STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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: 06/26/23 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 At this Emergency Preparedness survey, Robin Run Health Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 84 certified beds. At the time of the survey, the census was 51. Quality Review completed on 06/30/23 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during the Life Safety Survey at Robin Run Village. Hopefully, you will find our remedies to be both sufficient. and thoroughly explained. The Plan of Correction is not to be. construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting Paper. Compliance Review with the submission of these remedies. If after reviewing the plan of correction you have any. questions, please do not hesitate. to contact us.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Newcomer	Executive Director	07/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency preparedness plan available has not been reviewed within the past 12 months with an initial date of 01/01/2017 with no further documented updates. Based on interview at the time of record review, the Maintenance Supervisor agreed that the facility has not had its emergency preparedness program reviewed within the most recent twelve-month period and added that the facility was working on it currently and it should be updated very soon. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.	E 0004	1. No residents were adversely affected by not having the emergency preparedness plan reviewed within the most recent twelve-month period. 2. All residents are potentially determined to be at risk. The emergency preparedness plan will be reviewed and updated. 3. The emergency preparedness plan will be reviewed annually as a part of the facility's quality assurance program. A document page will be kept with the emergency preparedness plan that will be signed by the administrator and dated when it is reviewed and approved by the quality assurance program. (See Exhibit A) 4. Administrator/designee will be responsible to monitor that the emergency preparedness plan is reviewed on an annual basis as a part of the quality assurance program.	08/31/2023
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	§483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures that were updated at least annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation of policies and procedures	E 0013	1. No residents were adversely affected by not having the emergency preparedness plan reviewed within the most recent twelve-month period. 2. All residents are potentially determined to be at risk. The emergency preparedness plan will be reviewed and updated. 3. The emergency preparedness plan will be reviewed annually as a part of the facility's quality assurance program. A document page will be kept with the emergency preparedness plan that will be signed by the	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	reviewed or updated by the facility within the most recent twelve-month period was not available for review. The policies and procedures plan available had not been reviewed within the past 12 months with an initial date of 01/01/2017 with no further documented updates. Based on interview at the time of record review, the Maintenance Supervisor agreed that the facility has not had its emergency preparedness program reviewed within the most recent twelve-month period and added that the facility was working on it currently and it should be updated very soon. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.		administrator and dated when it is reviewed and approved by the quality assurance program. (Exhibit A) 4. Administrator/designee will be responsible to monitor that the emergency preparedness plan is reviewed on an annual basis as a part of the quality assurance program.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance	E 0029	1. No residents were adversely affected by not having the communication plan updated within the most recent	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation of a communication plan reviewed or updated by the facility within the most recent twelve-month period was not available for review. The communication plan available had not been reviewed within the past 12 months. The communication plan available had not been reviewed within the past 12 months with an initial date of 01/01/2017 with no further documented updates. Based on interview at the time of record review, the Maintenance Supervisor agreed that the facility has not had its emergency preparedness program reviewed within the most recent twelve-month period and added that the facility was working on it currently and it should be updated very soon. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.		twelve-month period. 2. All residents are potentially determined to be at risk. The communication plan will be reviewed and updated. 3. The communication plan will be reviewed annually as a part of the facility's quality assurance program. A document page will be kept with the emergency preparedness plan that will be signed by the administrator and dated when it is reviewed and approved by the quality assurance program. (Exhibit A) 4. Administrator/designee will be responsible to monitor that the communication plan is reviewed on an annual basis as a part of the quality assurance program.	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation of a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the Maintenance Supervisor agreed that a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives could not be located for review as of the time of this survey.	E 0035	1. No residents were adversely affected by not having documented a method for sharing information from the emergency plan with residents, families or representatives. 2. All residents are potentially determined to be at risk. A documented method for sharing information from the emergency plan with residents, families, or representatives will be reviewed and updated. 3. A documented method for sharing information from the emergency plan with residents, families, or representatives will be identified. This method will be a part of the emergency plan. The method will consist of verbal, email, and direct phone calls. The documented method will be reviewed annually by the quality assurance program. (Exhibit A and B) 4. Administrator/designee will	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.		be responsible to monitor that the communication plan is reviewed on an annual basis as a part of the quality assurance program.