STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155294	A. BUILDING -- B. WING	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 04/15/19 & 04/16/19 Facility Number: 000191 Provider Number: 155294 AIM Number: NA At this Emergency Preparedness survey, Forum at the Crossing was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 74 certified beds. At the time of the survey, the census was 34. Quality Review completed on 04/23/19 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0031 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation with the Executive	E 0031	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by this clerical oversight.** **2. All residents and staff members of the facility could potentially be affected by an emergency preparedness plan**	05/16/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Director, the Administrator and the Interim Maintenance Director during record review from 9:00 a.m. to 11:40 a.m. on 04/16/19, the emergency preparedness plan did not include contacting the Indiana State Department of Health (ISDH) by telephone at 317-460-7287 for emergency incidents that require a full or partial evacuation. Based on interview at the time of the exit conference at 11:40 a.m., the Administrator agreed the plan did not include the correct telephone contact information for the aforementioned emergency preparedness source of assistance for emergency incidents that require a full or partial evacuation.		**lacking salient details.** **3. The HFA corrected this finding during the survey by inserting the missing information into the emergency preparedness plan on April 16, 2019.** **3. The HFA will collaboratively audit the Emergency Preparedness plan with other community managers and corporate advisory leaders no less than annually. Revisions will be made as indicated based on regulatory agencies and/or community needs.** **4. Date of Compliance with actions: April 27th, 2018**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 04/15/19 & 04/16/19 Facility Number: 000191 Provider Number: 155294 AIM Number: NA At this Life Safety Code survey, Forum at the Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 0000		

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	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 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 in all resident sleeping rooms. The facility has a capacity of 74 and had a census of 34 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/23/19			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.			

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	Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the attached Independent Living area in accordance with Section 19.1.3.4.1. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor door to Independent Living. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the corridor door to Independent Living by the Laundry in the 2-hour fire rated separation wall between the skilled nursing unit and the attached Independent Living area was equipped with a self closing device and a latching mechanism but the latching mechanism failed to latch the door into the door frame when tested to close multiple times. The door was equipped with an affixed 90 minute fire resistance rating label. Based on interview at the time of the observations, the Interim Maintenance Director stated the door leads to the attached Independent Living Area, the door has not latched into the door frame since he has been working there but agreed the door would not latch into the door frame when tested to close multiple times. 3.1-19(b)	K 0131	**In response to the cited deficiency, the following actions will be taken:** **1.No specific residents were affected by this automated door which securely closes but lacks a latching mechanism.** **2.Residents situated between this non-latching door and other smoke barrier doors could potentially be affected by a door's failure to latch when smoke/fire are present in the immediate environment.** **3.The maintenance supervisor will secure necessary parts to repair this latching mechanism or otherwise arrange for an outside vendor to make essential repairs. Final adjustment/repairs were made on or before May 15, 2019.** **4.The maintenance supervisor will audit this and all other automated doors to ensure proper latching hardware is in place/functional. Latching devices will be emphasized when preventive maintenance rounds are completed**	05/16/2019

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			annually. This inspection is included in the community's automated TELS tracking system. Any defective or non-functional parts will be modified/repaired to ensure proper functionality is attained. The Executive Director or his designee monitors compliance with documentation of preventive maintenance per the TELS system. Maintenance personnel who fail to complete duties will be reprimanded. **5.Date of Compliance with proposed actions: May 16th, 2018**	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to ensure 4 of 4 battery backup lights were tested annually to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual	K 0291	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by insufficient documentation of battery checks for emergency lighting.** **2. Residents situated in the therapy gym where emergency lighting has battery back-up could be affected if power and generators failed.** **3. The maintenance**	05/16/2019

