vicinity of resident sleeping Room 512. Findings include: Based on observations with the Maintenance	K 0920	It is the intent of Ripley Crossing to provide a safe environment for all residents and staff. Corrective Action – Maintenance replaced the power strip with the appropriate UL listing and the lift chair is now plugged into the wall as is the light, all other items, stereo and phone charger, are plugged into the power source. No residents, staff or visitors were affected by the alleged deficient practice. Maintenance will continue to monitor the use of power strips in the facility on weekly rounds To further prevent any deficiency from reoccurring the weekly rounds sheet will include power strips. /p>	09/19/2023

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	Supervisor during a tour of the facility from 12:50 p.m. to 3:10 p.m. on 09/18/23, a lamp, a stereo and an electric upholstered chair were plugged into a power strip placed on the floor within five feet of the resident bed in resident sleeping Room 512. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Supervisor agreed a power strip with an unknown UL listing was being used in the patient care vicinity at the aforementioned location. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			