PRINTED: 08/31/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505			JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/12/2022		
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD OBIN RUN W		
ROBIN F	RUN HEALTH CEN	TER			APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 0000 Bldg	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 06/15/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/12/22 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 At this PSR survey to the Emergency Preparedness survey, Robin Run Health Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.		E 0000				
	the survey, the cen Quality Review or						
K 0000							
Bldg. 01	Code Recertification conducted on 06/1		K 0	000			
	Facility Number: Provider Number:						

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

AIM Number: 100453350

(X6) DATE

TITLE

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: UUU722 Facility ID: 001156 If continuation sheet Page 1 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505		A. BUILDING B. WING					
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER		6370 RC	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 FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 0354	At this Life Safety Code survey, Robin Run Health Center was found in substantial 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the nurses call system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 41 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached maintenance building which was not sprinklered. Quality Review on 08/12/22. NFPA 101	e e					
SS=C Bldg. 01	Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are	e e					

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

Event ID:

UUU722 Facility ID: 001156

If continuation sheet

Page 2 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155505		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/12/2022				
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	(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)	(X5) COMPLETION DATE			
	evacuated or an a provided until the returned to service 18.3.5.1, 19.3.5.1. Based on record revialled to provide a containing procedur protection of all result automatic sprinkler out-of-service for 1 period in accordance 9.7.5 requires sprincomply with NFPA Inspection, Testing Water-Based Fire PEdition, Section 15. that the impairment deficient practice coand visitors. Findings include: Based on review of documentation with during record review on 08/12/22, the fire system impairment watch policy for autompairment failed to company, the buildicompany would be automatic sprinkler hours or more in a 2 interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim Maintenance Direct documentation for a impairment did not alarm monitoring coal interview at the tim	exproved fire watch is sprinkler system has been es., 9.7.5, 15.5.2 (NFPA 25) view and interview, the facility complete written policy res to be followed for the idents in the event the system has to be placed 0 hours or more in a 24-hour rewith LSC, Section 9.7.5. LSC kler impairment procedures 25. NFPA 25, Standard for the and Maintenance of rotection Systems, 2011 5.2 requires nine procedures coordinator shall follow. This build affect all residents, staff "Fire Watch Procedures" the Maintenance Director with form 10:00 a.m. to 10:25 a.m. rewatch plan for sprinkler was incomplete. The fire tomatic sprinkler system to state the alarm monitoring ing owner and the insurance contacted if the required system is out-of-service for 10 24-hour period. Based on re of record review, the cor agreed fire watch automatic sprinkler system include notification of the company, the building owner		The following is the Plan of Correction for the deficiencies cited during the Annual Survey Event ID UUU722 dated Augu 12, 2022. The Plan of Correct is not to be construed as an admission of or agreement wit the findings and conclusions in Statement of Deficiencies, or a related sanction or fine. Rathe is submitted as confirmation or ongoing efforts to comply with statutory and regulatory requirements. In this document we have outlined specific action in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health services and will continue to make changes and improvement to satisfy that objective. K354 It is the practice of the provide when the sprinkler system is impaired, the extent and durat of the impairment has been	DATE 08/31/2022 y st tion the any er it four nt ons s. ed We . I d			
	and the insurance company.			determined, areas or buildings involved are inspected and risk				

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

Event ID:

UUU722 Facility ID: 001156

If continuation sheet Page 3 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155505	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COM	E SURVEY PLETED 2/2022
	PROVIDER OR SUPPLIE		6370 F	ADDRESS, CITY, STATE, ZIP C ROBIN RUN W NAPOLIS, IN 46268	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	This finding was re Director during the This deficiency wa	eviewed with the Maintenance e exit conference. s cited on 06/15/22. The facility t a systemic plan of correction		are determined, recome are submitted to manadesignated representative department and othe authorities having juristic been notified, including monitoring company, the owner and the insurantive fithe required sprinkles out for 10 hours or monitoring company. What corrective actions accomplished for those found to have been affective deficient practice: All residents could be at the alleged deficient practicy, has updated the fire was include language of if the system is out-of-service hours or more in a 24-lest the authority having juristic be notified, including the monitoring company, the womer and the insurant company. How other residents has potential to be affected same deficient practice identified and what cornaction(s) will be taken: All residents could be at the alleged deficient prother fore the facility has the Fire Watch Policy facility has updated the	imendations gement or tive, and the her diction have go the alarm he building ce company resystem is re in a 24 (s) will be exercised by the affected by the affected by the assupdated. The facility atch plan to the sprinkler for 10 hour period risdiction will the alarm he building ce aving the alarm he building ce aving the arective affected by ractice as updated. The facility are alarm he building the alarm he building the aving the arective affected by ractice as updated. The	

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

Event ID:

UUU722 Facility ID: 001156

If continuation sheet Page 4 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/31/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ì		ONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155505			A. BUILDING <u>01</u> B. WING		COMPL 08/12/		
		100000		_	ADDRESS CITY STATE ZID COD	00/12/	
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER			IAPOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYI		ICY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE	COMPLETION DATE	
					plan to include language of if t sprinkler system is out-of-serv	ice	
					for 10 hours or more in a 24-h	our	
					period the authority having jurisdiction will be notified,		
					including the alarm monitoring		
					company, the building owner a	and	
					the insurance company.		
					What measures will be put into		
					place and what systemic chan	-	
					will be made to ensure that the deficient practice does not rec		
					The Health Center Maintenand		
					Staff have been educated that		
					fire watch plan has been upda	ted	
					to include language of if the		
					sprinkler system is out-of-serv for 10 hours or more in a 24-h		
					period the authority having	oui	
					jurisdiction will be notified,		
					including the alarm monitoring		
					company, the building owner a	and	
					the insurance company.		
					How the corrective action(s) w	ill be	
					monitored to ensure the defici	ent	
					practice will not recur, i.e., who		
					quality assurance program will put into place:	ı be	
					As part of the providers Qualit	V	
					Assurance Performance	,	
					Improvement process, the		
					Maintenance Director of desig		
					will randomly audit of 2 Health Center of Maintenance Staff		

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

Event ID:

UUU722

Facility ID: 001156

associates per week for knowledge of the updated Fire Watch Policy. These audits will

If continuation sheet

Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2022 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 08/12/2022		
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	(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
					be conducted weekly for 90 da and will be reviewed in the mo QAPI meetings for 90-days. Date of Compliance August 31, 2022	•		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UUU722 Facility ID: 001156 If continuation sheet Page 6 of 6