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	inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Koorsen Fire & Security's "Fire Extinguisher Work Order" documentation dated 02/26/19 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, annual 90 minute functional testing documentation for all battery backup lights in the facility within the most recent twelve month period was not available for review. Koorsen's 02/26/19 documentation stated a "Quick Check" was performed for battery lights but it was not it did not state if the quick check was an annual 90 minute functional test and it did not itemize the location of each light tested and the result of the test. Based on interview at the time of the exit conference on 04/16/19 at 12:00 p.m., the Executive Director agreed additional battery backup lighting testing documentation was not available for review. Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, a total of four battery backup lighting systems were noted in the facility at the emergency generator transfer switch location in the small boiler room, in the Therapy Room and in the vestibule outside the Therapy Room and each lighting system operated when its respective test button was pushed. 3.1-19(b)		**supervisor will perform 90-minute functional testing on such lights on or before May 9, 2019. Any necessary replacement batteries/lights/bulbs will be secured on or before May 16, 2019.** **4. The maintenance supervisor will ensure the annual testing is completed. This inspection is included in the community's automated TELS tracking system. The Executive Director or his designee monitors compliance with documentation of preventive maintenance per the TELS system. Maintenance personnel who fail to complete duties will be reprimanded.** **5. Date of Compliance with proposed actions: May 16th, 2018**	

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K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace 1 of over 30 resident sleeping room battery operated smoke alarms in accordance with manufacturer's specifications. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect over 10 residents, staff and visitors in the 400 Hall. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, resident sleeping Room 427 has one battery operated smoke detector installed in the room. Manufacturer's specifications affixed to the First Alert Model SA340 smoke detector installed in Room 427 stated the detector was manufactured October 27, 2006 and was equipped with a 10 year	K 0300	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by operational but aged smoke detectors** **2. Residents in rooms where battery-operated smoke detectors are not fully functional could be affected.** **3. The maintenance supervisor will audit all battery-operated smoke detectors in associated rooms and create a log to monitor installation dates, battery change dates and other pertinent details. New detector units and/or battery components will be secured on or before May 16, 2019.** **4. The maintenance supervisor will ensure monthly battery testing is completed. This inspection is included in the community's automated TELS tracking system. The Executive Director or his designee monitors compliance**	05/16/2019

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	non-replaceable lithium battery. Manufacturer's specifications also stated to replace the detector 10 years after the date of installation. The installation date was not affixed to the detector. Based on interview at the time of the observations, the Interim Maintenance Director stated he was unsure of the date of the installation of the smoke detector installed in Room 427 and agreed the battery operated smoke detector was more than 10 years old. 3.1-19(b)		**with documentation of preventive maintenance per the TELS system. Maintenance personnel who fail to complete duties will be reprimanded.** **5. Date of Compliance with proposed actions: May 16th, 2018**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops			

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	d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 13 hazardous areas such as trash collection rooms exceeding 64 gallons were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the latching mechanism for the self closing corridor door to the kitchen by the Breakroom failed to latch the door into the door frame when tested to close multiple times. The kitchen contained over four 32 gallon capacity trash cans being utilized by kitchen staff. Based on interview at the time of the observations, the Interim Maintenance Director agreed the aforementioned corridor door had an impediment to closing, latching and did not separate this hazardous area from other spaces by smoke resistant partitions and doors. 3.1-19(b)	K 0321	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by this utility door which securely closes but lacks a latching mechanism.** **2. Residents situated between this non-latching door other smoke barrier doors could potentially be affected by a door's failure to latch when smoke/fire are present.** **3. The maintenance supervisor will secure necessary parts to repair this latching mechanism or otherwise arrange for an outside vendor to make essential repairs. Final adjustment/repairs will be made on or before May 16, 2019.** **4. The maintenance supervisor will audit this and all other automated doors to ensure proper latching hardware is in place/functional. Latching devices will be emphasized when preventive maintenance rounds are completed**	05/16/2019

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			annually. This inspection is included in the community's automated TELS tracking system. Any defective or non-functional parts will be modified/repaired to ensure proper functionality is attained. The HFA will audit for compliance on monthly QA environmental rounds. Revisions will be made as indicated. **5. Date of Compliance with proposed actions: May 16th, 2018**	
K 0331 SS=D Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 1 laundries were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice	K 0331	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by these fire code infractions.** **2. Residents situated within the vicinity of the laundry facility could potentially be affected by the**	05/16/2019

