PRINTED: 07/18/2023

DEPARTMEN		RM APPROVED							
	R MEDICARE & MEDIC						IB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING		COMPL			
		155505	B. W	ING	_	06/26	/2023		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD				
ROBIN I	RUN HEALTH CEN	TER		6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DEFICIENCY		DATE		
E 0000									
Bldg									
	An Emergency Preparedness Survey was		E 0	000	Please accept the following pl				
	conducted by the Indiana Department of Health in				of correction as credible evide	nce			
	accordance with 42	2 CFR 483.73.			of compliance to the deficience	ies			
					cited during the Life Safety				
	Survey Date: 06/2	6/23			Survey at Robin Run Village.				
					Hopefully, you will find our				
	Facility Number:	001156			remedies to be both sufficient.				
	Provider Number:	155505			and thoroughly explained.				
	AIM Number: 100	0453350							
					The Plan of Correction is not t	0			
	At this Emergency	Preparedness survey, Robin			be.				
	Run Health Center	was found not in compliance			construed as an admission of	or			
	with Emergency P	reparedness Requirements for			agreement with the findings ar	nd			
	Medicare and Med	icaid Participating Providers			conclusions in the Statement	of			
	and Suppliers, 42 (CFR 483.73.			Deficiencies, or any related				
					sanction or fine.				
	The facility has 84	certified beds. At the time of							
	the survey, the cen	sus was 51.			We are requesting Paper.				
					Compliance Review with the				
	Quality Review co	mpleted on 06/30/23			submission of these remedies				
		-			If after reviewing the plan of				
	The requirement at	t 42 CFR Subpart 483.73 is NOT			correction you have any.				
	MET as evidenced				questions, please do not hesit	ate.			
		•			to contact us.				
E 0004	403.748(a), 416 !	54(a), 418.113(a),							
SS=F	\ /.	15(a), 483.475(a), 483.73(a),							
Blda	, ,	625(a), 485,68(a),							

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

485.727(a), 485.920(a), 486.360(a),

Develop EP Plan, Review and Update

§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),

491.12(a), 494.62(a)

Annually

TITLE (X6) DATE

Robert Newcomer **Executive Director** 07/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JOWT21 Facility ID: 001156 If continuation sheet Page 1 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	ľ í	JILDING	NSTRUCTION	(X3) DATE COMPL 06/26	ETED
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	The [facility] must Federal, State an preparedness required must develop estate comprehensive elegand must incomprehensive elegand must incomprehensive elegand must incomprehensive elegand updated at legand updated at legand updated at legand must do all of the section, utilizing a section and updated at legand updated and updat	an. The [facility] must atain an emergency in that must be [reviewed], ast every 2 years. The plan following: § \$482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency quirements. The [hospital or op and maintain a mergency preparedness is the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must atain an emergency in that must be reviewed,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 2 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2023	
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP COD OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to develop an preparedness plan to at least annually in 483.73(a). This definition occupants. Findings include: Based on review of Preparedness Plan of Living Solutions Displayed to the fact twelve-month period The emergency preparedness programment of the preparedness programment of the fact twelve-month period documented update time of record reviewed that the facility was working be updated very soor This finding was readministrator, the Internal the facility was be a deministrator, the Internal the facility was the Team-Lead during the Team-Lead during the facility was the Team-Lead during the Team-Lead during the facility was the Team-Lead during the	viewed with the facility Maintenance Supervisor, and ing the exit conference.	E 00	004	1. No residents were adverse affected by not having the emergency preparedness plar reviewed within the most receit twelve-month period. 2. All residents are potential determined to be at risk. The emergency preparedness plan be reviewed and updated. 3. The emergency preparedness plan will be reviannually as a part of the facilit quality assurance program. A document page will be kept with the emergency preparedness that will be signed by the administrator and dated when reviewed and approved by the quality assurance program. (S Exhibit A) 4. Administrator/designee where responsible to monitor that emergency preparedness plar reviewed on an annual basis a part of the quality assurance program.	n mt Illy will ewed y's th plan it is eee vill the	08/31/2023
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 3 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BUILDING B. WING		COMPLETED 06/26/2023			
	PROVIDER OR SUPPLIER			6370 RG	DBIN RUN W		
KORIN F	RUN HEALTH CENT	EK		INDIAN	APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and pridevelop and imple preparedness poli	cies and procedures, based					
	(a) of this section, paragraph (a)(1) of communication plates section. The policy	r plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. To develop and imples preparedness policing on the emergency (a) of this section, paragraph (a)(1) communication plasection. The policing	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.					
	*[For PACE at §46 procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) c communication pla section. The police	60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 4 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BUILDING CC			COMPL	DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	limited to: Fire; eq failure; care-relate disasters likely to safety of the partic. The policies and previewed and upd. *[For ESRD Facilit and procedures.develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plate.	gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or sipants, staff, or the public. Procedures must be atted at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must					
	be reviewed and u years. These eme not limited to, fire, failures, care-relat supply interruption	rgencies include, but are equipment or power ed emergencies, water and natural disasters ne facility's geographic					
	failed to develop an preparedness policioupdated at least ann procedures must be annually in accorda This deficient practithe facility.	riew and interview, the facility d implement emergency es and procedures that were ually. The policies and reviewed and updated at least nee with 42 CFR 483.73(b). ice could affect all residents in	E 0013	1 1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. No residents were advers affected by not having the emergency preparedness plan reviewed within the most recertwelve-month period. 2. All residents are potential determined to be at risk. The emergency preparedness plan be reviewed and updated.	nt Iy	08/31/2023
	Preparedness Plan e Living Solutions Di 06/26/23 between 1	the facility's Emergency entitled "Brookdale Senior saster Manual - 2017" on 1:36 a.m. to 12:19 p.m., policies and procedures		1	3. The emergency preparedness plan will be revie annually as a part of the facility quality assurance program. A document page will be kept wit the emergency preparedness paths will be signed by the	,'s th	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 5 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155505	B. WI	NG		06/26/	2023
E 0E B			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			6370 R	OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		:4 :-	DATE
	_	I by the facility within the month period was not			administrator and dated when		
		The policies and procedures			reviewed and approved by the quality assurance program.		
		not been reviewed within the			(Exhibit A)		
	_	an initial date of 01/01/2017			4. Administrator/designee w	ill	
	-	imented updates. Based on			be responsible to monitor that		
		e of record review, the			emergency preparedness plan		
		visor agreed that the facility			reviewed on an annual basis a		
	_	gency preparedness program			part of the quality assurance		
		most recent twelve-month			program.		
	period and added th	at the facility was working on			1 3		
	-	ould be updated very soon.					
	This finding was rev	viewed with the facility					
	Administrator, the M	Maintenance Supervisor, and					
	the Team-Lead duri	ng the exit conference.					
E 0029	403.748(c), 416.54	4(c), 418.113(c),					
SS=F	441.184(c), 482.1	5(c), 483.475(c), 483.73(c),					
Bldg	484.102(c), 485.62	25(c), 485.68(c),					
	485.727(c), 485.92	20(c), 486.360(c),					
	491.12(c), 494.62(* *					
	-	ommunication Plan					
	- , , -	5.54(c), §418.113(c),					
	- , , -	0.84(c), §482.15(c),					
	- , , -	475(c), §484.102(c),					
		625(c), §485.727(c),					
		5.360(c), §491.12(c),					
	§494.62(c).						
	(c) The [facility] m	ust develop and maintain					
		paredness communication					
		with Federal, State and					
		st be reviewed and updated					
		ears [annually for LTC					
	facilities].	- ,					
		riew and interview, the facility	E 00	29	1. No residents were advers	sely	08/31/2023
	failed to develop an	d maintain an emergency			affected by not having the		
		unication plan that complies			communication plan updated		
	with Federal, State,	and local laws in accordance			within the most recent		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 6 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	ì í	JILDING	NSTRUCTION	(X3) DATE : COMPL 06/26/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	with 42 CFR 483.73 could affect all occurrences. Findings include:	B(c). This deficient practice apants.			twelve-month period. 2. All residents are potential determined to be at risk. The communication plan will be	lly	
	Preparedness Plan et Living Solutions Di 06/26/23 between 1 documentation of a or updated by the fat twelve-month period The communication reviewed within the communication plan reviewed within the date of 01/01/2017 updates. Based on in review, the Maintenthe facility has not be preparedness programecent twelve-month	on reviewed within the most in period and added that the ig on it currently and it should			reviewed and updated. 3. The communication plan be reviewed annually as a parthe facility's quality assurance program. A document page wikept with the emergency preparedness plan that will be signed by the administrator and ated when it is reviewed and approved by the quality assuration program. (Exhibit A) 4. Administrator/designee where the program is reviewed on an annual basis as a part of quality assurance program.	t of II be d ance rill the	
5 0005	Administrator, the Machine Team-Lead duri	Viewed with the facility Maintenance Supervisor, and ng the exit conference.					
E 0035 SS=C Bldg	§483.73(c)(8); §48 *[For LTC Facilitie [(c) The LTC facility maintain an emerged communication plate of the second communication plate of the	Sharing Plan with Patients 33.475(c)(8)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 7 of 52

STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) M				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL		
		155505	B. W	ING		06/26/	/2023	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	ROVIDER OR SUPPLIER			6370 R	OBIN RUN W			
ROBIN F	RUN HEALTH CENT	ΓER		INDIAN	IAPOLIS, IN 46268			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	following:]							
	*(Fam IOF/IIDa at 9	2402 475/ ₂ \.1						
	*[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an							
		redness communication						
		s with Federal, State and						
		st be reviewed and updated						
		ears. The communication						
	pian must include	all of the following:]						
	(8) A method for s	haring information from the						
		that the facility has						
		ropriate, with residents [or						
		amilies or representatives.						
		view and interview, the facility	E 0	035	1. No residents were advers	sely	08/31/2023	
	failed to ensure the	emergency preparedness		affected by not having documented		•		
		n includes a method for sharing			a method for sharing informati			
	information from th	ne emergency plan that the			from the emergency plan with			
	facility has determi	ned is appropriate with			residents, families or			
		families or representatives in			representatives.			
	accordance with 42	CFR 483.73(c)(8). This			2. All residents are potentia	lly		
	deficient practice co	ould affect all occupants.			determined to be at risk. A	•		
					documented method for sharir	ng		
	Findings include:				information from the emergen	су		
					plan with residents, families, o	r		
	Based on review of	the facility's Emergency			representatives will be reviewe	ed		
	Preparedness Plan	entitled "Brookdale Senior			and updated.			
	Living Solutions D	isaster Manual - 2017" on			3. A documented method for	r		
		1:36 a.m. to 12:19 p.m.,			sharing information from the			
	documentation of a	method for sharing			emergency plan with residents	5,		
	information from th	ne emergency plan that the			families, or representatives wi			
	facility has determi	ned is appropriate with			identified. This method will be	а		
	residents and their t	families or representatives.			part of the emergency plan. The	ne		
	Based on interview	at the time of record review,			method will consist of verbal,			
		pervisor agreed that a method			email, and direct phone calls.	The		
		tion from the emergency plan			documented method will be			
		determined is appropriate with			reviewed annually by the qual	ity		
		assurance program. (Exhibit A						
		d for review as of the time of			and B)			
this survey.				4 Administrator/designee w	/ill			

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 06/26			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Administrator, the I	viewed with the facility Maintenance Supervisor, and ing the exit conference.		be responsible to mo communication plan i on an annual basis a quality assurance pro	is reviewed s a part of the			
E 0036 SS=F Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §483. §485.68(d), §485. §485.920(d), §486 §494.62(d).	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) Testing 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 5.360(d), §491.12(d),						
	PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testir develop and main preparedness train that is based on the in paragraph (a) of assessment at passection, policies a (b) of this section, plan at paragraph training and testin	13, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at IC/FHQs at §491.12:] (d) ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years.						
	and testing. The I	s at §483.73(d):] (d) Training _TC facility must develop mergency preparedness						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 9 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BUILDII B. WING	NG	COMPI	COMPLETED 06/26/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	training and testing the emergency plate of this section, risk (a)(1) of this section at paragraph (b) of communication plate section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plan section, risk at (a)(1) of this section at paragraph (b) of communication plate section. The train must be reviewed 2 years. The ICF/II requirements for eat §483.470(i).	g program that is based on an set forth in paragraph (a) assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least 483.475(d):] Training and D must develop and gency preparedness training on that is based on the et forth in paragraph (a) of essessment at paragraph on, policies and procedures of this section, and the en at paragraph (c) of this ing and testing program and updated at least every		CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
	and patient orienta on the emergency (a) of this section,	redness training, testing ation program that is based plan set forth in paragraph risk assessment at of this section, policies and					
	procedures at para and the communio of this section. Th	agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and					
	Based on record rev	riew and interview, the facility d maintain an emergency	E 0036	 No residents were ad affected by not having the 	-	08/31/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 10 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		STREE 6370 INDIA		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ng and testing program that pdated at least annually in		and testing program reviewed within the most recent	d
		CFR 483.73(d). This deficient		twelve-month period.	
	practice could affec	* *		All residents are potential	ally
	Findings include:			determined to be at risk. The training and testing program	
	Dagad on marriagy of	the facility's Emergency		be reviewed and updated.	
		entitled "Brookdale Senior		3. The training and testing program will occur bi-annual	and
	_	saster Manual - 2017" on		be reviewed annually as a pa	
		1:36 a.m. to 12:19 p.m.,		the facility's quality assurance	
		n emergency preparedness		program. A document page v	vill be
training and testing program that was reviewed or			kept with the emergency		
	updated by the facility within the most recent			preparedness plan that will be	
	_	d was not available for review.		signed by the administrator a	
	1	sting program available had		dated when it is reviewed and	
		within the past 12 months. The		approved by the quality assu	rance
		program available has not		program. (Exhibit A)	
		in the past 12 months with an		4. Administrator/designee	
		/2017 with no further s. Based on interview at the		be responsible to monitor that	
	_	w, the Maintenance Supervisor		training and testing program reviewed on an annual basis	l l
		ity has not had its emergency		part of the quality assurance	as a
	~	am reviewed within the most		program. To ensure compliar	nce
		h period and added that the		the annual review will be add	l l
		g on it currently and it should		the quality assurance prograi	
	be updated very soc	-			
	This finding was re-	viewed with the facility			
		Maintenance Supervisor, and			
	the Team-Lead duri	ng the exit conference.			
E 0039 SS=F	441.184(d)(2), 482	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),			
Bldg	1 ' ' ' '	102(d)(2), 485.625(d)(2),			
	1 ' ' ' '	727(d)(2), 485.920(d)(2),			
	. , , ,	1.12(d)(2), 494.62(d)(2)			
	EP Testing Requir				
		18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2),			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 11 of 52

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIEI		6370 R	ADDRESS, CITY, STATE, ZIP COD OBIN RUN W IAPOLIS, IN 46268	•
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI	OBE COMPLETION
TAG	`			CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE
PREFIX TAG	REGULATORY OF \$483.475(d)(2), \$483.475(d)(2), \$485.625(d)(2), \$(2), \$491.12(d)(2)* [For ASCs at \$4* OPO, "Organizati CMHCs at \$485.5 \$491.12, and ESF (2) Testing. The [factorial community-based (A) When a community-based (A) When a community-based (B) If the [factorial exercises to the sexempt from error activation of the exercise is exempt from error community-based functional exercise actual event. (ii) Conduct an activation of the exercise actual event. (iii) Conduct an activational exercise actual exercise (i) of this section in the sexempt from error activational exercise actual event. (iii) Conduct an activational exercise (i) of this section in the sexempt from error actual exercise actual exercise actual exercise (ii) of this section in the sexempt from error actual exercise actual exercise (iii) Conduct an activation of the sexempt from error actual exercise actual exercise actual exercise actual exercise (iii) Conduct an activation of the sexempt from error actual exercise actual exercise actual exercise actual exercise (iii) Conduct an activation of the sexempt from error actual exercise ac	RECY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) 4, §494.62(d)(2). 16.54, CORFs at §485.68, 50ns" under §485.727, 520, RHCs/FQHCs at RD Facilities at §494.62]: 16.654, Correct at a standard and a standard a standard and a standard a standard and a standard	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
	(A) A second full-	scale exercise that is			
	1	or individual, facility-based			
	functional exercis				
	(B) A mock disast				
		ercise or workshop that is and includes a group			
	discussion using	- ·			
	_	emergency scenario, and a			
	•	emengency scenario, and a stements, directed			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 12 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	r í	UILDING	NSTRUCTION	(X3) DATE COMPI 06/26	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	messages, or preto challenge an er (iii) Analyze the [famintain documer exercises, and enthe [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annuate following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of this section is continued, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star	pared questions designed mergency plan. acility's] response to and natation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must at to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the gency event. Editional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a						
	1	-1	- 1				I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 13 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155505		UILDING	NSTRUCTION	COMPL 06/26	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a community-based functional exercise emergency exempt from engal full-scale community functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disassi (C) A tabletop exercise facilitator that including a narrated, emergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency's emergency is emergency to the hospice's emergency emergency.	spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise based; or hunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is lightly based or facility-based et following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based et; or ter drill; or ercise or workshop led by a ludes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared						
	*[For PRFTs at §4 §482.15(d), CAHs							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 14 of 52

