STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155762	A. BUILDING -- B. WING	08/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

(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: 08/26/19 Facility Number: 011387 Provider Number: 155762 AIM Number: 200853180 At this Emergency Preparedness survey, Forest Park Health Campus was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey the census was 57. Quality Review completed on 08/27/19	E 0000		
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's Emergency Preparedness Plan (EPP). The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency	E 0039	Immediate intervention The Director of Plant Operations has completed required documentation. He will review, analyze, and revise the Emergency plan for the facility. The Director of Plant Operations was educated by the Executive Director on the E039 EP Testing requirements. The Director of Plant Operations will conduct these drills annually	09/07/2019

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

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	preparedness plan (EPP), the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the FMS (Facilities Management Support) on 08/26/19 at 10:12 a.m., the following documentation for the community-based event and the table top exercise were incomplete: a) A real event with the fire department took place on 04/02/19. There was no documentation provided to show what EEP policies were used, and if the facility's response was analyzed. Based on interview at the time of records review, Maintenance Director and the FMS stated no report was written to show what EEP policies were used, and if the facility's response was analyzed. b) A table top exercise was conducted at the local hospital on 11/19/18. No documentation was provided to show if the LTC facility was involved in the table top discussion, what questions were designed to challenge an emergency plan, and if		and review with Executive Director upon completion. Results of these Drills will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice has the potential to affect all residents at the time of the survey.	

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FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

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	the facility's response was analyzed. Based on interview at the time of records review, the Maintenance Director and the FMS stated only the Maintenance Director and Administrator attended the table top. The table top was a Hazmat spill at the local hospital and did not involve the LTC facility. The Maintenance Director stated no report was written to show what EEP policies were used, and if the facility's response was analyzed.			
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: 08/26/19 Facility Number: 011387 Provider Number: 155762 AIM Number: 200853180 At this Life Safety Code survey, Forest Park Health Campus 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 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, all areas open to the corridor and hard wired detectors in all resident sleeping rooms. The facility has a capacity of 70	K 0000		

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	and had a census of 57 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/27/19			
K 0131 SS=F 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. 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 1. Based on observation and interview, the facility failed to ensure 1 of 3 separation fire doors was self-closing. LSC 8.3.3.3 states unless otherwise specified, fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. This deficient practice could affect all residents due to all residents use the dining room.	K 0131	Immediate intervention The Director of Plant Operations has contacted A1 Locks and had them install a rated door closure to the door in question. The Director has contacted Koorsen Fire and Security to install a	09/03/2019

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director and the FMS (Facilities Management Support) on 08/26/19 at 12:40 p.m., the door to the assisted feed dining room was in the fire wall that separated health care from assisted living. The door was not equipped with a self-closing device. Based on interview at the time of observation, the Maintenance Director and the FMS stated the door to the assisted feed dining room was in a separation fire barrier and was not equipped with a self-closing device. 2. Based on observation, records review, and interview the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 60 residents on the second floor. Findings include:		magnetic door holder that will close the door in the event the fire alarm is set off. The Director of Plant Operations was educated by the Executive Director on the K 131 NFPA 101 Multiple Occupancies ·CMS requires all fire doors on a fire wall separation to be self closing and latching. The Director of Plant Operations will inspect the deficient door for latching and proper operation daily x 14 followed with once per week x 2 months.	

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	Based on observation during a tour of the facility with the Maintenance Director and the FMS on 08/26/19 at 2:00 p.m., in the attic of the separation fire barrier around the main sprinkler line there was mixed of red and yellow caulk. Based on records review with the Maintenance Director and the FMS at 2:40 p.m., there was no documentation to show the yellow caulk meets ASTM E 814, and the documentation for the red caulk stated "all foreign material must be removed before application." Based on interview at the time of observation, the Maintenance Director and FMS stated the fire rating of the yellow caulk is unknown and the red caulk should not be mixed with other caulks. 3.1-19(b)			
K 0353 SS=E 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			