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	could affect two Laundry staff. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the following was noted: a. exposed wood studs were noted above and behind the dryers in the Laundry. No affixed flame spread rating documentation was printed on any of the wood studs. b. a twelve inch by twelve inch piece of cardboard was affixed to the ceiling to cover a vent in the Laundry. Based on interview at the time of the observations, the Interim Maintenance Director stated he was unaware if the wood studs and cardboard had been treated with flame retardant material and agreed interior finish flame spread rating documentation for the wood studs and the cardboard was not available for review at the time of the survey. 3.1-19(b)		**threat of rapidly moving combustion when smoke/fire is present.** **3. Cardboard will be removed by May 1, 2019. The maintenance supervisor will either secure fire retardant treatment for application to the exposed wood studs in the exhaust chamber or install drywall material over the exposed wood. Final adjustment/repairs will be made on or before May 16, 2019.** **4. The maintenance supervisor will ensure visual inspections of these types of isolated infractions will be incorporated into all ongoing maintenance activities. Dryer vent inspections are included in the community's automated TELS tracking system. The HFA will audit for compliance on monthly QA environmental rounds.** **5. Date of Compliance with proposed actions: May 16th, 2018**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72,			

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	National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 02/21/19 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, the "On/Off Premises Monitoring" section of the report indicated "Unable to verify signals-override switch on panel disables dialer monitoring did get daily test signals." In addition, review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 08/24/18 also stated the facility's fire alarm panel had dialer issues for which the off-site monitoring company was unable to verify signals. Based on interview during the exit conference on 04/16/19 at 12:00	K 0345	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by the ambiguous state of the community's off-site monitoring system.** **2. All Residents could potentially be affected by the threat of compromised alarm monitoring equipment.** **3. ATT verified the line for alarm monitoring was fully operational as of April 26, 2019.** **4. A wireless dialer back-up is being evaluated by the alarm company, depending on availability and technical compatibility. If feasible, this will be installed on or before May 16, 2019 as a separate back-up dedicated phone line.** **5. The maintenance supervisor will ensure trouble alarms on the control panel are addressed promptly when identified. Full alarm panel inspections are included in the community's automated TELS tracking system on an annual basis. The Executive Director or his designee monitors compliance with documentation of preventive**	05/16/2019

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	p.m., the Administrator provided "Service Work Order" documentation from Koorsen dated 04/10/19 for fire alarm system and sprinkler system repairs but it was agreed it was not conclusive that fire alarm system dialer repairs on or after 02/21/19 had been performed. 3.1-19(b)		**maintenance per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **6. Date of Compliance with proposed actions: May 16th, 2018**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure closets in 1 of 1 Activities Rooms were provided with an automatic sprinkler to ensure sprinkler coverage in all portions of the	K 0351	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents**	05/16/2019

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FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

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	building. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Activities Room in the 600 Hall. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the closet for the Activities Room in the 600 Hall was not provided with automatic sprinklers. Based on interview at the time of the observations, the Interim Maintenance Director agreed the aforementioned location did not have sprinkler coverage. 3.1-19(b) 3.1-19(ff)		**were affected by the lack of sprinkler coverage of a storage closet.** **2. All Residents could potentially be affected by eruption of a fire in an area without fire/sprinkler protection.** **3. The community's sprinkler maintenance/repair company will outfit the closet with an appropriate pendant. Measurements will be taken by May 2, 2016. Installation of equipment will be as soon as practicable following the pendant being ordered.** **4. Sprinkler inspections are performed on a quarterly basis. This device and all others associated with equipment will be evaluated during inspections for functionality. Quarterly sprinkler inspections are included in the community's automated TELS tracking system on a quarterly basis. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Vendors who fail to complete duties (including documentation of inspections) will be replaced.**	

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			5. Date of Compliance with proposed actions: May 16, 2018 (order placed for equipment).	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to ensure the automatic sprinkler system was maintained in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all	K 0353	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by:** **a) insufficient documentation regarding jockey pump operation** **b) a quick-opening device being shut off** **c) fire hydrant inspections not being found or** **d) system gauges exceeding the use of recommended**	05/16/2019

