

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2013
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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/22/13</p> <p>Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (000) 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 except for the Companion Dining Room. The facility</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after August 16, 2013.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 132 and had a census of 105 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which is not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<p><b>K017 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure required areas are equipped with automatic smoke detection system.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The 22 residents identified could have been affected by this deficient practice.</li> <li>· The identified issue was</li> </ul>	08/16/2013			

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	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 22 residents, staff and visitors in the Companion Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the Companion Dining Room had a 35 inch by twelve foot rectangular opening in the corridor wall. The Companion Dining Room was not provided with an automatic smoke detection system. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview at the time of observation, the Maintenance Director acknowledged the Companion Dining Room was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection.</p>		<p>resolved by Integrated Electronics installing an automatic smoke detector in the companion dining room on 7/24/2013.</p> <p><b>2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents who participate in companion dining meal service have the potential to be affected.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Future areas identified as open areas and not allowing for direct supervision by staff from a continuously staffed area will be reviewed and rectified with the proper equipment for compliance.</li> <li>· Maintenance director/designee will review areas through observation of the facility and preventative maintenance checks.</li> </ul>		

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	3.1-19(b)		<p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the Environmental Safety CQI 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013.</b></p>		

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 100 doors protecting corridor openings resist the passage of smoke. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the bathroom by Room 125.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, the gap between the face of the corridor door and the door jamb for the bathroom by Room 125 measured one inch when closed and latched. The face of the corridor door and the door jamb were each worn away near the door</p>	K010018	<p><b>K018 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure the doors protecting the corridor openings resist the passage of smoke.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>This deficient practice could have affected the 22 residents, staff and visitors in the vicinity of the bathroom by Room 125.</p>	08/16/2013			

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	<p>handle which caused the one inch gap. Based on interview at the time of observation, the Maintenance Director acknowledged the gap between the face of the corridor door and the door jamb for the bathroom by Room 125 was greater than one half inch when closed and latched.</p> <p>3-1.19(b)</p>		<ul style="list-style-type: none"> <li>· The area was immediately addressed by the maintenance assistant and no longer has a gap.</li> </ul> <p><b>2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All other residents, visitors and staff could be affected by this deficient practice.</li> <li>· A complete sweep of the facility was made and any identified areas that needed additional wood putty and sanding were addressed during this time.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> <li>· The maintenance department will be reeducated on areas to address when completing room/facility</li> </ul>		

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			<p>inspections by August 8.</p> <ul style="list-style-type: none"> <li>· The management team will be reeducated on areas to address and filling out maintenance request forms when completing their customer care rounds by August 16.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the Environmental Safety CQI 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16,</b></p>		

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K010020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to maintain a one hour fire resistance rating for 1 of 1 stairways. This deficient practice could affect 12 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, the stairwell access door to the basement on the first floor near the employee entrance did not provide a fire resistance rating of one hour. The aforementioned stairwell access door was not equipped with a fire resistance rating label. Based on interview at the time of observation, the Maintenance Director acknowledged the stairwell access door to the basement on the first floor near the employee entrance had no fire resistance rating.</p> <p>3.1-19(b)</p>	K010020	<p><b>K020 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain a one hour fire resistance rating for stairway access doors.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected 12 residents, staff and visitors.</li> <li>· The door identified was replaced with a new door that is one hour fire resistance rated on 7/30/2013.</li> </ul> <p><b>2 .How will you identify other residents having the potential to be affected by these same</b></p>	08/16/2013	

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			<p><b>deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All other residents, visitors and staff could be affected by this deficient practice.</li> <li>The other doors were checked for their fire resistance rating. No other doors noted in the comprehensive care unit.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks</li> </ul>		