PRINTED: 07/18/2023 FORM APPROVED

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION DESTRICTATION NUMBER 155505 NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER NINAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP COD 6372 ROBIN RUN W INDIANAPOLIS, IN 46268 STREET ADDRESS, CITY, STATE, ZIP COD 6372 ROBIN RUN W INDIANAPOLIS, IN 46268 STREET ADDRESS, CITY, STATE, ZIP COD 6372 ROBIN RUN W INDIANAPOLIS, IN 46268 (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 (ii) View a community-based, or (iii) Conduct an annual individual, facility-based functional exercise, or (iii) Conduct an annual individual, facility-based functional exercise, or (iii) Conduct an annual individual, facility-based functional exercise following the onset 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. (iii) 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 functional exercise (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 genanio, 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. "Fer PACE at \$460.84(d):]	CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER STRIPT ADDRESS, CITY, STATIL, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION (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 (g) if the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency plan, the [facility] is exempt from engaging in its next required activation of the emergency plan, the facility-based functional exercise following the onset of the emergency plan, the facility-based functional exercise following the onset of the emergency plan, the facility-based functional exercise following the onset of the emergency plan, the facility-based functional exercise following the onset of the emergency plan, the 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 community based or inclividual, a facility-based functional exercise; or (g) 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 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 yeans an eneeded.	STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ROBIN RUN HEALTH CENTER (X4)D SUMMARY STATEMENT OF DEFICIENCIE (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises that is community-based; or (A) When a community-based exercise that is community-based or individual, facility-based functional exercise; or (B) if the [PRTF, Hospital, CAH] experiences an actual natural or man-made 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.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
ROBIN RUN HEALTH CENTER (X9 ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION (2) Testing. The [PRFT, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRFT, Hospital, CAH] must do the following: (1) Participate in an annual full-scale exercise that is community-based dunctional exercise or a datal natural or man-made emergency plan, the [facility-based functional exercise or an actual natural or man-made emergency plan, the facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or of the mergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise or or individual, a facility-based functional exercise or individual, a facility-based functional			155505	B. WING		06/26	/2023
ROBIN RUN HEALTH CENTER (X9 ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION (2) Testing. The [PRFT, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRFT, Hospital, CAH] must do the following: (1) Participate in an annual full-scale exercise that is community-based dunctional exercise or a datal natural or man-made emergency plan, the [facility-based functional exercise or an actual natural or man-made emergency plan, the facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or of the mergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an [additional] annual exercise or of individual, a facility-based functional exercise or or individual, a facility-based functional exercise or individual, a facility-based functional				STREET	ADDRESS CITY STATE ZIP COD		
INDIANAPOLIS, IN 46268 INDIANAPOLIS, IN 46	NAME OF	PROVIDER OR SUPPLIEI	R				
PRIETX TAG REGULATORY OF ILE DENTIFYING INFORMATION REGULATORY OF ILE DENTIFYING INFORMATION DATE COMPLETION DATE COMPLETI	ROBIN F	RUN HEALTH CEN	TER				
TAG REGITATORY OR ISC IDENTEFING INFORMATION (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 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 or more problem or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or individual, a facility-based or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or more problem or individual, a facility-based or individual, a fac	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECT			(X5)
(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 ffacility 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 yeants and revise the [facility's] emergency plan, as needed.	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
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.	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
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.		(2) Testing. The [I	PRTF, Hospital, CAH] must				
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.		conduct exercises	s to test the emergency				
(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.		plan twice per yea	ar. The [PRTF, Hospital,				
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.		-	_				
(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.							
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.		1					
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.		(A) When a comm	nunity-based exercise is not				
(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 plan, as needed.							
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 plan, as needed.		1					
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.							
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.							
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 plan, as needed.		1					
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.							
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.		1					
(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.			-				
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.		_					
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.		, ,	= =				
(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.			-				
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.			_				
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.		1 ' '					
(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.		1					
(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.		1					
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.		` '					
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.		` '	•				
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.							
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.							
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.		1	- ·				
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.							
(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.			·				
and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.		_	- · ·				
tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.		1 ' '					
and revise the [facility's] emergency plan, as needed.							
needed.		· ·					
		_	omy of emergency plan, as				
*[For PACF at \$460.84(d):]		neeueu.					
		*IFor PACE at 8/1	60 84(d)·1				
(2) Testing. The PACE organization must			` / -				

FORM CMS-2567(02-99) Previous Versions Obsolete

conduct exercises to test the emergency plan at least annually. The PACE

Event ID:

