STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395778	A. BLDG: __--_____ B. WING: _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
COMMUNITIES AT INDIAN HAVEN, THE STATE LICENSE NUMBER: **090102**	**1675 SALTSBURG AVENUE INDIANA, PA 15701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 11, 2025, at The Communities at Indian Haven, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.475.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

COMMUNITIES AT INDIAN HAVEN, THE

STATE LICENSE NUMBER: 090102

SURVEY EXIT DATE: 02/11/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID #090102 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on February 11, 2025, it was determined that The Communities at Indian Haven was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.70(a). This is a one-story, Type V (111), protected, wood frame building, that is fully sprinklered.	K 0000		
K 0223 SS=B		K 0223		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0223 SS=B	Continued from page 1 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Communities at Indian Haven agrees with the allegations and citations listed on the statement of deficiencies. Communities at Indian Haven maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Communities at Indian Haven's written credible allegation of compliance. By submitting this plan of correction, Communities at Indian Haven does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Communities at Indian Haven reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action	Completion Date: **03/30/2025** Status: **APPROVED** Date: **02/28/2025**

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K 0223 SS=B	Continued from page 2	K 0223	or proceeding. K0023 1. Door on 300 wing has been adjusted. Both leaves positively latch. 2. House audit shows other doors positively latch as required. 3. Weekly checks of self closing doors will be documented by maintenance supervisor or designee ongoing. 4. A monthly random door audit will be conducted by administrator or designee for 3 months. Reviews submitted to QAPI's Safety Committee for review. Administrator to monitor for compliance.	

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K 0223 SS=B	Continued from page 3 Based on observation and interview, the facility failed to maintain doors with self-closing devices for one of over twenty doors. Findings include: Observation on February 11, 2025, at 11:59 a.m., revealed the self-closing doors in the corridor from the 300 wing to the dining room area had one of two leaves fail to positively latch in the frame. Interview with the maintenance supervisor on February 11, 2025, at 11:59 a.m., confirmed the self-closing door deficiency.	K 0223		
K 0271 SS=D		K 0271		

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K 0271 SS=D	Continued from page 4 NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by:	K 0271	1. A wheel-chair width hard packed surface will be installed at the laundry exit. This exit is not used for resident egress. 2. The other emergency exits have been audited and meet requirements. 3. A monthly check of hard packed surfaces from exit doors will be performed by the maintenance supervisor or designee to ensure that they are in good repair. 4. QAPI's Safety Committee will oversee building services for action or review. Administrator to monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/04/2025**

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K 0271 SS=D	Continued from page 5 Based on observation and interview, the facility failed to maintain one of six emergency exits. Findings include: Observation on February 11, 2025, at 11:52 a.m., revealed the emergency exit discharge near the laundry area did not maintain a hard-packed, all-weather travel surface that led to a public way. Interview with the maintenance supervisor on February 11, 2025, at 11:52 a.m., confirmed the exit discharge deficiency.	K 0271		
K 0353 SS=B		K 0353		

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K 0353 SS=B	Continued from page 6 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 This REQUIREMENT is not met as evidenced by:	K 0353	1. Sprinkler heads behind dryers have been cleaned. 2. House audit was done and documented to check the other sprinkler heads for cleanliness. 3. A weekly check of sprinkler heads in laundry and a monthly check of sprinkler heads will be documented by maintenance supervisor or designee. 4. QAPI's Safety Committee will oversee for action or review. Administrator to monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/04/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=B	Continued from page 7 Based on observation and interview, the facility failed to maintain the sprinkler system for two of over thirty sprinkler heads. Findings include: Observation on February 11, 2025, at 11:53 a.m., revealed the room behind the dryers in the laundry room had sprinkler heads covered with a layer of dust/lint. A build-up of material can insulate the sprinkler thermal element, impacting the temperature activation/response time of the sprinkler and/or can cause inadequate spray coverage. Interview with the maintenance supervisor on February 11, 2025. At 11:53 a.m., confirmed the sprinkler head deficiency.	K 0353		
K 0919 SS=E		K 0919		

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K 0919 SS=E	Continued from page 8 NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, 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. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0919	1. Extension cord has been removed. 2. House audit to check for other extension cords has been conducted. 3. During weekly rounds, extension cords will be removed if found. 4. Random monthly check x3 by Administrator or designee will watch for extension cords. QAPI's Safety Committee will monitor for action or review. Administrator to monitor.	Completion Date: **03/30/2025** Status: **APPROVED** Date: **03/04/2025**

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K 0919 SS=E	Continued from page 9 Based on observation and interview, the facility failed to maintain electrical wiring and equipment, affecting one of more than four smoke compartments. Findings include: Observation on February 11, 2025, at 11:50 a.m., revealed the 300-wing mechanical room had an extension cord plugged into a power strip. Interview with the maintenance supervisor on February 11, 2025, at 11:50 a.m., confirmed the electrical deficiency.	K 0919		

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