STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155330	A. BUILDING -- B. WING	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/03/22 Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 At this Emergency Preparedness survey, Salem Crossing was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 92 certified beds. At the time of the survey, the census was 81. Quality Review completed on 08/08/22	E 0000	Please find the enclosed plan of correction for the survey ending August 3, 2022. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the plan of correction. Life Safety Code Waiver Request submitted for K761. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Please find the enclosed plan of correction for the survey ending August 3, 2022. Submission of this plan of correction does not constitute	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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	Survey Date: 08/03/22 Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 At this Life Safety Code survey, Salem Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 92 and had a census of 81 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered. Quality Review completed on 08/08/22		admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the plan of correction. Life Safety Code Waiver Request submitted for K761. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1			

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	Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Maintenance Director during an initial walk through of the facility from 9:40 a.m. to 10:00 a.m. on 08/03/22, the latching mechanism on the door handle for the corridor door to the Therapy Room (a treatment room) was in the "dogged down" position which prevented the mechanism from latching into the door frame when tested to close multiple times. The door was also equipped with a thumb twist latching device which required a key to unlock the door from the corridor side of the door. Based on interview at the time of the observations, the Maintenance Director agreed the latching mechanism on the door handle for the corridor door to the Therapy Room was in the "dogged down" position which prevented the mechanism from latching into the door frame when tested to close multiple times. The Maintenance Director had the latching mechanism released from the	K 0361	1. No residents were harmed. Latching mechanism on therapy room door released from the “dogged down” position during the survey. 2. All residents have the potential to be affected. No further areas of concern noted. 3. Life Safety Code Standard for K361 reviewed with Maintenance Director by 8-19-22 by Executive Director (See Attachment A). Maintenance Director will inspect doors during daily walk thru to ensure appropriateness. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	08/19/2022

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

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	sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during an initial walk through of the facility from 9:40 a.m. to 10:00 a.m. on 08/03/22, the latching mechanism on the door handle for the corridor door to the Therapy Room was in the "dogged down" position which prevented the mechanism from latching into the door frame when tested to close multiple times. The door was also equipped with a thumb twist latching device which required a key to unlock the door from the corridor side of the door. Based on interview at the time of the observations, the Maintenance Director agreed the latching mechanism on the door handle for the corridor door to the Therapy Room was in the "dogged down" position which prevented the mechanism from latching into the door frame when tested to close multiple times. The Maintenance Director had the latching mechanism released from the "dogged down" position during the survey.	K 0363	1. No residents were harmed. Latching mechanism on therapy room door released from the “dogged down” position during the survey. Latching mechanism on corridor door to resident sleeping Room 301 repaired and corrected during the survey. Single leaf entry door to kitchen has been equipped with a positive latching device. 2. All residents have the potential to be affected. No further areas of concern noted. 3. Life Safety Code Standard for K363 reviewed with Maintenance Director by 8-19-22 by Executive Director (See Attachment A). Maintenance Director will inspect corridor doors during daily walk thru. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the	08/19/2022

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	Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 08/03/22, the corridor door to resident sleeping Room 301 would not latch into the door frame. The latching mechanism was stuck in the door and would not protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to Room 301 would not latch into the door frame and had the releasing mechanism repaired during the survey. In addition, the single leaf entry door to the kitchen from the main dining room was equipped with a deadbolt lock on the door. The door was not equipped with a positive latching device. The main dining room was open to the corridor. The Maintenance Director agreed the single leaf entry door to the kitchen was not equipped with a positive latching device to ensure the door would close and latch into the door frame. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		monthly QAPI meeting with follow-up as necessary.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have			

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	fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on record review, observation and interview; the facility failed to ensure doors in 1 of 7 smoke barrier walls would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of facility floor plan documentation with the Executive Director and the Maintenance Director during record review from 10:00 a.m. to 12:40 p.m. on 08/03/22, one of seven fire walls in the facility is located by Room 101. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 08/03/22, the self closing device on the smoke barrier door in the attic above the corridor door set by resident sleeping Room 101 was detached which would not ensure the door would fully self close. Based on interview at the time of the observations, the Maintenance Director agreed the self closing device on the smoke barrier door in the attic above the corridor door set by resident sleeping Room 101 did not function properly to ensure the door would restrict the movement of	K 0374	1. No residents were harmed. Self-closing device on the smoke barrier door in the attic above the corridor door set by the resident sleeping Room 101 was reattached to ensure the door would fully self-close. 2. All residents have the potential to be affected. No further areas of concern noted. 3. Life Safety Code Standard for K374 reviewed with Maintenance Director by 8-19-22 by Executive Director (See Attachment A). Maintenance Director will inspect areas during monthly walk thru and correct as needed. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	08/19/2022

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	smoke. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame.	K 0761	1. No residents were harmed. Pricing to repair new fire door panic devices obtained on 8-15-22 and contract awarded on same date. Contractor has ordered parts and awaiting delivery to schedule installation date. Work to begin on or before 9-30-22. Work to be completed by 11-4-22. Life Safety Code Waiver Request submitted under attached documents. 3. Life Safety Code Standard for K761 reviewed with Maintenance Director by 8-19-22 by Executive Director (See Attachment A). Maintenance Director will inspect areas during monthly walk thru and correct as needed. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with	11/04/2022

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	(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor door set by the entrance to Alzheimer's wing by Room 401. Findings include: Based on review of facility floor plan documentation with the Executive Director and the Maintenance Director during record review from 10:00 a.m. to 12:40 p.m. on 08/03/22, seven fire walls are located in the facility including the fire wall by Room 401. In addition, the review of "Fire/Smoke Door Inspection" inspection documentation dated 03/21/22 with the Executive Director and the Maintenance Director Supervisor		follow-up as necessary.	

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	did not include any deficiencies noted as a result of the fire door inspections. The fire door inspections were conducted by American Senior. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:15 p.m. on 08/03/22, each door in the corridor door set by the entrance to the Alzheimer's wing by Room 401 was equipped with a 90 minute fire resistance rating label affixed to the hinge side of the door. Each door was equipped with a self closing device and each door in the door set was held in the fully closed position with a magnetic device which required a code entered into an adjoining keypad to release the doors to open. Latching hardware was on the top of the door frame near the meeting edges of the door set but neither door was equipped with latching hardware. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed floor plan documentation indicated the door set by Room 401 was in a fire wall but neither door in the door set was equipped with latching hardware to latch the door set into the door frame. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			