JOWT21

Facility ID: 001156

If continuation sheet

Page 15 of 52

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIEI		•	6370 RG	ODDRESS, CITY, STATE, ZIP COD OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, REFERENCED TO THE APPROPRI	ΔTF	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	organization must (i) Participate in a that is community (A) When a comm accessible, condu- facility-based fund (B) If the PACE ex- or man-made emeractivation of the exist exempt from en- full-scale community-based fund onset of the emeractivation of the emeractivation of the emeractivation of the exempt from en- full-scale community-based functional exercis- of this section is of the section is of this secti	R LSC IDENTIFYING INFORMATION In do the following: an annual full-scale exercise abased; or aunity-based exercise is not act an annual individual, ational exercise; or aperiences an actual natural argency that requires argency plan, the PACE agaging in its next required aity based or individual, ational exercise following the agency event. an additional exercise every ander paragraph (d)(2)(i) anducted that may include, attended that the following: ascale exercise that is ard includes a group a narrated, and includes a gr			CROSS-REFERENCED TO THE APPROPRI	ATE	
		announced staff drills using ocedures. The [LTC facility, he following:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 16 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155505	B. W	ING		06/26/	2023	
				CTREET	DDDECC CITY CTATE ZID COD			
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD			
DODIN D					OBIN RUN W			
ROBIN R	RUN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268			
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.2	DATE	
	(i) Participate in a	ın annual full-scale exercise					•	
	that is community	-based; or						
	(A) When a comm	nunity-based exercise is not						
	accessible, condu	ct an annual individual,						
	facility-based fund	tional exercise.						
	(B) If the [LTC fac	ility] facility experiences an						
	actual natural or n	nan-made emergency that						
	requires activation	of the emergency plan, the						
	LTC facility is exe	mpt from engaging its next						
	required a full-sca	le community-based or						
	individual, facility-	based functional exercise						
	following the onse	t of the emergency event.						
	(ii) Conduct an ac	dditional 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 e	exercise; or						
	(B) A mock disast	ter drill; or						
	(C) A tabletop ex	ercise or workshop that is						
	led by a facilitator	includes a group						
	discussion, using	a narrated,						
	clinically-relevant	emergency scenario, and a						
	set of problem sta	tements, directed						
	messages, or prep	pared questions designed						
	to challenge an er	- · · ·						
	_ ` '	_TC facility] facility's						
	response to and n	naintain documentation of						
	-	exercises, and emergency						
		the [LTC facility] facility's						
	emergency plan, a	as needed.						
	*[For ICF/IIDs at §	. , , =						
	. ,	CF/IID must conduct						
		he emergency plan at least						
		e ICF/IID must do the						
	following:							
		n annual full-scale exercise						
	that is community-							
	(A) When a comm	nunity-based exercise is not						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 17 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155505		UILDING	nstruction 	COMP	LETED 5/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	accessible, conduracility-based functions of the entire sexempt from entire full-scale community-based functions on the entire community-based facility-based functions of the emerging (ii) Conduct an additional following: (A) A second full-scommunity-based facility-based functions of the emerging (ii) Conduct an additional facility-based functions of the emerging (iii) A second full-scommunity-based facility-based functions of the exemption of	ct an annual individual, tional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID gaging in its next required ity-based or individual, tional exercise following the gency event. ditional annual exercise out is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or roise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. eF/IID's response to and attation of all drills, tabletop mergency events, and revise gency plan, as needed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 18 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155505	r í	UILDING	NSTRUCTION	COMPL 06/26	ETED
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD OBIN RUN W		
ROBIN F	RUN HEALTH CENT	TER			APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ade emergency that requires		IAG			DATE
		mergency plan, the HHA is					
		aging in its next required					
	full-scale commun	nity-based or individual,					
	facility based fund	tional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an ad	ditional exercise every 2					
	1	e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
	The state of the s	limited to the following:					
		full-scale exercise that is					
	community-based						
	1	tional exercise; or isaster drill; or					
	` '	exercise or workshop that					
		or and includes a group					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
	-	emergency scenario, and a					
	set of problem sta						
	•	pared questions designed					
	to challenge an er						
	_	HA's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48						
	` ' ' '	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	S .					
		er-based, tabletop exercise					
	· ·	ast annually. A tabletop					
	1	a facilitator and includes a					
		using a narrated, clinically					
	_	cy scenario, and a set of its, directed messages, or					
	l •	ns, directed messages, or ns designed to challenge an					
	1	f the OPO experiences an					
		nan-made emergency that					
	1		1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 19 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2023			
	F PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	X (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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	OPO is exempt for required testing e of the emergency (ii) Analyze the Omaintain documer exercises, and enthe [RNHCI's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCI must doto the (i) Conduct a papart least annually. It is group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain documer exercises, and enthe RNHCI's eme Based on record regalled to conduct explan at least twice punannounced staff procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based function is community-based function in the LTC facility or man-made emergency potential in the LTC facility or man-made emergency potential in the late of the	PO's response to and notation of all tabletop hergency events, and revise OPO's] emergency plan, as a 3.748]: e RNHCI must conduct he emergency plan. The her following: er-based, tabletop exercise a led by a facilitator, using a development of problem statements, as, or prepared questions enge an emergency plan. NHCI's response to and notation of all tabletop hergency events, and revise regency plan, as needed. When we have to extend the emergency plan as needed. When an interview, the facility hercises to test the emergency ber year, including drills using the emergency of facility must do the annual full-scale exercise that drives and individual,	E 0039	1. No residents were adves affected by not having a sect full-scale exercise that is community based or an individual facility based functional exercian mock disaster drill, or a tabletop exercise or workshot that is led by a facilitator that includes a group discussion, a narrated, clinically relevant emergency scenario, and a sproblem statements, directed messages, or prepared quest designed to challenge the emergency plan.	ond ridual, cise, op using set of			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 20 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP COD OBIN RUN W IAPOLIS, IN 46268		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	1	or individual, facility-based			2. All residents are potentia	lly	
	the onset of the acti	l exercise for 1 year following			determined to be at risk. The		
		itional exercise that may			facility will conduct a second		
	, ,	imited to the following:			full-scale exercise that is	dual	
	a. A second full-sca				community based or an individual facility based functional exerci		
		or an individual, facility-based			a mock disaster drill, or a	SE,	
	functional exercise.	_			tabletop exercise or workshop	•	
	b. A mock disaster				that is led by a facilitator that	,	
		ise or workshop that is led by a			includes a group discussion, u	ısina	
	_	ides a group discussion, using			a narrated, clinically relevant	ion ig	
		y relevant emergency scenario,			emergency scenario, and a se	et of	
		n statements, directed			problem statements, directed		
	_	red questions designed to			messages, or prepared questi	ons	
	challenge an emerg	ency plan.			designed to challenge the		
	(iii) Analyze the L7	ΓC facility's response to and			emergency plan.		
	maintain document	ation of all drills, tabletop			3. A second full scale exerc	ise	
	exercises, and emer	rgency events, and revise the			will be conducted on an annua	al	
	LTC facility's emer	gency plan, as needed in			basis as a part of the emerger	псу	
		CFR 483.73(d)(2). This			preparedness plan. (Exhibit C)	
	deficient practice co	ould affect all occupants.			4. The administrator/design		
	Findings include:				will be responsible for monitor second full scale exercise is conducted on an annual basis		
	Based on review of	the facility's Emergency			a part of the emergency	เลอ	
		entitled "Brookdale Senior			preparedness plan and the qu	ality	
	_	isaster Manual - 2017" on			assurance program. To ensure	•	
	_	1:36 a.m. to 12:19 p.m.,			compliance, the exercises will		
		full-scale drill that was			added to the quality assurance		
	community based v	vas available for review but the			program.		
		rovide documentation of: a			' '		
	second full-scale ex						
	community-based of	or an individual, facility-based					
		, a mock disaster drill, or a					
		workshop that is led by a					
		ides a group discussion, using					
		y relevant emergency scenario,	- [
	_	n statements, directed					
		red questions designed to					
	challenge an emerg	ency plan. Based on interview					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 21 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		JILDING	NSTRUCTION	COMPL 06/26/	ETED	
	PROVIDER OR SUPPLIER		6370 RC	DDRESS, CITY, STATE, ZIP COD DBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
E 0041 SS=F Bldg	at the time of record Supervisor agreed the exercise could not be time of this survey. This finding was reven Administrator, the Mathematical the Team-Lead during the Team-Lead	review, the Maintenance nat another emergency drill or e located for review as of the viewed with the facility Maintenance Supervisor, and ng the exit conference. (e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new	TAG	DEFICIENCY)		DATE
	structure or buildir	ig is renovated.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 22 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155505		JILDING	NSTRUCTION	COMPL 06/26/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	482.15(e)(2), §483 Emergency gener. The [hospital, CAI- implement the em- inspection, testing requirements foun Facilities Code, NI Code. 482.15(e)(3), §483 Emergency gener. and LTC facilities] source to power e- have a plan for ho	ator inspection and testing. Hand LTC facility] must ergency power system and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must by it will keep emergency perational during the		TAG	DEFICIENCY		DATE	
	§483.73(g), and C The standards inc this section are ap reference by the D Federal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resour Boulevard, Baltime Archives and Reco (NARA). For information this material at NA go to: http://www.archive _of_federal_regular	s it evacuates. §482.15(h), LTC at EAHs §485.625(g):] corporated by reference in corporated by reference in corporated for incorporation by Director of the Office of the in accordance with 5 U.S.C. It part 51. You may obtain the sources listed below. It copy at the CMS Urce Center, 7500 Security ore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or Pes.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a						
	document in the F announce the cha	ederal Register to nges. Protection Association, 1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 23 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2023				
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
TAG	Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issu (ii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NI 22, 2013.	9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	TAG	DEFICIENCY	DATE			
	. ,	Standard for Emergency and ystems, 2010 edition,						
	•	chapter 7, issued August 6,						
	Based on record red failed to implement inspection, testing, found in the Health 110, and Life Safet	view and interview, the facility t the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could	E 0041	 No residents were adversaffected by not having the were generator inspection documer an annual fuel quality test, and annual load-bank test. All residents are potential determined to be at risk. The facility will document that a weekly generator inspection, a 	ekly nts, d an			
	Based on record re-	view of the facility maintenance rgency generator on 06/26/23		annual fuel quality test, and a annual load-bank test occurs.	n			
	records for the eme	rgency generator on 00/20/23		The maintenance director	u wiii			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 24 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ROBIN RUN W	
ROBIN R	RUN HEALTH CENT	ER		NAPOLIS, IN 46268	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE
	at 11:08 a.m., the fo	y generator testing document		document weekly generator inspections, an annual fuel qua	slity
		erator - under load) for the		test, and an annual load-bank	•
		3 could be provided for review.		occurs. (Exhibit D)	lesi
	-	rator inspection documents		4. Administrator/designee w	au
	could be provided f	-		be responsible to monitor	""
	_	uality test for the facility		documentation that a weekly	
		be provided for review.		generator inspection, an annua	al
		oank test could not be		fuel quality test, and an annual	
	provided for review			load-bank test occurs and repo	
	Based on an intervi	ew at the time of record review,		to the quality assurance	
	the Maintenance Supervisor advised that the			committee.	
		ce 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 rec	ords and testing documents			
	would not be availa	ble for review for the current			
	survey.				
	This finding was re	viewed with the facility			
	_	Maintenance Supervisor, and			
		ng the exit conference.			
K 0000					
Bldg. 01					
	A Life Safety Code	Recertification and State	K 0000	Please accept the following pla	an
	Licensure Survey w	as conducted by the Indiana		of correction as credible evider	nce
	Department of Heal	th in accordance with 42 CFR		of compliance to the deficienci	es
	483.90(a).			cited during the Life Safety	
				Survey at Robin Run Village.	
	Survey Date: 06/26	5/23		Hopefully, you will find our	
				remedies to be both sufficient.	
	Facility Number: 0			and thoroughly explained.	
	Provider Number:				
	AIM Number: 100	453350		The Plan of Correction is not to	
				be.	
	-	Code survey, Robin Run		construed as an admission of o	
		found not in compliance with		agreement with the findings an	
	Requirements for P	articipation in	1	conclusions in the Statement of	of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 25 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPLETED	
		155505	B. WING	G		06/26/	2023
				CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DODIN D	LINI LIE AL TIL OFNI	TED			OBIN RUN W		
L KORIN K	UN HEALTH CEN	IER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Medicare/Medicaio	d, 42 CFR Subpart 483.90(a),			Deficiencies, or any related		
	Life Safety from Fi	ire and the 2012 Edition of the			sanction or fine.		
	-	ection Association (NFPA) 101,					
		LSC), Chapter 19, Existing			We are requesting Paper.		
		vancies and 410 IAC 16.2.			Compliance Review with the		
	Trouver care coup				submission of these remedies.		
	This one-story faci	lity was determined to be of			If after reviewing the plan of	•	
		truction and was fully			correction you have any.		
		cility has a fire alarm system				oto	
	•	on in the corridors and in all			questions, please do not hesita to contact us.	al e .	
					to contact us.		
	-	orridor. The facility has smoke					
		ed to the nurses call system in					
	_	g rooms. The facility has a					
		had a census of 51 at the time					
	of this survey.						
	All areas where res	sidents have customary access					
	were sprinklered. T	The facility has one detached					
	maintenance buildi	ng which was not sprinklered.					
	Quality Review con	mpleted on 06/30/23					
K 0211	NFPA 101						
SS=E	Means of Egress	- General					
Bldg. 01	Means of Egress						
	_	ays, corridors, exit					
		ocations, and accesses are					
	_	th Chapter 7, and the means					
		nuously maintained free of					
		o full use in case of					
		ss modified by 18/19.2.2					
	through 18/19.2.1	-					
	18.2.1, 19.2.1, 7.						
		on and interview, the facility	K 021	1	No resident was adversel	V	08/31/2023
		he means of egress free from	K 021	1 1	affected by temporarily having	-	08/31/2023
		f 8 corridors within the facility.				а	
		ates, projections into the			laundry cart in the hallway.	lb.	
		ll be permitted for wheeled			2. All residents are potential	ıy	
	_	ed that all of the following			determined to be at risk by	ort	
		_			temporarily having a laundry c	arı	
	conditions are met:				in the hallway. Nursing and		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 26 of 52