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	residents, staff, and visitors. Findings include: a. Based on review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 02/21/19 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, the "On/Off Premises Monitoring" section of the report indicated "Unable to verify signals-override switch on panel disables dialer monitoring did get daily test signals." In addition, review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 08/24/18 also stated the facility's fire alarm panel had dialer issues for which the off-site monitoring company was unable to verify signals. Based on interview during the exit conference on 04/16/19 at 12:00 p.m., the Administrator provided "Service Work Order" documentation from Koorsen dated 04/10/19 for fire alarm system and sprinkler system repairs but it was agreed it was not conclusive that fire alarm system dialer repairs on or after 02/21/19 had been performed. b. Based on review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 11/21/18 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, the facility has a dry sprinkler system with a fire pump and a jockey pump. Review of the "Deficiencies" section of the 11/21/18 report stated "The fire pump has been shut off and is out of service due to the Jockey Pump quit and needs to be replaced. It was shut off upon arrival and left shut off upon departure		**service lives.** **2. All Residents could potentially be affected by any malfunction or failure of automatic sprinkler equipment.** **3. a) The community's sprinkler maintenance/repair company will test and document functionality of the newly-installed jockey pump by May 16, 2019. Documentation will be secured to verify this . Sprinkler inspections are performed on a quarterly basis. This device and all others associated with equipment will be evaluated during inspections for functionality. Quarterly sprinkler inspections are included in the community's automated TELS tracking system on a quarterly basis.** **b) The cited quick-opening device will be made fully operational and kept in continuous service. Service repairs and/or equipment replacement will be arranged on or before May 10, 2019 with completion of work to be done as soon as practicable. Sprinkler inspections are performed on a quarterly basis. This device and all others associated with equipment will be evaluated**	

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	and will need to remain shut off until the Jockey Pump is replaced to maintain the system pressure and ensure there are no false alarms." Based on interview at the time of record review, the Interim Maintenance Director stated the Jockey Pump was recently replaced but agreed repair, replacement and retesting documentation on or after 11/21/18 was not available for review. Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, electrical power for the Jockey Pump controller was turned on and the manufacture's nameplate documentation affixed to the "Tornatech Inc." controller indicated the controller was manufactured 01/28/19. c. Based on review of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 02/21/19 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, the quick opening device for the facility's sprinkler system was shut off in the pump room. In addition, a review of the "Deficiencies" section of Koorsen Fire & Security's "Inspection & Test Report" documentation dated 11/21/18 stated "The QOD was shut off due to the numerous leaks in the System." Based on interview at the time of record review, the Interim Maintenance Director stated quick opening device repair or replacement documentation on or after 02/21/19 was not available for review. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure all private fire hydrants were continuously maintained in reliable operating condition and inspected and		**during inspections for functionality. Quarterly sprinkler inspections are included in the community's automated TELS tracking system on a quarterly basis.** **c) Fire hydrant inspections will be arranged on or before May 10, 2019 with completion of work to be done as soon as practicable. Fire hydrant inspections are performed on a bi-annual basis. Hydrants will be evaluated during inspections for functionality. These inspections are included in the community's automated TELS tracking system. . The Regional Engineer monitors compliance with documentation of outside inspections per the TELS system. Vendors who fail to complete duties (including documentation of inspections) will be replaced.** **d) Gauges were replaced during the survey and will continue to be included on the TELS preventive maintenance system. Records will be updated to reflect the next anticipated date for gauge replacement (2024 for the ones recently replaced). Sprinkler inspections are performed on a quarterly basis. This device and all others associated with equipment will be evaluated**	

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	tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, annual fire hydrant testing documentation within the most recent twelve month period was not available for review. Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, one private dry fire hydrant was noted near the north entrance to the building outside the 400 Hall. Based on interview during the exit conference on 04/16/19 at 12:00 p.m., the Executive Director stated annual fire hydrant testing documentation within the most recent twelve month period was not available for review. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure 5 of 7 sprinkler system fire pump and jockey pump gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested		**during inspections for functionality. Quarterly sprinkler inspections are included in the community's automated TELS tracking system on a quarterly basis. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Vendors who fail to complete duties (including documentation of inspections) will be replaced.** **Date of Compliance with proposed actions: May 16, 2018 (orders placed for equipment inspections and repairs with permanent corrections made as soon as practicable**	

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	every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Hydro Fire Protection's "Fire Sprinkler System Inspection" documentation dated 05/31/18 and 08/24/18 and Koorsen Fire & Security's "Inspection & Test Report" documentation dated 11/21/18 and 02/21/19 with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:45 a.m. to 12:30 p.m. on 04/15/19 and from 9:00 a.m. to 11:40 a.m. on 04/16/19, the calibration date or the replacement date of sprinkler system gauges was not available for review. Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the facility has a supervised dry sprinkler system and had a fire pump and a jockey pump for the sprinkler system. Five of seven air and water pressure gauges for the fire pump and a jockey pump each had a manufacture date listed on the face of the gauge which was greater than five years old. Two of the five gauges had a manufacture date of 2007 and three of the five gauges had a manufacture date of 2000, 2009 or 2010. Based on interview at the time of the observations, the Interim Maintenance Director stated two of the seven gauges were replaced when the jockey pump was recently replaced but agreed the other five gauges each had a manufacture date listed on the face of the gauge which was greater than five years old. Based on interview during the exit conference on 04/16/19 at 12:00 p.m., the Administrator stated the five pump gauges were replaced the morning of			

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	04/16/19 by the sprinkler contractor. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 5 of over 10 portable fire extinguishers was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 20 residents, staff and visitors. Findings include:	K 0355	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by undocumented inspections of fire extinguishers.** **2. Residents in the immediate area of a compromised (uninspected) fire extinguisher could potentially be affected by eruption of a fire.** **3. Inspection of fire extinguishers on a monthly basis is the responsibility of the maintenance staff. A more comprehensive inventory of extinguishers will be utilized to ensure there are no further missed inspections.** **4. These devices are evaluated monthly for functionality. Attached tickets are initialed to verify**	05/16/2019

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	Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the ABC type portable fire extinguisher located in the kitchen near the double doors, in the Beauty Shop and in the vestibule in the 600 Hall each had an affixed maintenance tag documenting an annual inspection was performed by Koorsen Fire & Security in February 2019 but each maintenance tag did not document a monthly inspection for March 2019. In addition, the K Class portable fire extinguisher located in the kitchen and the carbon dioxide portable fire extinguisher located in the small boiler room each had an affixed maintenance tag documenting an annual inspection was performed by Koorsen Fire & Security in February 2019 but each maintenance tag did not document a monthly inspection for March 2019. Based on interview at the time of the observations, the Interim Maintenance Director stated additional monthly fire extinguisher inspection documentation was not available for review and agreed a monthly inspection for March 2019 was not documented for the aforementioned five portable fire extinguisher locations. 3.1-19(b)		**inspections. Monthly inspections are included in the community's automated TELS tracking system. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **5. Date of Compliance with proposed actions: May 16, 2018.**	
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			

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	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 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 2 of over 50 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors. Findings include:	K 0363	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by a compromised latch or auto-release door holder magnet.**	05/16/2019

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	Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the following was noted: a. a wedge was placed on the floor under the corridor door to the Director of Engineering Office to prop the door in the fully open position. b. the latching mechanism for the self closing corridor door to the kitchen by the Breakroom failed to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Interim Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing, latching and would not resist the passage of smoke. 3.1-19(b)		**2. Residents in the immediate area of a compromised latch or auto-release door holder magnet could be affected in the event of a fire or smoke.** **3. Inspections of smoke/fire doors will be a focus for community maintenance personnel for the next 3 months. They will be inspected on a rotating basis to ensure 100% are audited prior to the next scheduled inspection.** **4. Inspections of smoke/fire doors and associated hardware are included in the community's scheduled automated TELS tracking system. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.**	
K 0372 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a			

