STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 01 B. WING	06/10/2024

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

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K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/14/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/10/24 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 At this PSR survey, Community 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. 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 55 at the time of this visit. 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	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		06/21/2024

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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	which are each not sprinklered. Quality Review completed on 06/12/24			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window			

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	assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 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. Findings include: Based on observation with the Executive Director on 06/10/24 at 12:13 p.m. during a tour of the facility, the corridor door to resident room 119 failed to close and latch positively into the door frame. Based on interview at the time of observation, the Executive Director stated that the Maintenance Director had worked on the door and confirmed the resident room door did not latch into the door frame when tested. This finding was reviewed with the Executive Director at the exit conference. This deficiency was cited on 05/14/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0363	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Hardware was noted to be knocked out of place. The Striker plate was changed, filed down, and adjusted door for repair on 6/13/2024. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Area Supervisor completed audit on 6/19/2024 with all doors latching into frames properly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** 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	06/19/2024

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			first floor. Any corridor door found to not be properly latched will be added to TELS work order system immediately to be addressed. The facility will ensure doors protecting corridor openings will be smoke resistive; have no impediments to closing; are self-latching and provided with positive latching hardware. Ongoing, the Administrator or designee will monitor corridor doors to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** 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. The Executive Director/designee additionally 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. If the threshold of 95% is	

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			not achieved an action plan will be developed to ensure compliance.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric 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. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility 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. Findings include: Based on observation with the Executive Director on 06/10/24 at 12:18 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 Executive Director confirmed the GFCI receptacle within two feet of the sink in resident room 139 did not trip when tested. This finding was reviewed with the Executive Director during the exit conference.	K 0511	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·GFCI was replaced on 6/13/2024. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. GFCI audit for all units was completed on 6/13/2024. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Supervisor to	06/19/2024

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	This deficiency was cited on 05/14/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		conduct spot checks bi-monthly to include all resident rooms by end of month. The facility will ensure all ground fault circuit interrupter (GFCI) receptacles are properly maintained for protection against electric shock in accordance with NFPA 70, National Electrical Code. Ongoing, the Administrator or designee will monitor for live wiring connections to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** ·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. ·Executive Director/designee will additionally 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. · If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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