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155505	B. W	ING		06/26/	2023
				CED FEET A	A PROPERTY OF A THE STAN COR		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DODIN D					OBIN RUN W		
KOBIN K	RUN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINED'S BLAN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	-	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
		uipment does not reduce the			laundry staffing will be in-servi	ced	
		corridor width to less than 60			about not leaving laundry carts		
	in. (1525 mm.)				the hallway.		
		occupancy fire safety plan and			The Laundry department	will	
		ldress the relocation of the			in-service all their staff about r		
		during a fire or similar			leaving laundry carts in the		
	emergency.	<u> </u>			hallways. Each employee will l	nave	
		uipment is limited to the			to sign that they have been		
	following:				in-serviced. (Exhibit E) Also,		
	i. Equipment in use	and carts in use			laundry supervisor will inspect	on	
		ncy equipment not in use			a weekly basis and is on		
	iii. Patient lift and t				checklist. (Exhibit F)		
		c) states, wheeled equipment			4. Administrator/designee w	ill	
		lude food service carts,			monitor it on a weekly basis ar		
		medication carts, isolation			report to the quality assurance		
		ems. Isolation carts should be			committee.		
		ridor only where patients			committee.		
	1 ~	ecautions. Unattended wheeled					
		er similar wheeled emergency					
		nitted to be located in the					
		in use," because they need to					
		essible during an emergency.					
		e" in not the same as "in					
		not permitted to be open to					
		it meets unless it meets one of					
		nitted in 19.3.6.1 and it is not a					
	hazardous area.	iii 17.0.0.1 und it is not a					
		ice could affect approximately					
	16 residents, 4 staff						
	10 residents, 4 stari	and 2 visitors.					
	Findings include:						
	rindings include.						
	Based on observation	ons made with the					
		visor on 06/26/23 at 1:10 p.m.					
	_	cility, there was a cart					
		• •					
		found shirts, slacks, and a					
		of clothing items in the corridor					
		nurse's station. Based on					
		Maintenance Supervisor at the					
	time of the observat	tion, he acknowledged the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 27 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155505	B. W	B. WING 06/26/202			2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	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) NFPA 101 Discharge from Exits		K 0.	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	sely S	
		05-38. This deficient practice y as 14 residents, 4 staff, and 2			room #16 and #17.	llv.	
	visitors in the comp				All residents are potential at risk for the sidewalk that is eroded and uneven.	ıy	
	Findings include:				The Maintenance Directo will have the referenced portio		
	with the Maintenand 1:28 p.m., the exit d rooms #16 and #17 street was a 60-inch eroded and uneven. time of the observat Supervisor agreed the	ons during a tour of the facility ce Supervisor, on 06/26/23 at lischarge nearest to resident was concrete. Halfway to the strip of concrete that was Based on interview at the cion, the Maintenance that the walkway was not a ther surface and was in need			the sidewalk replaced. The Maintenance Director will inspend of sidewalks leaving the facility make sure that they are in good repair. The Maintenance Direct will include this on the monthly checklist. 4. The Administrator/design will review on a monthly basis, the next 6 months, and report	ect y to od ttor , ee for	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 28 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155505	B. WI	NG		06/26/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ROBIN R	UN HEALTH CENT	ER			OBIN RUN W APOLIS, IN 46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY) 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 committ	эе.	
K 0221	NEDA 404						
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas						
5 -		are protected by a fire					
	barrier having 1-ho	our fire resistance rating					
	(with 3/4 hour fire rated doors) or an						
	automatic fire extinguishing system in						
		i.7.1 or 19.3.5.9. When the ic fire extinguishing system					
		e areas shall be separated					
		by smoke resisting					
	-	rs in accordance with 8.4.					
	Doors shall be sel	f-closing or					
	_	and permitted to have					
		pplied protective plates that					
		inches from the bottom of					
	the door.	and zone locations of					
		hat are deficient in					
	REMARKS.	nat are denoted in					
	19.3.2.1, 19.3.5.9						
	Aron	Automotic Carialdor					
	Area Separation	Automatic Sprinkler N/A					
	-	-Fired Heater Rooms					
		er than 100 square feet)					
		ance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection						
	(exceeding 64 gall	•					
		orage Rooms/Spaces					
	(over 50 square fe	et)		l			I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 29 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023		
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP COD OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	Hazard - see K32 Based on observation failed to ensure 1 or was separated by a construction. NFPA gas storage and administrator, the I down the Team-Lead during the seed on observation of the Seed on the Seed o	on and interview, the facility of 1 oxygen transferring room 1-hour fire resistive a 101, 18.3.2.4 states: Medical ministration areas shall be ance with NFPA 99. NFPA 99, ransfilling to liquid oxygen base or to liquid oxygen portable a designated area separated a facility wherein patients are or treated by a fire barrier of 1 construction. This deficient at as many as 14 residents, 4 ons during a tour of the facility ce Supervisor, on 06/26/23 at ar on the oxygen transfilling self-close and latch into the attempts. This was are Maintenance Supervisor at arvation who added that he ar closer adjusted as soon as	K 0	321	1. No residents were adveraffected by the door on the transfilling room failed to full self-close and latch into the 2. All residents are potent to be determined at risk for door on the oxygen transfilling room not fully close and latch the frame. The self-closing will be adjusted so that whe closes and latch into the framation 3. The maintenance directing inspect the oxygen transfilling room on a weekly basis. The weekly checklist will be updeted include an inspection of the door. (Exhibit H) 4. The administrator/designal review on a monthly base the next 6 months to ensure compliance, and report to the quality assurance committee.	oxygen ly frame. tially the ng ch into door n it me. ctor will ng e ated his gnee sis, for	08/31/2023
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipme						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 30 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIEF		6370 F	ADDRESS, CITY, STATE, ZIP COD ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accordance in the cooking in accordance in the cooking facilities in the cooking facilities with 30 or fewer productions under a Cooking facilities with 30 or fewer productions under a Cooking facilities in the cooking semiannually. NFP ventilation Control Commercial Cooking facilities in the cooking fa	in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 19.9.2.3, TIA 12-2 19.9.2.3, TIA 12-2 19.9.2.1 Edition, Standard for and Fire Protection of and Operations, Section 11.4 19.9.2.1 Edition of 19.9 19.9.2.1 Edition of 19.9 19.9.2.2 Edition of 19.9 19.9.2.3 Edition of 19.9 19.9.	K 0324	1. No residents were adver affected by not documenting a semi-annual kitchen exhaust system inspection for twelve months. 2. All residents are to be determined to be at risk of no documenting semi-annual kitchexhaust system inspection for twelve months. 3. The Culinary Director wiresponsible for ensuring kitch exhaust system inspection semi-annually. The Facility direction have the exhaust system inspected (Exhibit I) 4. The administrator/design will review on a monthly basis ensure compliance, and repo	t chen r II be en d

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 31 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155505	B. W	NG		06/26/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OBIN RUN W		
ROBIN F	RUN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CTION SHOULD BE TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	fied person(s) acceptable to the			the quality assurance committe	ee.	
		risdiction. Hoods, grease					
	removal devices, fans, ducts, and other						
		be cleaned to remove					
		ninants prior to surfaces					
		ontaminated with grease or					
		ne exhaust system is cleaned, it					
		with powder or other					
		n exhaust cleaning service is					
		howing the name of the					
		the name of the person					
	` -	k, and the date of inspection or					
		aintained on the premises. This vould affect as many as 6					
	residents, 8 staff, ar						
	residents, o starr, ar	id 4 visitors.					
	Findings include:						
		view on 06/26/23 at 11:06 a.m.					
	with the Maintenan	ce Supervisor, the					
		emiannual kitchen exhaust					
		for the last twelve months was					
		view. Based on observations					
		of the facility, the kitchen had					
		ood system in use. The lack of					
		al overhead hood inspection in					
		ified by the Maintenance					
	_	me of record review who stated					
		the testing scheduled as soon					
	as he could.						
	This finding was re	viewed with the facility					
		Maintenance Supervisor, and					
		ing the exit conference.					
	lie Team Boad dur	and this contended.					
	3.1-19(b)						
	2) Based on record	review, observation, and					
		ty failed to ensure 1 of 1					
		ssion system was inspected					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 32 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		ľ í	JILDING	01	COMPL 06/26/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
ROBIN R	UN HEALTH CENT	ER	INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Ventilation Control Commercial Cooking states Maintenance of systems and listed effects and listed to extinguish a devices. Hood exhaus ducts shall be made and certified person having jurisdiction a deficient practice were residents, 8 staff, and Findings include: Based on record revewith the Maintenance of semiannual kitchet twelve months was on observations made there was a fire supplied the kitchen. The lack semiannual overhead kitchen was verified Supervisor at the time that he would have that he would have that he could. 3.1-19(b)	A 96, 2011 Edition, Standard for and Fire Protection of and Fire Protection of and Operations, Section 11.2.1 of the fire-extinguishing shaust hoods containing a vated water system that is a fire in the grease removal ust plenums, and the exhaust by properly trained, qualified, (s) acceptable to the authority at lease every six months. This ould affect as many as 6 dd 4 visitors. The Supervisor, documentation en exhaust system inspection not available for review. Based de during a tour of the facility, pression system installed in k of a current annual or d hood inspection in the l by the Maintenance ne of record review who stated the testing scheduled as soon					
K 0345 SS=F Bldg. 01	in accordance with complying with the	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 33 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155505	B. WI	NG		06/26/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DODIN D	LINI LICAL TLI OCNIT	TED			OBIN RUN W APOLIS, IN 46268		
KUDIN K	UN HEALTH CENT	ER		INDIAN	APOLIS, IN 40200		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	National Fire Alarr	n and Signaling Code.					
	Records of system	n acceptance, maintenance					
	and testing are rea	adily available.					
	9.6.1.3, 9.6.1.5, N	FPA 70, NFPA 72					
	Based on record rev	view and interview, the facility	K 0.	345	1. No residents were advers	sely	08/31/2023
	failed to ensure 1 of	f 1 fire alarm systems was			affected by not documenting a		
	maintained in accor	dance with 9.6.1.3. LSC 9.6.1.3			smoke detector sensitivity test		
	requires a fire alarm	system to be installed, tested,			every other alternate year.		
	and maintained in a	ccordance with NFPA 70,			2. All residents are potentia	lly	
	National Electrical	Code and NFPA 72, National			determined to be at risk for no	t	
	Fire Alarm Code. N	IFPA 72, 14.4.5 states unless			documenting a smoke detecto	r	
	_	by other sections of this			sensitivity test every alternate		
		be performed in accordance			year.		
		n Table 14.4.5, or more often if			3. The Maintenance Directo	r	
		nority having jurisdiction.			will be responsible for ensuring	-	
		1 states sensitivity shall be			that a smoke detector sensitiv	ity	
	-	ear after installation. NFPA 72,			test occurs before or on date		
		sitivity shall be checked every			certain. The Maintenance Director		
	-	after unless otherwise			will be responsible for ongoing	l	
		iance with 14.4.5.3.3. This			compliance.		
	deficient practice co	ould affect all occupants.			4. The Administrator/design		
					will review annually and report		
	Findings include:				the quality assurance committ	ee.	
		view with the Maintenance					
	_	6/23 at 11:03 a.m., no					
		smoke detector sensitivity					
		or review. Based on interview					
		d review, the Maintenance					
	•	edged the aforementioned					
		I that he would get the testing					
	scheduled as soon a	s he could.					
	TT1 : C' 1:	1 1 24 4 6 22					
	_	viewed with the facility					
		Maintenance Supervisor, and					
	me ream-Lead duri	ng the exit conference.]
	2 1 10(%)						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JOWT21 Facility ID: 001156 If continuation sheet Page 34 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER			COMPL	ETED	
		155505	B. WI	NG	06/26/2023		
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER	INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353	NFPA 101						
SS=F	•	- Maintenance and Testing					
Bldg. 01	•	- Maintenance and Testing					
	Automatic sprinkle	er and standpipe systems					
	are inspected, test	ted, and maintained in					
	accordance with N	IFPA 25, Standard for the					
	Inspection, Testing	g, and Maintaining of					
		Protection Systems.					
	Records of system	n design, maintenance,					
	inspection and tes	ting are maintained in a					
	secure location an	id readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAR	RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,						
		review and interview, the	K 0	353	1. No residents were advers	ely	08/31/2023
	facility failed to doc	cument 1 of 1 sprinkler system			affected by not having all		
	inspections in accor	dance with NFPA 25. NFPA			inspections, tests, and		
	25, Standard for the	Inspection, Testing, and			maintenance of the system an	d its	
		ter-Based Fire Protection			components and shall be mad		
	Systems, 2011 Editi	ion, Section 5.2.4.1 states			available to the authority havin		
	gauges on wet pipe	sprinkler systems shall be			jurisdiction upon request. No	Ĭ	
	inspected monthly to	o ensure that they are in good			residents were adversely affect	ted	
	condition and that n	ormal water supply pressure			by damaged ceiling tiles and		
	is being maintained.	. Section 5.2.4.2 states gauges			ceiling tiles that have been		
	on dry pipe sprinkle	er systems shall be inspected			removed to make repairs for le	aks	
	weekly to ensure that	at normal air and water			that had just occurred.		
	pressures are being	maintained. Section 5.1.2			2. All residents are potential	ly	
	states valves and fir	e department connections			determined to be at risk for not	t	
	shall be inspected, to	ested, and maintained in			having all inspections, tests, a	nd	
	accordance with Chapter 13. Section 13.1.1.2			maintenance of the system an			
	states Table 13.1.1.2	2 shall be utilized for			components and shall be mad		
	inspection, testing a	and maintenance of valves,			available to the authority havin		
	valve components a	nd trim. Section 4.3.1 states	1		jurisdiction upon request. All		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 35 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		6370 R	ADDRESS, CITY, STATE, ZIP COD ROBIN RUN W NAPOLIS, IN 46268	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRODERIC	O BE COMPLETION
TAG	records shall be may and maintenance of components and sha authority having jur deficient practice of and visitors within the same of the most record reves supervisor on 06/20 documentation coul weekly dry sprinkle documentation for 52-week period was Monthly wet sprink documentation for 112-month period was In addition, monthly all sprinkler system of the most recent 1 available for review time of record review time of record review acknowledged sprint valve inspection do aforementioned we not available for review to the Team-Lead during 3.1-19(b) 2) Based on observe failed to maintain the smoke compartment Section 3.3.5.4 deficontinuous ceiling for the section of the same of the section of the same of the section of the same of the section of	all be made available to the risdiction upon request. This build affect all residents, staff, the facility. The facility. The facility of the maintenance of the facility of the facility. The facility of	TAG	residents are to be determ risk for having damaged or tiles and ceiling tiles that he been removed to make repleaks that have just occurr 3. The maintenance dire be responsible for ensuring inspections, tests, and maintenance of the system components occur and are available to the authority high jurisdiction. All ceiling tiles are damaged or missing we repaired or replaced on or or the date certain. The Maintenance Director will into a weekly basis. (Exhibit 4. The administrator/des will review on a monthly basix months and report to the quality assurance program.	eiling eave pairs for ed. ector will g that all n and its eaving that vill be before inspect t K) signee easis for

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 36 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155505	A. BU B. WI		01	06/26	
		100000	ъ. W.	_		00/20/	2020
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ΓER			APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ses around the sprinkler and					
	_	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 ty						
		ice could affect approximately					
	_	loyees, and 2 visitors.					
	_	• /					
	Findings include: Based on observations made during a tour of the facility with the Maintenance Supervisor on						
		0 p.m. to 2:40 p.m., the following					
	was noted:						
		ng resident rooms #30 through					
	-	or missing ceiling tiles					
	throughout the corr						
		ing resident rooms #1 through					
	-	or missing ceiling tiles					
	throughout the corr	ng resident rooms #20 through					
		or missing ceiling tiles					
	throughout the corr						
		ng resident rooms #20 through					
		or missing ceiling tiles					
	throughout the corr						
		ed missing, wet, or sagging					
		l acknowledged by the					
	Maintenance Super	<u> </u>					
	_	dded that they were currently					
	having humidity iss	sues and they were aware and					
	taking care of the p	roblem as fast as they could.					
	This finding was re	viewed with the facility					
	Administrator, the	Maintenance Supervisor, and					
	the Team-Lead dur	ing the exit conference.					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 37 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	UILDING	nstruction 01	(X3) DATE COMPL 06/26	ETED
	PROVIDER OR SUPPLIER		6370 RG	NDDRESS, CITY, STATE, ZIP COD OBIN RUN W APOLIS, IN 46268		
			 1			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0363	NFPA 101		1110			Bille
SS=E	Corridor - Doors					
Bldg. 01	Corridor - Doors					
Diag. 01	_	corridor openings in other				
		losures of vertical openings,				
	· ·	s areas resist the passage				
		made of 1 3/4 inch				
		wood or other material				
		ng fire for at least 20				
	1	fully sprinklered smoke				
		only required to resist the				
		e. Corridor doors and doors				
	to rooms containir					
		rials have positive latching				
		atches are prohibited by				
		hese requirements do not				
	apply to auxiliary	spaces that do not contain				
	flammable or com	bustible material.				
	Clearance betwee	en bottom of door and floor				
	covering is not ex	ceeding 1 inch. Powered				
	doors complying v	vith 7.2.1.9 are permissible				
	if provided with a	device capable of keeping				
	the door closed w	hen a force of 5 lbf is				
	applied. There is	no impediment to the				
	closing of the doo	rs. Hold open devices that				
	release when the	door is pushed or pulled are				
	permitted. Nonrate	ed protective plates of				
	1	re permitted. Dutch doors				
		6 are permitted. Door				
		beled and made of steel or				
		compliance with 8.3,				
	unless the smoke					
	1 -	fire window assemblies are				
	1	n sprinklered compartments				
		ctions in area or fire				
	I -	s or frames in window				
	assemblies.					
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 38 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155505	B. Wl	NG		06/26	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	FR			NAPOLIS, IN 46268		
	1				52.6, 152.65		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
		(S details of doors such as					
		ngs, automatics closing					
	devices, etc.		17.0	2.62	A No wasidanta wana adwan	1	00/21/2022
		on and interview, the facility	K 0	363	1. No residents were advers	-	08/31/2023
		f 44 sets of resident room			affected by not having 1 of 44	sets	
	doors to the corridor would close completely and latch into the door frame. This deficient practice				of resident room doors to the	toly.	
		imately 14 residents, 4 staff,			corridor that would not comple	•	
	and 2 visitors.	imatery 14 residents, 4 starr,			close and latch into door frame 2. All residents are potentia		
	and 2 visitors.				All residents are potentia at risk for not having residents	-	
	Findings include:				room doors to the corridor not		
	Based on observations made with the				completely close and latch into		
					the door frame.	,	
Maintenance Supervisor on 06/26/23 at 1:16 p.m.,				3. The maintenance			
	_	resident room # 21 failed to			director/designee will repair th	۵	
		the frame. Based on interview			referenced door either on or b		
		vations, the Maintenance			date certain. The maintenance		
		ledged the aforementioned			director will inspect all doors of		
		adding that he would have it			monthly basis to ensure doors		
	looked at immediate				that they completely close and		
		,			latch into the door frame. (Exh		
	This finding was re	viewed with the facility			(H)		
	_	Maintenance Supervisor, and			4. The administrator/design	ee	
		ing the exit conference.			will review on a monthly basis		
					six months and report to the		
	3.1-19(b)				quality assurance program.		
			İ				
K 0374	NFPA 101						
SS=E	Subdivision of Bui	lding Spaces - Smoke					
Bldg. 01	Barrie						
	Subdivision of Bui	lding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
		arriers are 1-3/4-inch thick					
	solid bonded woo	d-core doors or of					
		esists fire for 20 minutes.					
	-	e plates of unlimited height					
		ors are permitted to have					
		assemblies per 8.5. Doors					
	are self-closing or	automatic-closing, do not	1				I