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency	E 0036	1. No residents were adversely affected by not having the training	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation of an emergency preparedness training and testing program that was reviewed or updated by the facility within the most recent twelve-month period was not available for review. The training and testing program available had not been reviewed within the past 12 months. The training and testing program available has not been reviewed within the past 12 months with an initial date of 01/01/2017 with no further documented updates. Based on interview at the time of record review, the Maintenance Supervisor agreed that the facility has not had its emergency preparedness program reviewed within the most recent twelve-month period and added that the facility was working on it currently and it should be updated very soon. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.		and testing program reviewed within the most recent twelve-month period. 2. All residents are potentially determined to be at risk. The training and testing program will be reviewed and updated. 3. The training and testing program will occur bi-annual and be reviewed annually as a part of the facility's quality assurance program. A document page will be kept with the emergency preparedness plan that will be signed by the administrator and dated when it is reviewed and approved by the quality assurance program. (Exhibit A) 4. Administrator/designee will be responsible to monitor that the training and testing program is reviewed on an annual basis as a part of the quality assurance program. To ensure compliance, the annual review will be added to the quality assurance program.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	§483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale	E 0039	1. No residents were adversely affected by not having a second full-scale exercise that is community based or an individual, facility based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Brookdale Senior Living Solutions Disaster Manual - 2017" on 06/26/23 between 11:36 a.m. to 12:19 p.m., documentation of a full-scale drill that was community based was available for review but the facility could not provide documentation of: a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on interview		2. All residents are potentially determined to be at risk. The facility will conduct a second full-scale exercise that is community based or an individual, facility based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan. 3. A second full scale exercise will be conducted on an annual basis as a part of the emergency preparedness plan. (Exhibit C) 4. The administrator/designee will be responsible for monitoring a second full scale exercise is conducted on an annual basis as a part of the emergency preparedness plan and the quality assurance program. To ensure compliance, the exercises will be added to the quality assurance program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	at the time of record review, the Maintenance Supervisor agreed that another emergency drill or exercise could not be located for review as of the time of this survey. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.			
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. 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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 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,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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. (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 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 occupants. Findings include: Based on record review of the facility maintenance records for the emergency generator on 06/26/23	E 0041	1. No residents were adversely affected by not having the weekly generator inspection documents, an annual fuel quality test, and an annual load-bank test. 2. All residents are potentially determined to be at risk. The facility will document that a weekly generator inspection, an annual fuel quality test, and an annual load-bank test occurs. 3. The maintenance director will	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	at 11:08 a.m., the following was noted: a) Only one monthly generator testing document ("Monthly test generator - under load) for the month of May, 2023 could be provided for review. b) No weekly generator inspection documents could be provided for record review. c) An annual fuel quality test for the facility generator could not be provided for review. d) An annual load-bank test could not be provided for review. Based on an interview at the time of record review, the Maintenance Supervisor advised that the previous maintenance staff all quit at the same time and they took or discarded many of the testing records with them. Because of this, many of the necessary records and testing documents would not be available for review for the current survey. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference.		document weekly generator inspections, an annual fuel quality test, and an annual load-bank test occurs. (Exhibit D) 4. Administrator/designee will be responsible to monitor documentation that a weekly generator inspection, an annual fuel quality test, and an annual load-bank test occurs and report it to the quality assurance committee.	
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: 06/26/23 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 At this Life Safety Code survey, Robin Run Health Center was found not in compliance with Requirements for Participation in	K 0000	Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during the Life Safety Survey at Robin Run Village. Hopefully, you will find our remedies to be both sufficient. and thoroughly explained. The Plan of Correction is not to be. construed as an admission of or agreement with the findings and conclusions in the Statement of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the nurses call system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 51 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached maintenance building which was not sprinklered. Quality Review completed on 06/30/23		Deficiencies, or any related sanction or fine. We are requesting Paper. Compliance Review with the submission of these remedies. If after reviewing the plan of correction you have any. questions, please do not hesitate. to contact us.	