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	1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 3 staff and visitors in the kitchen. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, a 16 inch by 12 inch opening was noted in the ceiling of the Environmental Services closet in the kitchen which exposed the attic above. A metal grill covered the opening which was not part of an HVAC system supply or return. The grill for the opening and the opening did not maintain the fire	K 0372	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by these fire code infractions.** **2. Residents situated within the vicinity of the kitchen utility closet could potentially be affected by the threat of rapidly moving combustion when smoke/fire is present.** **3. The improper opening will be sealed with non-combustible material on or before by May 10 2019. The maintenance supervisor will inspect similar areas of the community to ensure there are no additional utility or living spaces ventilated to the attic without proper fire protection.** **4. The maintenance supervisor will ensure visual inspections of these types of isolated infractions will be incorporated into all ongoing maintenance activities. Inspection of ventilation equipment is included in the**	05/16/2019

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FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

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	resistance rating of the ceiling smoke barrier. Based on interview at the time of the observations, the Interim Maintenance Director stated the opening was not part of the HVAC system for the room and agreed the aforementioned opening in the ceiling was not protected to maintain the fire resistance rating of the ceiling smoke barrier. 3.1-19(b)		**TELS tracking system. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **5. Date of Compliance with proposed actions: May 10th, 2018**	
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 1 of over 2 electrical light switches in the Laundry was protected. NFPA 70, National Electric Code, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect two Laundry staff. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, the cover	K 0511	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by this missing cover plate.** **2. Residents situated within the vicinity of the laundry facility could potentially be affected electrical malfunctions in this or any area of the community.** **3. The missing cover plate will be replaced by May 16, 2019. The maintenance**	05/16/2019

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	plate for the wall mounted light switch in the Laundry behind the dryers was missing. As a result, the electrical wiring for the light switch was not confined within the outlet box and exposed the electrical wiring for the switch. Based on interview at the time of observation, the Interim Maintenance Director agreed the light switch box was missing its cover plate and exposed the electrical wiring for the switch. 3.1-19(b)		**supervisor will inspect similar areas of the community to ensure there are no additional missing cover plates. Any identified locations will be corrected immediately.** **4. The maintenance supervisor will ensure visual inspections of these types of isolated infractions will be incorporated into all ongoing maintenance activities. Inspection of laundry ventilation facilities is included in the TELS tracking system. The Executive Director or his designee monitors compliance with documentation of outside inspections per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **5. Date of Compliance with proposed actions: May 16, 2018**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded			

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	announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:00 a.m. to 11:40 a.m. on 04/16/19, documentation of a fire drill conducted on the third shift in the second quarter (April, May, June) 2018 was not available for review. In addition, documentation of a fire drill conducted on the third shift in the third quarter (July, August, September) 2018 was also not available for review. Based on interview at the time of record review, the Executive Director and the Maintenance Director stated the facility had maintenance staff turnover for the position in 2018 and agreed documentation of a fire drill conducted on the aforementioned shifts and quarters was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600	K 0712	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by fire drills not incorporating system monitoring verification.** **2. All residents could potentially be affected by a fire alarm not being transmitted to the monitoring center.** **3. The Executive Director and/or Health Facility Administrator will arrange for the fire alarm system to be placed on "test" mode so signals can be verified during the work shifts fire drills/alarms are initiated. The next fire drill will be completed on or before April 30, 2019.** **4. Documentation of related fire drills and equipment testing will be included in records beginning April, 2019. The Executive Director or his designee monitors compliance with documentation of fire drills per the TELS system.** **5. Date of Compliance with proposed actions: May 16, 2018**	05/16/2019

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	hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:00 a.m. to 11:40 a.m. on 04/16/19, documentation for the second shift fire drill conducted on 02/28/19 at 6:00 p.m. did not include activation of the fire alarm system and the transmission of the fire alarm signal. The 02/28/19 drill documentation was left blank as the response to "All Fire Equipment Functional?" and "Fire Panel Performed Properly?" Based on interview at the time of record review, the Executive Director stated he conducted the fire drill, he did not activate the fire alarm system and agreed the aforementioned second shift fire drill documentation did not include activation of the fire alarm system and transmission of the fire alarm signal for this fire drill conducted after 6:00 a.m. and before 9:00 p.m. 3.1-19(b) 3. Based on record review and interview, the facility failed to document the time of day 1 of 13 fire drills were conducted within the most recent twelve month period. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used			