<u> </u>		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155505		B. WING			06/26/2023	
		100000	ъ. W.	_		00/20/	2020	
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD OBIN RUN W			
ROBIN R	RUN HEALTH CENT	ΓER			IAPOLIS, IN 46268			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION and are not required to swing		TAG	DEI CHERCIT		DATE	
		egress travel. Door opening						
		ım clear width of 32 inches						
	for swinging or ho							
	19.3.7.6, 19.3.7.8							
		on and interview, the facility	K 0	374	No residents were advers		08/31/2023	
		f 4 sets of barrier doors would			affected by not having 1 of 4 s			
	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				of barrier doors would restrict			
					movement of smoke for at lea minutes.	St ZU		
					2. All residents are potentia	llv		
					at risk for not having 1 of 4 se	•		
					barrier doors to restrict the			
					movement of smoke for at lea	st 20		
	staff, and 2 visitors.				minutes.			
					3. The maintenance			
	Findings include:				director/designee will make re	-		
	D 1 1 1	1 1 1			of the 1 barrier door to ensure			
		ons made during a tour of the			it will restrict the movement of			
	1	intenance Supervisor on m., the set of smoke barrier			smoke for at least 20 minutes The maintenance director will			
		lent rooms #2 and #4 did not			inspect all barrier doors to ens	sure		
		sted. There was a two-inch gap			proper closure on a monthly b			
		when closed to their fullest.			(Exhibit J)			
	Based on interview	during the time of			4. The administrator/design	ee		
		laintenance Supervisor			will review on a monthly basis			
	_	e smoke barrier doors did not			six months and report to the			
		nd would not resist the passage			quality assurance program.			
	of smoke.							
	This finding was re	viewed with the facility						
		Maintenance Supervisor, and						
		ing the exit conference.						
	3.1-19(b)							
K 0524								
K 0521 SS=F	NFPA 101 HVAC							
33-г Bldg. 01	HVAC							
ag. 0 i		n. and air conditioning shall						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	comply with 9.2 a accordance with the specifications. 18.5.2.1, 19.5.2.1 Based on record review; the facility dampers in the facility dampers in the facility for the specification of the specification of the standard for the line and Ventilating Systems 5.4.8.1 statemaintained in according for Fire Doors and NFPA 80, 2010 Eddamper shall be test installation. Section inspection frequency for hospitals 6 years. If the damplink, the link shall be full closure and lock damper shall not be way. All inspection documented, indicated amper, date of installation deficiencies discovered have a space to indicate incidence of the specification of the specificatio	R LSC IDENTIFYING INFORMATION nd shall be installed in he manufacturer's	K 0	TAG		sely ng ility. ng ility. r will or on e at e e vill	
	Supervisor on 06/2	view with the Maintenance 6/23 at 11:07 a.m., ld not be provided regarding					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 41 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIER		6370 R	ADDRESS, CITY, STATE, ZIP COD OBIN RUN W IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
K 0753 SS=E Bldg. 01	dampers within the facility had fire and Maintenance Super testing and mainten be located for it. Baduring a tour of the dampers were noted lack of four-year mafire or smoke dampers were noted lack of four-year mafire or smoke dampers were noted lack of four-year mafire or smoke dampers were view. This finding was revadministrator, the Maintenance Super review. This finding was revadministrator, the Maintenance Super review. NFPA 101 Combustible Decorations of the composition of t	orations rations shall be prohibited following is met: ant or treated with approved ing that is listed and labeled	K 0753	No residents were adv	rersely 08/31/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 42 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023		
	PROVIDER OR SUPPLIER			6370 R	DDRESS, CITY, STATE, ZIP COD DBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	failed to ensure 1 or accordance with 18 combustible decora any health care occifollowing criteria is (1) They are flame-approved fire-retard labeled for applicat applied. (2) The decorations NFPA 701, Standar Flame Propagation (3) The decorations exceeding 100 kW NFPA 289, Standar Individual Fuel Pacignition source. (4)*The decoration paintings, and other the walls, ceiling, a accordance with the (a) Decorations on interfere with the oplatching of the door limitations of 18.7.3 (b) Decorations do wall, ceiling, and despace of a smoke corprotected throughout sprinkler system in (c) Decorations do wall, ceiling, and despace of a smoke corprotected throughout by an apprinkler system in (d) Decorations do wall, ceiling, and despace of a smoke corprotected throughout by an apprinkler system in (d) Decorations do wall, ceiling, and despace of a smoke controlled the property of the door apprinkler system in (d) Decorations do wall, ceiling, and despace of a smoke controlled the property of the p	meet the requirements of d Methods of Fire Tests for of Textiles and Films. exhibit a heat release rate not when tested in accordance with d Method of Fire Test for kages, using the 20-kW s, such as photographs, art, are attached directly to and non-fire-rated doors in e following: non-fire-rated doors do not peration or any required and do not exceed the area		TAG	affected by having a candle in locked memory box outside of resident room #35. 2. All residents are potentia 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 chon a weekly basis that no combustible decorations are utilized. 4. The administrator/design will be responsible for reportin findings for the next 6 months the quality assurance program (Exhibit L)	a Illy eck ee g to	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 43 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		ľ	ILDING	nstruction 01	(X3) DATE : COMPL 06/26/	ETED	
	ROVIDER OR SUPPLIER			6370 RC	.DDRESS, CITY, STATE, ZIP COD DBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Section 9.7. This de	system in accordance with ficient practice could affect as s, 4 staff, and 2 visitors.					
	Based on observation facility with the Ma 06/26/23 at 1:16 p.n. immediately outside candle with a burnt at the time of the ob Supervisor stated th	ons made during a tour of the intenance Supervisor on in., the memory box located a resident room #35 had a wick in it. Based on interview servations, the Maintenance at he was unaware of the ave it, or with wick removed as					
	Administrator, the M	viewed with the facility Maintenance Supervisor, and ng the exit conference.					
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade reclocations and whe anesthesia is adminitial installation, radditional testing idefined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. s performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not on this. Line isolation monitors are tested at intervals of to 1 month by actuating on per 6.3.2.6.3.6, which and and audible alarm. For					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 44 of 52

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/26/2023	
	PROVIDER OR SUPPLIEF		6370 R	ADDRESS, CITY, STATE, ZIP COD ROBIN RUN W NAPOLIS, IN 46268	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DESCRIPTION OF THE OR A TION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on observation interview, the facilia nonhospital-grade or resident room locat annually. NFPA 99 2012 Edition, Section to listed as hospital locations and in locations in each confirmed. Correct connections in each confirmed; and reter blade of each electrolocking-type recept 115 grams (4 ounce could affect all residents).	on 6.3.3.2, Receptacle Testing oms requires the physical ceptacle shall be confirmed by the continuity of the each electrical receptacle shall to polarity of the hot and neutral electrical receptacle shall be ention force of the grounding circal receptacle (except acles) shall be not less than es). This deficient practice dents.	K 0914	1. No residents were advers affected by not having all nonhospital-grade electrical receptacles in resident room locations inspected on an annubasis. 2. All residents are potential at risk for not having all nonhospital-grade electrical receptacle in resident room locations on an annual basis. 3. The maintenance director have all nonhospital-grade electrical receptable in the resident room location on or be date certain. The maintenance director will ensure and track the nonhospital-grade electrical receptables in resident room locations are inspected monthl (Exhibit M) 4. The administrator/designer will monitor for one year and restor the quality assurance programments.	DATE DATE DATE DATE DATE
	an electrical recepta	ld not be provided regarding acle testing the facility's 45 roughly 6 electrical			