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			<p>and monthly for 6 months.</p> <ul style="list-style-type: none"> <li>If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 8 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the following openings in the ceiling smoke barrier were noted:</p> <p>a. a two foot by one foot rectangular hole in the ceiling in the C Hall Housekeeping Room above the natural gas fired water heater.</p> <p>b. a one inch diameter hole in the ceiling of the Physical Therapy Room water heater closet.</p> <p>c. the annular space surrounding two, five inch diameter pipes protruding through</p>	K010025	<p><b>K025 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure ceiling smoke barriers are maintained to provide at least a one half hour fire resistance rating.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The 8 residents identified could have been affected by this deficient practice.</li> <li>· The identified areas in C Hall Housekeeping Room, Physical Therapy water closet and annual space surrounding</li> </ul>	08/16/2013			

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	<p>the ceiling of the sprinkler riser room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling smoke barrier did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 3 of 11 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 13 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the following was openings in smoke barrier walls were noted:</p> <p>a) the one inch annular space surrounding each of three water lines in the wall next to the water heater in the C Hall Housekeeping Room.</p> <p>b) the one inch annular space surrounding each of three water lines in the wall above the entrance door to the C Hall Housekeeping Room.</p> <p>c) a one inch hole in the wall next to the</p>		<p>two pipes in the sprinkler riser room have been repaired and have the required one half hour fire resistance rating required for the ceiling smoke barrier.</p> <ul style="list-style-type: none"> <li>The additional areas identified could have affected 13 residents, staff and visitors.</li> <li>The identified areas of the one inch annual spaces in the C Hall Housekeeping Room and the three inch hole in the mechanical room by room 22 have been repaired to maintain a smoke barrier.</li> </ul> <p><b>2.How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents have a potential to be affected by this deficient practice.</li> <li>Sweep of the facility was completed to locate any additional deficient areas. None to be noted.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>water heater in the C Hall Housekeeping Room.</p> <p>d) a three inch in diameter hole in the wall through which three water lines passed in the Mechanical Room by Room 22.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the smoke barrier wall in each of the aforementioned rooms failed to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>		<ul style="list-style-type: none"> <li>· Maintenance director/designee will review areas through observation of the facility and preventative maintenance checks.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the Environmental Safety CQI 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013.</b></p>		

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 9 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 21 residents, staff or visitors in vicinity of the C Hall Housekeeping Room and the Mechanical Room by Room 22.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, the following was noted:</p> <p>a. in the C Hall Housekeeping Room a two foot by one foot rectangular hole in the ceiling exposing the attic above the natural gas fired water heater, the one inch annular space surrounding each of three water lines in the wall next to the</p>	K010029	<p><b>K029 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure required areas are equipped with automatic smoke detection system.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· The 8 residents identified could have been affected by this deficient practice.</li> <li>· The identified areas in C Hall Housekeeping Room, Physical Therapy water closet and annual space surrounding</li> </ul>	08/16/2013			

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	<p>water heater, the one inch annular space surrounding each of three water lines in the wall above the entrance door to the room, and a one inch hole in the wall next to the water heater were not smoke resistant.</p> <p>e. in the Mechanical Room by Room 22 which contained one natural gas fired furnace, a three inch diameter hole in the wall through which three water lines passed was not smoke resistant. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the smoke barrier ceiling and walls of the C Hall Housekeeping Room and the Mechanical Room by Room 22 failed to separate the areas from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>two pipes in the sprinkler riser room have been repaired and have the required one half hour fire resistance rating required for the ceiling smoke barrier.</p> <ul style="list-style-type: none"> <li>The additional areas identified could have affected 13 residents, staff and visitors.</li> <li>The identified areas of the one inch annual spaces in the C Hall Housekeeping Room and the three inch hole in the mechanical room by room 22 have been repaired to maintain a smoke barrier.</li> </ul> <p><b>2.How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents have a potential to be affected by this deficient practice.</li> <li>Sweep of the facility was completed to locate any additional deficient areas. None to be noted.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p>		

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			<ul style="list-style-type: none"> <li>· Maintenance director/designee will review areas through observation of the facility and preventative maintenance checks.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the Environmental Safety CQI 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>	