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	Based on observation and interview, the facility failed to ensure 4 of 4 sprinkler heads in the laundry and 15 of 15 exterior sprinkler were not corroded, loaded, or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff in the laundry and up to 30 residents of the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the FMS (Facilities Management Support) on 08/26/19 between 12:00 p.m. to 2:00 p.m., the following sprinkler heads were covered in lint or showed signs of corrosion, a) Two sprinkler heads in the clean side of the laundry room were covered with dust and lint. b) On the dirty side of the laundry room, the two sprinkler heads showed signs of corrosion due to they were covered in a green substance. c) All 15 exterior sprinkler heads showed signs of corrosion due to they were covered in a green substance. Based on interview at the time of observation, the Maintenance Director and the FMS confirmed the aforementioned sprinkler heads showed dirt accumulation and corrosion.	K 0353	Immediate intervention The Director of Plant Operations has contacted Koorsen Fire and Security and scheduled them to remove and replace all heads with corrosion. 31 heads in total. The Director of Plant Operations was educated by the Executive Director on the K 353 NFPA 101 Sprinkler Head Maintenance and Testing The Director of Plant Operations will conduct visual audit of all sprinkler heads to ensure they do not have corrosion and debris buildup. This audit will take place monthly for six months. Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice has the potential to affect 30 residents at the time of the survey.	09/03/2019

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K 0372 SS=C Bldg. 01	3.1-19(b) NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 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 observations, records review, and interview, the facility failed to ensure 3 of 3 smoke barrier walls were constructed to requirements according the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affects all residents. Findings include: Based on observation during a tour of the facility	K 0372	Immediate intervention The Director of Plant Operationd has removed all Yellow Fire caulk and replaced it with approved rated red fire caulk. The Director of Plant Operations was educated by the Executive Director on the K 372 NFPA 101 Subdivision of Building Spaces – Smoke Barrier Construction. 2012 existing The Director of Plant Operations will conduct a visual audit of all fire and smoke wall penetrations. This audit will take place monthly for six months, or anytime a contractor or any persons enter the attic. Results of these inspections will be presented by Executive	09/06/2019

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	with the Maintenance Director and the FMS on 08/26/19 between 2:00 p.m. and 2:30 p.m., in the attic of the all smoke barrier walls around the main sprinkler line was sealed with yellow caulk. Based on records review with the Maintenance Director and the FMS at 2:40 p.m., there was no documentation to show the yellow caulk meets ASTM E 814. Based on interview at the time of observation, the Maintenance Director and FMS stated the fire rating of the yellow caulk was unknown. 3.1-19(b)		Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice has the potential to affect all residents at the time of the survey.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in resident sleeping areas. This deficient practice could affect up to 20 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the FMS on 08/26/19 at 1:30 p.m., a portable space heater was discovered in the Director of Health Services office which is in patient care and sleeping areas. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was being used in a resident care area and removed the space heater.	K 0781	Immediate intervention The Director of Plant Operations has removed the space heater in question. The Director of Plant Operations was educated by the Executive Director on the K 781 NFPA 101 Portable Heaters The Director of Plant Operations will conduct a building audit to ensure that we do not use space heaters per our policy. This audit will take place monthly for six months. Results of these inspections will	09/03/2019

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	3.1-19(b)		be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice has the potential to affect 20 residents at the time of the survey.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility	K 0920	Immediate intervention	09/03/2019

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	failed to ensure 10 of 10 flexible cords power strips in resident care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects 20 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the FMS (Facilities Management Support) on 08/26/19 between 12:11 p.m. and 1:30 p.m., the following power strips or lamps with built in power taps in resident care areas did not meet UL 1363A or 60601-1 upon inspection: a) In rooms 305 through 312, there were lamps with built in power taps. b) A power strip was lying on a resident's recliner in room 203. c) A power strip was under the resident's bed in room 110. Based on interview at the time of observation, the Maintenance Director and FMS agreed the aforementioned power strips and lamps with built in power taps were within 6 feet of a resident care area and did not meet 1363A or 60601-1. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring or were used to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the FMS on		The Director of Plant Operations has removed the deficient power strips. The Director of Plant Operations was educated by the Executive Director on the K 920 NFPA 101 Electrical Equipment – Power Cords and Extension Cords ·Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assemble by a qualified personnel and meet the conditions of 10.2.3.6 ·Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personnel electronics), except in long-term care resident rooms that do not use PCREE ·Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside the vicinity) meet UL1363 ·In non-patient care rooms, power strips meet other UL standards. ·All power strips are used temporarily are removed immediately upon the purpose for which it was installed and meets the conditions of 10.2.4, 10.2.3.6 (NFPA99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3 (D), (NFPA 70), TIA 12-5 The Director of Plant of Operations	

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	08/26/19 at 12:11 p.m., in the laundry room an iron press, high current draw equipment, was plugged into and supplied power by an extension cord and power strip. Based on interview at the time of observation, the Maintenance Director and FMS agreed the iron press was plugged into a power strip and did remove the power strip. 3.1-19(b)		will conduct audits of deficient areas noted in K 920. Audit will be conducted once per day x 4 weeks Followed with once per month x 3 months Results of these inspections will be presented by Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice has the potential to affect 15 residents in one smoke compartment at the time of the survey.	