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 maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:	K 0211	1. No resident was adversely affected by temporarily having a laundry cart in the hallway. 2. All residents are potentially determined to be at risk by temporarily having a laundry cart in the hallway. Nursing and	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment LSC A.19.2.3.4(4)(c) states, wheeled equipment and carts in use include food service carts, housekeeping carts, medication carts, isolation carts, and similar items. Isolation carts should be permitted in the corridor only where patients require isolation precautions. Unattended wheeled crash carts and other similar wheeled emergency equipment are permitted to be located in the corridor when "not in use," because they need to be immediately accessible during an emergency. Note that "not in use" in not the same as "in storage." Storage is not permitted to be open to the corridor, unless it meets unless it meets one of the provisions permitted in 19.3.6.1 and it is not a hazardous area. This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Maintenance Supervisor on 06/26/23 at 1:10 p.m. during a tour the facility, there was a cart containing lost-and-found shirts, slacks, and a miscellaneous bag of clothing items in the corridor nearest to the main nurse's station. Based on interview with the Maintenance Supervisor at the time of the observation, he acknowledged the		laundry staffing will be in-serviced about not leaving laundry carts in the hallway. 3. The Laundry department will in-service all their staff about not leaving laundry carts in the hallways. Each employee will have to sign that they have been in-serviced. (Exhibit E) Also, laundry supervisor will inspect on a weekly basis and is on checklist. (Exhibit F) 4. Administrator/designee will monitor it on a weekly basis and report to the quality assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	items in the corridor and added that he would find a new place for them to be stored. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 7 exit discharges was constructed of a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors in the compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor, on 06/26/23 at 1:28 p.m., the exit discharge nearest to resident rooms #16 and #17 was concrete. Halfway to the street was a 60-inch strip of concrete that was eroded and uneven. Based on interview at the time of the observation, the Maintenance Supervisor agreed that the walkway was not a hard packed all weather surface and was in need of repair.	K 0271	1. No residents were adversely affected by the sidewalk that is eroded and uneven near the exit discharge nearest to resident room #16 and #17. 2. All residents are potentially at risk for the sidewalk that is eroded and uneven. 3. The Maintenance Director will have the referenced portion of the sidewalk replaced. The Maintenance Director will inspect all sidewalks leaving the facility to make sure that they are in good repair. The Maintenance Director will include this on the monthly checklist. 4. The Administrator/designee will review on a monthly basis, for the next 6 months, and report to	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)		the quality assurance committee.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire 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)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transferring room was separated by a 1-hour fire resistive construction. NFPA 101, 18.3.2.4 states: Medical gas storage and administration areas shall be protected in accordance with NFPA 99. NFPA 99, 11.5.2.3.1 states: Transfilling to liquid oxygen base reservoir container or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor, on 06/26/23 at 12:46 p.m., the door on the oxygen transfilling room failed to fully self-close and latch into the frame after multiple attempts. This was acknowledged by the Maintenance Supervisor at the time of the observation who added that he would have the door closer adjusted as soon as he had time to do so. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)	K 0321	1. No residents were adversely affected by the door on the oxygen transfilling room failed to fully self-close and latch into the frame. 2. All residents are potentially to be determined at risk for the door on the oxygen transfilling room not fully close and latch into the frame. The self-closing door will be adjusted so that when it closes and latch into the frame. 3. The maintenance director will inspect the oxygen transfilling room on a weekly basis. The weekly checklist will be updated to include an inspection of this door. (Exhibit H) 4. The administrator/designee will review on a monthly basis, for the next 6 months to ensure compliance, and report to the quality assurance committee.	08/31/2023
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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			
	1) Based on record review, observation, and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained,	K 0324	1. No residents were adversely affected by not documenting of semi-annual kitchen exhaust system inspection for twelve months. 2. All residents are to be determined to be at risk of not documenting semi-annual kitchen exhaust system inspection for twelve months. 3. The Culinary Director will be responsible for ensuring kitchen exhaust system inspection semi-annually. The Facility did have the exhaust system inspected. (Exhibit I) 4. The administrator/designee will review on a monthly basis to ensure compliance, and report to	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice would affect as many as 6 residents, 8 staff, and 4 visitors. Findings include: Based on record review on 06/26/23 at 11:06 a.m. with the Maintenance Supervisor, the documentation of semiannual kitchen exhaust system inspections for the last twelve months was not available for review. Based on observations made during a tour of the facility, the kitchen had a kitchen exhaust hood system in use. The lack of a current semiannual overhead hood inspection in the kitchen was verified by the Maintenance Supervisor at the time of record review who stated that he would have the testing scheduled as soon as he could. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b) 2) Based on record review, observation, and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected		the quality assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice would affect as many as 6 residents, 8 staff, and 4 visitors. Findings include: Based on record review on 06/26/23 at 11:08 a.m. with the Maintenance Supervisor, documentation of semiannual kitchen exhaust system inspection twelve months was not available for review. Based on observations made during a tour of the facility, there was a fire suppression system installed in the kitchen. The lack of a current annual or semiannual overhead hood inspection in the kitchen was verified by the Maintenance Supervisor at the time of record review who stated that he would have the testing scheduled as soon as he could. 3.1-19(b)			