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	r í	UILDING	nstruction 01	(X3) DATE COMPL 06/26/	ETED
	PROVIDER OR SUPPLIER			6370 RC	DDRESS, CITY, STATE, ZIP COD DBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	made during a tour Maintenance Super rooms were found to electric receptacles. of the observation, to indicated all of the cresident rooms were indicated there was testing per NFPA 99 requirements. This finding was read Administrator, the Mathematical Systems (Systems System Maintenar The generator or source and associon of supplying service 10-second criterion monthly test, a proannually confirm the safety and critical and testing of the switches are performed in the switches are performed in the system of the switches are performed in the switches are performed in the switches are performed in 20-40 day once every 36 mo Scheduled test undard complete simula automatic or manual automatic or manual automatic or manual specific specific simula automatic or manual specific specific specific simula automatic or manual specific spe	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. der load conditions include					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 46 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155505	B. WI	NG	_	06/26/	/2023
NAME OF F	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP COD	•	
				1	OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ER	_	INDIAN	APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY (DATE
	•	nance and testing of stored					
		rces (Type 3 EES) are in NFPA 111. Main and feeder					
		re inspected annually, and a					
	program for periodically exercising the components is established according to manufacturer requirements. Written records						
	-	nd testing are maintained					
		ble. EES electrical panels					
	_	arked, readily identifiable,					
		n normal power circuits.					
	· ·	ssibility of damage of the					
	emergency power source is a design						
	consideration for r						
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
	1) Based on record	review and interview, the	K 09	918	1. No residents were advers	sely	08/31/2023
	facility failed to ens	sure a written record of weekly			affected by not having written		
	inspections for the g	generator was maintained for			documentation of weekly		
		PA 99, 6.4.4.1.3 requires onsite			inspection for the generator, n	ot	
	_	maintained in accordance with			having written documentation	of a	
		d for Emergency and Standby			monthly load inspection, and		
	-	PA 110, 8.4.1 requires an			annual fuel load inspection for		
		Supply System (EPSS)			diesel generator, or document	ation	
		enant components, shall be			of a 36-month generator test		
		nd exercised monthly. NFPA			where it runs for 4 hours.		
	_	a written record of inspection,			2. All residents are potentia	lly	
	_	ising period, and repairs for the			at risk of not having		
		ularly maintained and available			documentation of the above		
	for inspection by th	, ,			referenced generator testing. 3. The maintenance directo	النبيي	
	residents, staff, and	eficient practice could affect all			• • • • • • • • • • • • • • • • • • • •		
	residents, starr, and	VISITOIS.			have documentation of the ab	ove	
	Findings include: Based on record review with the Maintenance				testing on or before the date certain. The maintenance dire	ctor	
					will monitor and track to ensur		
					that the above referenced test		
	Supervisor on 06/26/23 at 11:08 a.m.,			occurs timely. (Exhibit N)	19		
	documentation for July of 2022 to June of 2023				4. Administrator/designee w	/ill	
		esting was not available for			monitor for 1 year and report t		
		interview at the time of record			quality assurance program.	-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 47 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505		JILDING	nstruction 01	(X3) DATE COMPL 06/26/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	weekly generator to be provided becaus team all quit at the testing documents v							
	Administrator, the	viewed with the facility Maintenance Supervisor, and ing the exit conference.						
	3.1-19(b)							
	facility failed to ma of monthly generate 12 months. Chapter requires monthly te the emergency elec accordance with NI Emergency and Sta 8. NFPA 110 8.4.2 service to be exerci minimum of 30 min 99 requires a writte performance, exerc generator to be regu for inspection by th	review and interview, the intain a complete written record or load testing for 11 of the last (6.4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving trical system to be in FPA 110, the Standard for Indby Powers Systems, Chapter requires diesel generator sets in Inseed at least once monthly, for a Inseed at least once monthly, for a Inseed of inspection, ising period, and repairs for the Inarly maintained and available the authority having efficient practice could affect all						
	Findings include:							
	Supervisor on 06/20 documentation for a monthly generator to review. Based on an review, the Mainter confirmed a load te	view with the Maintenance 5/23 at 11:09 a.m., June of 2022 to April of 2023 resting was not available for an interview at the time of record nance Supervisor and the st was conducted in May of a first month working in the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 48 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		IDENTIFICATION NUMBER	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023			
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			637	STREET ADDRESS, CITY, STATE, ZIP COD 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 facility.		ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION			
	Administrator, the the Team-Lead dur 3.1-19(b)	viewed with the facility Maintenance Supervisor, and ing the exit conference.							
	facility failed to ensure was performed for generator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power System NFPA 110, Section shall be performed	sure an annual fuel quality test the facility's diesel-powered 19, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states on performed in accordance undard for Emergency and tems, 2010 Edition, Chapter 8. 1 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient							
	Findings include:								
	Supervisor on 06/20 documentation of a the diesel generator Based on interview the Maintenance Su does have a diesel §	view with the Maintenance 6/23 at 11:12 a.m., in annual fuel quality test for was available for review. at the time of records review, approvisor stated the facility generator but he was unaware esting requirements.							
	Administrator, the	viewed with the facility Maintenance Supervisor, and ing the exit conference.							
	3.1-19(b)								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet

Page 49 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155505		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/26/2023		
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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		F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
	interview; the facili period emergency gemergency generate 99 and NFPA 110. Code, 2012 Edition 1 and Type 2 essent sources (EPSS) sha Class X, Level 1 ge NFPA 110, the Star Standby Powers Sy 8.4.9 states Level 1 once within every 3 states Level 1 EPSS for the duration of i 4.2). Section 8.4.9. class is greater than to terminate the test Section 8.4.9.5 state test shall be specific 8.4.9.5.3. Section 8 EPS's, loading shall This deficient pract staff, and visitors. Findings include: Based on record rev Supervisor on 06/20 documentation of a emergency generate four continuous hot emergency generate to available for reviets tated documentatic testing for four hou three-year period were sent to the four continuous to the energy of the four continuous hot emergency generate four continuous h	review, observation, and ty failed to document 36-month enerator testing for 1 of 1 ors in accordance with NFPA NFPA 99, Health Care Facilities and Section 6.4.1.1.6.1 states Type ital electrical system power ll be classified as Type 10, nerator sets per NFPA 110. Indianal for Emergency and stems, 2010 Edition, Section EPSS shall be tested at least 6 months. Section 8.4.9.1 is shall be tested continuously the assigned class (See Section 2 states where the assigned 4 hours, it shall be permitted after 4 continuous hours. The states where the assigned 4 hours, it shall be permitted after 4 continuous hours. The states where the assigned after 4 continuous hours. The states are shall be the available EPSS load. The states of the available EPSS load. The states where the states of the states of the diesel fired or for the main building was between the states of						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $JOWT21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 001156$

If continuation sheet

Page 50 of 52

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
155505		155505	B. WING			06/26/2023		
NAME OF D				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			6370 ROBIN RUN W					
ROBIN RUN HEALTH CENTER				INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	requirement.							
	This finding was rev	viewed with the facility						
	-	Maintenance Supervisor, and						
		ng the exit conference.						
		6						
	3.1-19(b)							
K 0920	NFPA 101							
SS=E	Electrical Equipme	ent - Power Cords and						
Bldg. 01	Extens							
		ent - Power Cords and						
	Extension Cords							
	used for compone	patient care vicinity are only						
	-	ed electrical equipment						
	•	les that have been						
	` '	ilified personnel and meet						
	•	0.2.3.6. Power strips in						
		cinity may not be used for						
	-	personal electronics),						
	, -	n 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 re	ooms, power strips meet						
	other UL standard	s. All power strips are						
	used with general	precautions. Extension						
		d as a substitute for fixed						
	_	re. Extension cords used						
	•	moved immediately upon						
		purpose for which it was						
		ts the conditions of 10.2.4.						
	•	9), 10.2.4 (NFPA 99), 400-8						
	(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5		177.0	020	A Namada (00/21/2022	
		on and interview, the facility ible cords were not used as a	K 0	920	No residents were advers	-	08/31/2023	
					affected by having flexible cord			
		wiring in 2 of 10 employee equires electrical wiring and			were not used as a substitute			
	offices. LSC 9.1.2 f	equites electrical withing and			fixed wiring in 2 of 10 employe	C		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JOWT21 Facility ID: 001156

If continuation sheet Page 51 of 52

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023		
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF equipment shall be National Electrical Article 400.8 requir permitted, flexible of used as a substitute This deficient pract residents in the A w Findings include: Based on observation facility with the Ma 06/26/23 from 12:4 was noted: a) a power strip was mini refrigerator in office. b) a power strip was in the Unit Manage Based on interview observation, the Ma acknowledged each power strip being u This finding was re Administrator, the Ma	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION in accordance with NFPA 70, Code. NFPA 70, 2011 Edition, res that, unless specifically cords and cables shall not be for fixed wiring of a structure. ice affects staff and up to 50 ving smoke compartments. ons made during a tour of the tintenance Supervisor on 0 p.m. to 2:40 p.m., the following s powering a microwave and the Admissions Directors s powering a mini refrigerator rs office at the time of each tintenance Supervisor a forementioned use of a		INDIAN ID PREFIX TAG	APOLIS, IN 46268 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PRIME CROSS-REFERENCE) offices. 2. All residents are potential at risk for using flexible cords substitute for fixed wire in 2 of employee offices. 3. All flexible cords will be removed on or before date ce. The maintenance director will check on a monthly basis to ensure that no flexible cords a being used. 4. Administrator/designee with monitor for 6 months and report the quality assurance program.	as a f 10 rtain. are vill	(X5) COMPLETION DATE	
	3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JOWT21 Facility ID: 001156 If continuation sheet Page 52 of 52