| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155029 | A. BUILDING -- B. WING | 05/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| COMMUNITY NURSING AND REHABILITATION CENTER | 5600 E 16TH ST INDIANAPOLIS, IN 46218 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 05/14/24<br><br>Facility Number: 000012<br>Provider Number: 155029<br>AIM Number: 100274900<br><br>At this Emergency Preparedness survey, Community Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 115 certified beds. At the time of the survey, the census was 50.<br><br>Quality Review completed on 05/15/24 | E 0000 | This provider respectfully requests a desk review in lieu of a post survey review on or after May 23rd, 2024. Please feel free to contact Paige Metzler, if you need any additional information to support the desk review at 317-406-4368. Thank you for your consideration | |
| K 0000<br><br>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).<br><br>Survey Date: 05/14/24<br><br>Facility Number: 000012<br>Provider Number: 155029<br>AIM Number: 100274900<br><br>At this Life Safety Code survey, Community | K 0000 | This provider respectfully requests a desk review in lieu of a post survey review on or after May 23rd, 2024. Please feel free to contact Paige Metzler, if you need any additional information to support the desk review at 317-406-4368. Thank you for your consideration | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Paige Metzler | Executive Director | 05/23/2024 |

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| | Nursing and Rehabilitation Center 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.<br><br>This two-story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in resident sleeping rooms 133 through 141 and 233 through 237. The facility has smoke detectors hard wired to the fire alarm system installed in all other resident sleeping rooms. The facility has a capacity of 115 and had a census of 50 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings providing facility storage services which are each not sprinklered.<br><br>Quality Review completed on 05/15/24 | | | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>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 | | | |

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| | to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>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 2 of over 40 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 4 residents.<br><br>Findings include:<br><br>Based on observations with the Maintenance | K 0363 | **K 363: Corridor Doors:**<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**<br>Both doors were adjusted to latch properly into its frame on | 05/23/2024 |

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| | Director and Field Maintenance Supervisor on 05/14/24 during a tour of the facility between 1:15 p.m. and 2:05 p.m., the corridor doors to resident rooms 119 and 110 failed to close and latch positively into their door frames. Based on interview at the time of each observation, the Maintenance Director confirmed the two resident room doors did not latch into their door frames when tested.<br><br>This finding was reviewed with the Executive Director, Maintenance Director, Director of Property Management and Field Maintenance Supervisor at the exit conference.<br><br>3.1-19(b) | | 4/15/2024.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by the alleged deficient practice.<br>Maintenance Director completed audit on 5/15/2024 with all doors latching into frames properly.<br>Maintenance Supervisor educated by Executive Director on checking all corridor doors monthly per TELS system by 5/23/2024.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Maintenance Supervisor educated by Executive Director on checking all corridor doors monthly per TELS system by 5/23/2024.<br>Executive Director/Director of Nursing/Maintenance Director to conduct Safety Rounds monthly, in addition to regularly scheduled task, to include testing of proper latching for all corridor doors on first floor. Any corridor door found to not be properly latching will be added to TELS work order system immediately to be addressed.<br>**How the corrective action(s) will be monitored to ensure the** | |

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| | | | **deficient practice will not recur?**<br>Maintenance Director/designee will conduct the Corridor Door Audit Tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br>If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| K 0374<br>SS=E<br>Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not 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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect 40 residents, staff and visitors in two smoke compartments.<br><br>Findings include: | K 0374 | **K 374: Subdivision of Building Spaces – Smoke Barrier Doors:**<br>**What corrective action will be accomplished for those residents found to have been affected by the deficient** | 05/23/2024 |

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| | Based on observation with the Maintenance Director and Field Maintenance Supervisor during a tour of the facility at 1:37 p.m. on 05/14/24, the set of smoke barrier doors by resident rooms 115 and 116 each swing in the same direction with the west door equipped with an astragal. The door set was equipped with a door closing coordinator, however the coordinator did not work properly to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Maintenance Director confirmed the smoke barrier door set by resident room 115 did not coordinate properly to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier and would work on the coordinator.<br><br>This finding was reviewed with the Executive Director, Maintenance Director, Director of Property Management and Field Maintenance Supervisor at the exit conference.<br><br>3.1-19(b) | | **practice?**<br>·Door coordinator was adjusted so that the smoke barrier door closed appropriately on 5/15/2024.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by the alleged deficient practice.<br>Audit of all smoke barrier doors was conducted on 5/15/2024 with no follow-up needed.<br>Maintenance Supervisor educated by Field Maintenance Supervisor on how to properly adjust coordinator for smoke barrier door on 5/15/2024.<br>Maintenance Supervisor educated by Executive Director on Smoke Barriers and Fire Walls, including Annual/Fire Smoke Door Inspections by 5/23/2024.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Maintenance Supervisor educated by Field Maintenance Supervisor on how to properly adjust coordinator for smoke barrier door on 5/15/2024.<br>Maintenance Supervisor educated by Executive Director on Smoke Barriers and Fire Walls, | |

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| | | | including Annual/Fire Smoke Door Inspections by 5/23/2024.<br>Executive Director/Director of Nursing/Maintenance Director to conduct Safety Rounds monthly to include testing of proper closure for all smoke barrier doors on first floor. Any smoke barrier door found to not be properly latching will be added to TELS work order system immediately to be addressed.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?**<br>·Maintenance Director/designee will conduct the Smoke Barrier Door Audit Tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br>· If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| K 0511<br>SS=D<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility | K 0511 | **K 511: Utilities – Gas and** | 05/23/2024 |

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| | failed to ensure all ground fault circuit interrupter (GFCI) were properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could one resident and staff in room 139.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director and Field Maintenance Supervisor on 05/14/24 at 1:45 p.m., when the GFCI receptacle located within two feet from a sink in resident room 139 was tested with a GFCI tester the electric receptacle did not trip. Based on interview at the time of observation, the Maintenance Director confirmed the GFCI electric receptacle within two feet of the sink in resident room 139 did not trip when tested.<br><br>This finding was reviewed with the Executive Director, Maintenance Director, Director of Property Management and Field Maintenance Superrvisor during the exit conference.<br><br>3.1-19(b) | | **Electric:**<br><br>**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**<br>·GFCI was replaced on 5/15/2024.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by the alleged deficient practice.<br>GFCI audit for all units was completed on 5/23/2024.<br>Maintenance Supervisor educated by Executive Director on GFCI testing being completed annually per TELS schedule by 5/23/2024.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Maintenance Supervisor educated by Executive Director on GFCI testing being completed annually per TELS schedule by 5/23/2024.<br>Maintenance Supervisor to conduct spot checks bi-monthly to include all resident rooms by end of month.<br>**How the corrective action(s)** | |

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| | | | **will be monitored to ensure the deficient practice will not recur?**<br>·Maintenance Director/designee will conduct the GCFI Audit Tool weekly for one month, bi-weekly for two months, and then monthly for six months. The results of these audits will be reviewed by the QAPI committee overseen by the ED.<br>· If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |