STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(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
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 483.70(a). Survey Date: 06/11/15 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Life Safety Code survey, Spring Mill 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. This two story facility with a basement was determined to be of Type II (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. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130	K 0000	June 26, 2015 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204 Dear Ms Rhoades, On June 11, 2015 a Life Safety Code Survey was conducted atSpring Mill Meadows. We respectfully request this document be submitted as thePlan of Correction and be considered for desk review by the staff of yourdivision. If any questions arise regarding this request or attacheddocuments, please feel free to contact me at your earliest convenience. Respectfully submitted, Austin Steele, HFA Cc: BernieMcGuiness, Director of Operations SueHornstein, Director of Compliance MarthaHerron, Director of Clinical Services File	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and had a census of 112 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered.			
K 0018 SS=E Bldg. 01	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of over 40 corridor doors on the first floor were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 28 residents, staff and visitors. Findings include:	K 0018	**What corrective action(s) will be accomplished for those residentsfound to have been affected by the deficient practice?** ·The facility purchased and installed newlatching mechanism, and latching plate to the linen closet located near room113. **How will you identify other residents having the potential to beaffected by the same deficient practice and what**	07/03/2015

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	Based on observation with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:25 p.m. on 06/11/15, the corridor door set to the clean linen room by Room 113 on the first floor failed to close and latch into the door frame. The east door in the door set was missing the latching mechanism at the top of the door and was missing a latching plate for the west door to latch into which caused an impediment to closing, latching and resisting the passage of smoke. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door set had an impediment to closing, latching and would not resist the passage of smoke. 3.1-19(b)		**corrective action will betaken?** ·28 resident have the potential to be affected. All rooms and doors have the potential to beaffected by the alleged deficient practice. As the The Life Safety Code agenttoured the building with Maintenance Director, the agent identified doors thatneeded attention. No other doors wereidentified needing replacement. ·Maintenance director toured the building andensured that all smoke barrier doors would latch correctly. . **What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur?** ·Maintenance director will check weekly the doorsto ensure that they doors open and close appropriately. **How will the corrective action be monitored to ensure the deficientpractice will not occur?** ·Maintenance director will complete a Life SafetyCQI report findings to the CQI meeting monthly x6 and quarterly thereafter for1 year.	
K 0025 SS=D Bldg. 01	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			

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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260	

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	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			
	Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 2 residents, staff and visitors in Room 107. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:25 p.m. on 06/11/15, the escutcheon plate was missing for the automatic sprinkler located in the closet nearest the window in Room 107 which left a two inch hole in the ceiling and exposed the second floor decking above the ceiling. Based on interview at the time of observation, the Maintenance Supervisor acknowledged an escutcheon for the aforementioned automatic sprinkler location was missing which left a two inch hole in the ceiling and exposed the second floor decking above the ceiling.	K 0025	**What corrective action(s) will be accomplished for those residents foundto have been affected by the deficient practice?** ·The facility purchased and installed theescutcheon on the sprinkler located in the closet nearest the window in room107. **How will you identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken?** ·2 resident have the potential to be affected. All rooms and doors have the potential to beaffected by the alleged deficient practice. As the Life Safety Code agenttoured the building with Maintenance Director, the agent identified thesprinklers that needed attention. Noother sprinklers were identified needing repair. ·Maintenance director toured the building andensured that all sprinklers had the proper escutcheon on the sprinkler. . **What measures will be put into place or what systemic changes**	07/03/2015

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	3.1-19(b)		**you willmake to ensure that the deficient practice does not recur?** ·Maintenance director will check weekly theescutcheons located on the sprinklers to ensure that they attached appropriately. **How will the corrective action be monitored to ensure the deficientpractice will not occur?** ·Maintenance director will complete a Life SafetyCQI report findings to the CQI meeting monthly x6 and quarterly thereafter for1 year.	
K 0062 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was 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 2 residents, staff and visitors in Room 107. Findings include: Based on observation with the	K 0062	**What corrective action(s) will be accomplished for those residentsfound to have been affected by the deficient practice?** ·The facility purchased and installed theescutcheon on the sprinkler located in the closet nearest the window in room107. **How will you identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken?** ·2 resident have the potential to be affected. All rooms and doors	07/03/2015

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	Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:25 p.m. on 06/11/15, the escutcheon plate was missing for the automatic sprinkler located in the closet nearest the window in Room 107 which left a two inch hole in the ceiling and exposed the second floor decking above the ceiling. Based on interview at the time of observation, the Maintenance Supervisor acknowledged an escutcheon for the aforementioned automatic sprinkler location was missing which left a two inch hole in the ceiling and exposed the second floor decking above the ceiling. 3.1-19(b)		have the potential to beaffected by the alleged deficient practice. As the Life Safety Code agenttoured the building with Maintenance Director, the agent identified thesprinklers that needed attention. Noother sprinklers were identified needing repair. ·Maintenance director toured the building andensured that all sprinklers had the proper escutcheon on the sprinkler. . **What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur?** ·Maintenance director will check weekly theescutcheons located on the sprinklers to ensure that they attachedappropriately. **How will the corrective action be monitored to ensure the deficientpractice will not occur?** ·Maintenance director will complete a Life SafetyCQI report findings to the CQI meeting monthly x6 and quarterly thereafter for1 year.	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the	K 0072	**What corrective action(s) will be**	07/03/2015

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	facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 5 first floor exits means of egress. This deficient practice could affect 28 residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:25 p.m. on 06/11/15, a portable three foot high by three foot wide wooden stairs with handrails used by Therapy was stored in the corridor outside Room 108. The aforementioned portable stairs was placed against the corridor wall and protruded three feet into the corridor outside Room 108. Based on interview at the time of observation, the Maintenance Supervisor stated the aforementioned stairs is stored by Therapy in the corridor and acknowledged the first floor exit means of egress outside Room 108 was not continuously maintained free of all obstructions or impediments to full instant use. 3.1-19(b)		**accomplished for those residentsfound to have been affected by the deficient practice?** ·The facility removed the wooden staircase fromthe hallway. **How will you identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken?** ·2 residents from 108 have the potential to be affected. As the Life Safety Code agent toured thebuilding with Maintenance Director, the agent identified other corridors thatneeded attention. No other corridorswere identified. ·Maintenance director toured the building andensured that all corridors did not have obstructions or impediments. . **What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur?** ·Maintenance director will check weekly thecorridors weekly to ensure that they free from impediments. **How will the corrective action be monitored to ensure the deficientpractice will not occur?** ·Maintenance director will complete a Life SafetyCQI report findings to the CQI meeting	

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			monthly x6 and quarterly thereafter for1 year.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not located within the patient care vicinity. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 20 residents, staff and visitors on	K 0147	**What corrective action(s) will be accomplished for those residentsfound to have been affected by the deficient practice?** ·The facility removed the power strips from room223 and 221. **How will you identify other residents having the potential to beaffected by the same deficient practice and what corrective action will betaken?** ·20 residents have the potential to be affected. As the Life Safety Code agent toured thebuilding with Maintenance Director, the agent identified other rooms thatneeded attention. No other rooms wereidentified. ·Maintenance director toured the building andensured that all rooms did not have a power strip within the allowable amount. . **What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur?**	07/03/2015

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	the second floor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:25 p.m. on 06/11/15, the following was noted on the second floor: a. a telephone charger and a CD player were plugged into a power strip which was on the floor underneath the resident bed nearest the corridor door in Room 221. b. a telephone charger was plugged into a power strip which was on the resident bed nearest the corridor door in Room 223. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged power strips were being used as a substitute for fixed wiring within the patient care vicinity at the aforementioned locations. 3.1-19(b)		·Maintenance director will check the rooms weeklyto ensure that they free from power strips. **How will the corrective action be monitored to ensure the deficientpractice will not occur?** ·Maintenance director will complete a Life SafetyCQI report findings to the CQI meeting monthly x6 and quarterly thereafter for1 year.	