K 0345 SS=F 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,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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 record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:03 a.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and stated that he would get the testing scheduled as soon as he could. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)	K 0345	1. No residents were adversely affected by not documenting a smoke detector sensitivity test every other alternate year. 2. All residents are potentially determined to be at risk for not documenting a smoke detector sensitivity test every alternate year. 3. The Maintenance Director will be responsible for ensuring that a smoke detector sensitivity test occurs before or on date certain. The Maintenance Director will be responsible for ongoing compliance. 4. The Administrator/designee will review annually and report to the quality assurance committee.	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to document 1 of 1 sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states	K 0353	1. No residents were adversely affected by not having all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. No residents were adversely affected by damaged ceiling tiles and ceiling tiles that have been removed to make repairs for leaks that had just occurred. 2. All residents are potentially determined to be at risk for not having all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. All	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:01 a.m., documentation could not be provided regarding weekly dry sprinkler system gauge inspection documentation for 52 weeks of the most recent 52-week period was not available for review. Monthly wet sprinkler system gauge inspection documentation for12 months of the most recent 12-month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12-month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b) 2) Based on observation and interview, the facility failed to maintain the ceiling construction in 4 of 5 smoke compartments. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling		residents are to be determined at risk for having damaged ceiling tiles and ceiling tiles that have been removed to make repairs for leaks that have just occurred. 3. The maintenance director will be responsible for ensuring that all inspections, tests, and maintenance of the system and its components occur and are available to the authority having jurisdiction. All ceiling tiles that are damaged or missing will be repaired or replaced on or before or the date certain. The Maintenance Director will inspect on a weekly basis. (Exhibit K) 4. The administrator/designee will review on a monthly basis for six months and report to the quality assurance program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 24 residents, 6 employees, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/23 from 12:40 p.m. to 2:40 p.m., the following was noted: a) The hall containing resident rooms #30 through #38 had visibly wet or missing ceiling tiles throughout the corridor. b) The hall containing resident rooms #1 through #17 had visibly wet or missing ceiling tiles throughout the corridor. c) The hall containing resident rooms #20 through #24 had visibly wet or missing ceiling tiles throughout the corridor. d) The hall containing resident rooms #20 through #24 had visibly wet or missing ceiling tiles throughout the corridor. The above mentioned missing, wet, or sagging ceiling tiles were all acknowledged by the Maintenance Supervisor at the time of observations who added that they were currently having humidity issues and they were aware and taking care of the problem as fast as they could. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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 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, 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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 44 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Supervisor on 06/26/23 at 1:16 p.m., the corridor door to resident room # 21 failed to close and latch into the frame. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the aforementioned door as not latching adding that he would have it looked at immediately. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)	K 0363	1. No residents were adversely affected by not having 1 of 44 sets of resident room doors to the corridor that would not completely close and latch into door frames. 2. All residents are potentially at risk for not having residents room doors to the corridor not completely close and latch into the door frame. 3. The maintenance director/designee will repair the referenced door either on or before date certain. The maintenance director will inspect all doors on a monthly basis to ensure doors that they completely close and latch into the door frame. (Exhibit H) 4. The administrator/designee will review on a monthly basis for six months and report to the quality assurance program.	08/31/2023
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 4 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/23 at 1:16 a.m., the set of smoke barrier doors between resident rooms #2 and #4 did not fully close when tested. There was a two-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Supervisor acknowledged these smoke barrier doors did not close completely and would not resist the passage of smoke. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)	K 0374	1. No residents were adversely affected by not having 1 of 4 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. 2. All residents are potentially at risk for not having 1 of 4 sets of barrier doors to restrict the movement of smoke for at least 20 minutes. 3. The maintenance director/designee will make repair of the 1 barrier door to ensure that it will restrict the movement of smoke for at least 20 minutes. The maintenance director will inspect all barrier doors to ensure proper closure on a monthly basis. (Exhibit J) 4. The administrator/designee will review on a monthly basis for six months and report to the quality assurance program.	08/31/2023
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation, and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:07 a.m., documentation could not be provided regarding	K 0521	1. No residents were adversely affected by not having documentation regarding testing and maintenance of fire and smoke dampers within the facility. 2. All residents are potentially at risk for not having documentation regarding testing and maintenance of fire and smoke dampers within the facility. 3. The maintenance director will have fire and smoke dampers tested and maintained before or on date certain. The maintenance director will track to ensure that testing and maintenance of fire and smoke dampers within the facility occurs every 4 years. 4. Administrator/designee will review on an annual basis and report to the quality assurance program.	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	testing and maintenance of fire and or smoke dampers within the facility. When asked if the facility had fire and smoke dampers in it, the Maintenance Supervisor answered yes, but testing and maintenance documentation could not be located for it. Based on observations made during a tour of the facility, several smoke dampers were noted throughout the facility. The lack of four-year maintenance conducted on the fire or smoke dampers was verified by the Maintenance Supervisor at the time of record review. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility	K 0753	1. No residents were adversely	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	failed to ensure 1 of 44 rooms was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20-kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised		affected by having a candle in a locked memory box outside of resident room #35. 2. All residents are potentially at risk of having a candle in a locked memory box. 3. The candle has been removed from the resident's memory box. The Administrator/designee will check on a weekly basis that no combustible decorations are utilized. 4. The administrator/designee will be responsible for reporting findings for the next 6 months to the quality assurance program. (Exhibit L)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/23 at 1:16 p.m., the memory box located immediately outside resident room #35 had a candle with a burnt wick in it. Based on interview at the time of the observations, the Maintenance Supervisor stated that he was unaware of the candle and would have it, or with wick removed as soon as he could. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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 observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:13 a.m., documentation could not be provided regarding an electrical receptacle testing the facility's 45 resident rooms had roughly 6 electrical	K 0914	1. No residents were adversely affected by not having all nonhospital-grade electrical receptacles in resident room locations inspected on an annual basis. 2. All residents are potentially at risk for not having all nonhospital-grade electrical receptacle in resident room locations on an annual basis. 3. The maintenance director will have all nonhospital-grade electrical receptable in the resident room location on or before date certain. The maintenance director will ensure and track that the nonhospital-grade electrical receptables in resident room locations are inspected monthly. (Exhibit M) 4. The administrator/designee will monitor for one year and report to the quality assurance program.	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	receptacles in each room. Based on observations made during a tour of the facility with the Maintenance Supervisor at 12:40 p.m., the resident rooms were found to have non-hospital grade electric receptacles. Based on interview at the time of the observation, the Maintenance Supervisor indicated all of the electrical receptacles in the resident rooms were not hospital-grade and also indicated there was no documentation of annual testing per NFPA 99, Receptacle Testing requirements. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			
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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	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) 1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:08 a.m., documentation for July of 2022 to June of 2023 weekly generator testing was not available for review. Based on an interview at the time of record	K 0918	1. No residents were adversely affected by not having written documentation of weekly inspection for the generator, not having written documentation of a monthly load inspection, and annual fuel load inspection for diesel generator, or documentation of a 36-month generator test where it runs for 4 hours. 2. All residents are potentially at risk of not having documentation of the above referenced generator testing. 3. The maintenance director will have documentation of the above testing on or before the date certain. The maintenance director will monitor and track to ensure that the above referenced testing occurs timely. (Exhibit N) 4. Administrator/designee will monitor for 1 year and report to quality assurance program.	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	review, the Maintenance Supervisor confirmed weekly generator testing documentation could not be provided because the previous Maintenance team all quit at the same time and took most testing documents with them. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b) 2) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 11 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:09 a.m., documentation for June of 2022 to April of 2023 monthly generator testing was not available for review. Based on an interview at the time of record review, the Maintenance Supervisor and the confirmed a load test was conducted in May of 2023 as that was his first month working in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	facility. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b) 3) Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:12 a.m., documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Supervisor stated the facility does have a diesel generator but he was unaware of the fuel quality testing requirements. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	4) Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Supervisor on 06/26/23 at 11:12 a.m., documentation of a thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the main building was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated documentation of supplemental load testing for four hours within the most recent three-year period was not available for review because he did not know about the testing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	requirement. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead 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 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 flexible cords were not used as a substitute for fixed wiring in 2 of 10 employee offices. LSC 9.1.2 requires electrical wiring and	K 0920	1. No residents were adversely affected by having flexible cords were not used as a substitute for fixed wiring in 2 of 10 employee	08/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(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
	equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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. This deficient practice affects staff and up to 50 residents in the A wing smoke compartments. Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on 06/26/23 from 12:40 p.m. to 2:40 p.m., the following was noted: a) a power strip was powering a microwave and mini refrigerator in the Admissions Directors office. b) a power strip was powering a mini refrigerator in the Unit Managers office Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned use of a power strip being used. This finding was reviewed with the facility Administrator, the Maintenance Supervisor, and the Team-Lead during the exit conference. 3.1-19(b)		offices. 2. All residents are potentially at risk for using flexible cords as a substitute for fixed wire in 2 of 10 employee offices. 3. All flexible cords will be removed on or before date certain. The maintenance director will check on a monthly basis to ensure that no flexible cords are being used. 4. Administrator/designee will monitor for 6 months and report to the quality assurance program.	