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	instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:00 a.m. to 11:40 a.m. on 04/16/19, documentation for the fire drill conducted on 06/15/18 did not include the time of day the drill was conducted. The 06/15/18 fire drill documentation stated the start time was 6:45 and the end time was 7:00 but it did not indicate which shift the fire drill was conducted on and did not include whether the start time and end time was a.m. or p.m. Based on interview at the time of record review, the Executive Director and the Maintenance Director stated the facility operates three shifts per day and agreed the 06/15/18 fire drill documentation did not include the time of day the drill was conducted. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not			

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	exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure electrical outlet receptacle testing at all resident bed locations within the most recent twelve month period was performed in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance	K 0914	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected electrical outlet receptacle testing lacking full documentation.** **2. Residents situated near malfunctioning electrical outlets could potentially be affected.** **3. Inspections of electrical outlets in resident bed areas will be completed on or before May 16, 2019. The maintenance supervisor or his designee will re-check polarity and proper grounding of outlets, but will also check to ensure sufficient tension is in place. Any outlets failing inspection will be corrected immediately via wiring or replacement.** **4. Inspection of electrical**	05/16/2019

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	requirements of this chapter. This could affect all residents. Findings include: Based on review of "Annual Inspection for Receptical Testing-2018" with the Executive Director, the Administrator and the Interim Maintenance Director during record review from 9:00 a.m. to 11:40 a.m. on 04/16/19, documentation of electrical outlet receptacle testing at all resident bed locations within the most recent twelve month period did not include the retention force of the grounding blade of each electrical receptacle. Based on interview at the time of record review, the Interim Maintenance Director stated the facility does not test the receptacles for retention force and agreed the aforementioned documentation did not include retention force testing. Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, all resident sleeping rooms had receptacles not listed as hospital-grade at patient bed locations. Based on interview at the time of the observations, the Interim Maintenance Director agreed non hospital-grade receptacles were within the patient care vicinity at all resident bed locations. 3.1-19(b)		**outlets is included in the TELS tracking system. The Executive Director or his designee monitors compliance with documentation of testing per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **5. Date of Compliance with proposed actions: May 16th, 2018**	
K 9999 Bldg. 01	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed,	K 9999	**In response to the cited deficiency, the following actions will be taken:** **1. No specific residents were affected by one resident room lacking a battery**	05/16/2019

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	constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to continuously provide smoke detectors in 1 of over 30 resident sleeping rooms. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 409. Findings include: Based on observations with the Interim Maintenance Director during a tour of the facility from 12:50 p.m. to 3:20 p.m. on 04/15/19, resident sleeping Room 409 was not equipped with a smoke detector. A mounting ring for a smoke detector was noted on the ceiling in the room but a smoke detector for the room was missing. Based on interview at the time of the observations, the Interim Maintenance Director stated this was an area of the building which had a recent flood, the battery operated smoke detector that had been in the room did not get reinstalled and agreed resident sleeping Room 409 was not equipped with a smoke detector. 3.1-19(a)		**operated smoke detector.** **2. Residents situated in or near a room lacking a secondary smoke detector system could potentially be affected.** **3. Inspections of smoke detectors in resident bed areas will be completed on or before May 16, 2019. The maintenance supervisor or his designee will replace any units with manufacturing dates greater than 9.5 years of the date of inspection. An inventory of detectors and manufacturer's recommended inspection dates will be created in order to ensure individual units are tracked properly.** **4. Inspection of smoke detectors in resident rooms is included in the TELS tracking system. The Regional Engineer monitors compliance with documentation of testing per the TELS system. Maintenance personnel who fail to complete duties (including documentation of inspections) will be reprimanded.** **5. Date of Compliance with proposed actions: May 16th, 2018**	