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K010033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection for 1 of 1 exit stairs. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. This deficient practice could affect 12 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, the stairwell access door to the basement on the first floor near the employee entrance did not provide a fire resistance rating of one hour. The aforementioned stairwell access door was not equipped with a fire resistance rating label. Based on interview at the time of observation, the Maintenance Director acknowledged the stairwell access door to the basement on the first floor near the employee entrance had no fire resistance</p>	K010033	<p><b>K033 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain a one hour fire resistance rating for stairway access doors.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected 12 residents, staff and visitors.</li> <li>· The door identified was replaced with a new door that is one hour fire resistance rated on 7/30/2013.</li> </ul> <p><b>2 .How will you identify other residents having the potential</b></p>	08/16/2013			

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	rating.  3.1-19(b)		<p><b>to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All other residents, visitors and staff could be affected by this deficient practice.</li> <li>The other doors were checked for their fire resistance rating. No other doors noted in the comprehensive care unit.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2</li> </ul>		

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			<p>weeks then weekly for 4 weeks and monthly for 6 months.</p> <ul style="list-style-type: none"> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 5 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 60 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the skilled unit corridor exit by Room 317, the Physical Therapy Room exit and the employee entrance by Room 119 were each marked as a facility exit. Each exit door was magnetically locked</p>	K010038	<p><b>K038 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure the means of egress is readily accessible for residents without a clinical diagnosis requiring specialized security measures.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected 60 residents, staff and visitors.</li> <li>· The access codes were immediately placed on the appropriate locations.</li> <li>· The deficient practice could have affected 12 residents, staff and visitors if needing to exit the building from the employee entrance near room 119.</li> <li>· The door was repaired by Integrated Electronics on</li> </ul>	08/16/2013			

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	<p>and could be opened by entering a four digit code, but the code was not posted. Based on interview at the time of the observations, the Maintenance Director acknowledged the four digit code was not posted at each of the aforementioned facility exits. Based on interview at 3:35 p.m. on 07/22/13, the Administrator stated skilled unit residents who have a clinical diagnosis to be in a secure building reside in the Alzheimer's wing in Rooms 121 through 133. The Administrator stated skilled unit residents and Assisted Living residents without a clinical diagnosis to be in a secure building reside in the remaining areas of the facility and acknowledged the exit access code should be posted at each of the aforementioned facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 7 exit door electromagnetic locks unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of</p>		<p>7/24/2013.</p> <p><b>2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents, staff and visitors have a potential to be affected by this deficient practice.</li> <li>· The access codes were immediately placed on the appropriate locations.</li> <li>· The doors are routinely checked during our routine preventative maintenance plan with Integrated Electronics.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Maintenance director/designee will review facility paths of egress weekly through visual observation to ensure the codes are properly placed.</li> <li>· Weekly checks by the maintenance director/designee of the magnetic locks will be performed.</li> </ul>				

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	<p>the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 12 residents, staff and visitors if needing to exit the building from the employee entrance near Room 119.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the electromagnetic lock on the employee exit door by Room 119 did not release and remain unlocked when the fire alarm was activated at 2:50 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the electromagnetic lock on the employee exit door by Room 119 did not release when the fire alarm system was activated.</p> <p>3.1-19(b)</p>		<p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the Environmental Safety CQI 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013.</b></p>				

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 3 of 11 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual 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.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights - Test Log for Year 2012 and 2013" with the Maintenance Director during record review from 9:15 a.m. to 11:10 a.m. on 07/22/13, an annual ninety minute test for seven battery operated emergency lights in the facility was performed on 04/15/2013. In</p>	K010046	<p><b>K046 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to document battery test of emergency lighting in accordance with LSC 7.9.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could affect all residents, staff and visitors.</li> <li>· The log was updated and reflects all battery-operated emergency lights in the facility.</li> </ul> <p><b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p>	08/16/2013			

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	<p>addition, documentation of functional testing at 30 day intervals for not less than 30 seconds for seven battery operated emergency lights in the facility for the most recent twelve month period was noted. Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. and from 12:50 p.m. to 3:35 p.m. on 07/22/13, a total of eleven battery operated emergency lights were observed in the facility. Based on interview at the time of the observations, the Maintenance Director stated one new battery operated light was installed in the foyer of the Main Entrance in July 2013 and three battery operated lights were not itemized in the aforementioned Test Log documentation because the log grouped areas where battery operated emergency lights were located in the facility rather than each individual light location. Based on interview at the time of the observations, the Maintenance Manager acknowledged documentation of an annual ninety minute test for three of eleven battery operated emergency lights in the facility for the most recent twelve month period was not available for review. In addition, the Maintenance Director acknowledged monthly functional testing for three of eleven battery operated emergency lights for a minimum of 30 seconds was not available</p>		<ul style="list-style-type: none"> <li>· All other residents, visitors and staff could be affected by this deficient practice.</li> <li>· The log was updated and reflects all battery-operated emergency lights in the facility.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Battery Operated Emergency Lighting will be tested monthly and documented on the Battery Operated Emergency Lighting Monthly and Annual Test Log.</li> <li>· This log will be reviewed and signed off on by the Executive Director monthly.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks</li> </ul>	
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	for review.  3.1-19(b)		and monthly for 6 months.  · If a threshold of 95% is not achieved, an action plan will be developed.  · Results of these audits will be forwarded to the monthly CQI Meeting.  <b>5. The facility alleges date of compliance on August 16, 2013</b>		

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K010052 SS=C	<p><b>NFPA 101</b> <b>LIFE SAFETY CODE STANDARD</b> A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>	K010052	<p><b>K052 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain a fire alarm system required for life safety that is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected all residents, staff and visitors.</li> <li>· A lock has been installed on the electrical room door in order to secure the fire alarm panel on 7/24/2013.</li> </ul>	08/16/2013

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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107		
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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, access to the fire alarm system breaker located in the electrical panel in the main electrical room in the basement was not locked. Based on interview at the time of observation, the Maintenance Director acknowledged access to the fire alarm system breaker located in the electrical panel in the main electrical room in the basement was not locked.</p> <p>3.1-19(b)</p>		<p><b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents, visitors and staff could be affected by this deficient practice.</li> <li>· The lock was placed on 7/24/2013.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2</li> </ul>		

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			<p>weeks then weekly for 4 weeks and monthly for 6 months.</p> <ul style="list-style-type: none"> <li>If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect seven residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the closet in the General Manager's Office and the Assisted Living Lobby outside the General Manager's Office each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area. Based on interview at the time of the observations, the Maintenance Director acknowledged the sprinkler heads in the aforementioned locations each had missing escutcheon plates which left a two inch opening in the ceiling into the</p>	K010062	<p><b>K062 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to require automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected 7 residents, staff and visitors.</li> <li>· The escutcheon plates in the general manager's office closet and outside the assisted living office have been replaced.</li> </ul> <p><b>2 .How will you identify other residents having the potential</b></p>	08/16/2013			

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	attic from each area.  3.1-19(b)		<p><b>to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All other residents, visitors and staff could be affected by this deficient practice.</li> <li>The area was surveyed for any other missing escutcheon plates and none were identified.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> <li>Sprinkler system maintenance and inspections occur throughout the year. During these inspections, the maintenance director will meet with the vendor to discuss any escutcheon plate needs.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</b></p>		

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			<p><b>program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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K010067 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 7 of 8 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Beech Grove Meadows "Disaster Action Plan: Fire Prevention" documentation with the Maintenance Director during record</p>	K010067	<p><b>K067 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to comply with heating, ventilating and air conditioning provisions of section 9.2 and are installed in accordance with the manufacturer's specifications.</p> <p><b>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected all residents, staff and visitors.</li> <li>· A subcontractor completed the required 4 year damper inspection of the facility on 8/6/2013.</li> <li>· This deficient practice could have affected 83 residents, staff and visitors.</li> <li>· The facility will not be using</li> </ul>	08/16/2013			

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	review from 9:15 a.m. to 11:10 a.m. on 07/22/13, documentation of an itemized listing of fire damper locations and the results of the inspection and necessary maintenance performed within the most recent four year period was not available for review. The aforementioned documentation stated "automatic dampers are located throughout the facility for additional fire safety." Based on interview at the time of record review, the Maintenance Director stated fire dampers are located in the facility but acknowledged an itemized listing of each fire damper location and the results of the necessary maintenance performed within the most recent four year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, five fire dampers were observed installed in the ceiling HVAC system in the corridor outside the Assisted Living Laundry Room and three fire dampers were observed installed in the ceiling HVAC system in the corridor outside the Main Dining Room. One of the aforementioned five fire dampers outside the Assisted Living Laundry Room had a sticker affixed to the fire damper stating inspection and maintenance was performed on 07/17/13. Based on interview at the time of the observation,		the fire place system until a corrective solution can be installed.  · The facility is collecting bids from contractors and requesting a temporary waiver for this project. Please see attached waiver.  <b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b>  · All other residents, visitors and staff could be affected by this deficient practice.  · The dampers have been inspected by a subcontractor on 8/6/2013.  · This deficient practice could affect all residents, staff and visitors.  · The facility will not be using the fire place system until a corrective solution can be installed. The facility is collecting bids from contractors and requesting a temporary waiver for this project. Please see attached waiver.				

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	<p>the Maintenance Director stated the facility was in the process of performing the necessary four year inspection and maintenance on facility fire dampers and had only performed such maintenance on one facility fire damper. The Maintenance Director acknowledged documentation of an itemized listing of fire damper locations and the results of the inspection and necessary maintenance performed within the most recent four year period for seven of eight fire dampers was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 vented gas fireplaces were installed in accordance with Exception No. 2 to LSC Section 19.5.2.2. Exception No. 2 states fireplaces shall be used only in areas other than patient sleeping areas provided such areas are separated from patient sleeping spaces by construction having not less than 1 hour fire resistance rating and such fireplaces comply with the provisions of 9.2.2. In addition, the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. This deficient practice could affect 83, staff and visitors.</p>		<p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· The facility will provide the necessary fire damper inspection at least every 4 years in accordance with NFPA 90A.</li> <li>· Documentation will be kept in the maintenance director's files and an additional copy will be kept in the Executive Director's inspection files for review.</li> <li>· The system will be inspected for proper functioning once the contracted work is complete on a quarterly basis by the maintenance director/designee.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> </ul>		

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:35 p.m. on 07/22/13, the following was noted:</p> <p>a. the vented natural gas fireplace in the Assisted Living Lobby by the General Manager's Office did not have a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. The vented natural gas fireplace was not separated from Assisted Living Room 1 through 11, patient sleeping spaces, by construction having at least a one hour fire resistance rating.</p> <p>b. the vented natural gas fireplace in the Activities area by the Main Dining Room did not have a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned vented natural gas fireplaces each did not have a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit constructed of heat tempered glass or other approved</p>		<ul style="list-style-type: none"> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>	
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	<p>material. Based on telephone interview with the Maintenance Director at 2:50 p.m. on 07/23/13, the Maintenance Director acknowledged the Assisted Living Lobby fireplace was not separated from Assisted Living Room 1 through 11 by construction having at least a one hour fire resistance rating. In addition, the Maintenance Director stated the corridor smoke doors by Room 335 and Room 101 separating the Activities area from patient sleeping spaces each had the affixed rating label painted and could not determine if the Activities area fireplace was separated from patient sleeping spaces by construction having one hour fire resistance rating.</p> <p>3.1-19(b)</p>			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the employee entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, eight liquid oxygen containers were stored in the oxygen storage and transfilling room by the employee entrance. The ceiling was constructed of one layer of five eighths inch thick</p>	K010076	<p><b>K076 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain a one hour fire resistance rating for oxygen storage.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected 12 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the employee entrance.</li> <li>· An additional layer of drywall was added to the ceiling</li> </ul>	08/16/2013			

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	drywall which did not provide a fire resistive construction of one or more hours. Based on interview at the time of observation, the Maintenance Director stated the ceiling was constructed of one layer of five eighths inch thick drywall and acknowledged the one layer of drywall did not provide one hour fire resistive construction.  3.1-19(b)		to provide the required one hour fire resistance needed in the oxygen storage and transfilling room on 7/26/2013.  <b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b>  · All other residents, visitors and staff could be affected by this deficient practice that were near the oxygen storage and transfilling room.  · An additional layer of drywall was added to the ceiling to provide the required one hour fire resistance needed in the oxygen storage and transfilling room on 7/26/2013.  <b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b>  · Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.		

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			<p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010130 SS=B	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 1 of 9 hazardous rooms were kept in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects five staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, combustible boxes filled with plastic water pitchers and three foam pads wrapped in plastic were stored next to a natural gas fired furnace in the basement central supply room. Based on interview at the time of observation, the Maintenance Director acknowledged combustible materials were being stored next to the natural gas fired furnace in the central supply room in the basement.</p> <p>3.1-19(b)</p>	K010130	<p><b>K 130 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain and operate to minimize the possibility of a fire emergency requiring the evacuation of occupants.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>· This deficient practice could have affected five staff and visitors.</li> <li>· The combustible materials were immediately removed from the area, a perimeter was marked and 5/8" drywall was added on the studded wall.</li> </ul> <p><b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p>	08/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2013
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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
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			<ul style="list-style-type: none"> <li>· Any other staff or visitors in this area could be affected by this deficient practice.</li> <li>· The combustible materials were immediately removed from the area, a perimeter was marked and a 5/8" drywall was added on the studded wall.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Environmental Safety Rounds will be completed by the Maintenance Director/Designee on a weekly basis.</li> </ul> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not</li> </ul>	

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			<p>achieved, an action plan will be developed.</p> <p>Results of these audits will be forwarded to the monthly CQI Meeting.</p> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the employee entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:10 p.m. on 07/22/13, eight liquid oxygen containers</p>	K010143	<p><b>K143 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to maintain a one hour fire resistance rating for oxygen storage.</p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>This deficient practice could have affected 12 residents, staff and visitors in the vicinity of the oxygen storage and</p>	08/16/2013	

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	<p>were stored in the oxygen storage and transfilling room by the employee entrance. The ceiling was constructed of one layer of five eighths inch thick drywall which did not provide a fire resistive construction of one or more hours. Based on interview at the time of observation, the Maintenance Director stated the ceiling was constructed of one layer of five eighths inch thick drywall and acknowledged the one layer of drywall did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>transfilling room by the employee entrance.</p> <ul style="list-style-type: none"> <li>An additional layer of drywall was added to the ceiling to provide the required one hour fire resistance needed in the oxygen storage and transfilling room on 7/26/2013.</li> </ul> <p><b>2 .How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All other residents, visitors and staff could be affected by this deficient practice that were near the oxygen storage and transfilling room.</li> <li>An additional layer of drywall was added to the ceiling to provide the required one hour fire resistance needed in the oxygen storage and transfilling room on 7/26/2013.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>Environmental Safety Rounds will be completed by the Maintenance Director/Designee</li> </ul>		

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			<p>on a weekly basis.</p> <p><b>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director/Designee will complete the CQI Environmental Safety 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks and monthly for 6 months.</li> <li>· If a threshold of 95% is not achieved, an action plan will be developed.</li> <li>· Results of these audits will be forwarded to the monthly CQI Meeting.</li> </ul> <p><b>5. The facility alleges date of compliance on August 16, 2013</b></p>		