						PRIN	TED: 1	10/08/2024		
DEPARTMENT OF HEALTH AND HUMAN SERVICES								FORM APPROVED		
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES			OM	B NO. 093	8-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)				(3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED				
		155352	B. WING		09/12/2024					
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS				2600 M	ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE RT, IN 46517	•				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	_	(X	(5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	3	COMPL	ETION		

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
E 0000				
DL-I				
Bldg		F 0000		
	An Emergency Preparedness Survey was	E 0000	The facility requests that this plan	
	conducted by the Indiana Department of Health in		of correction be considered its	
	accordance with 42 CFR 483.73.		credible allegation of compliance.	
	G D		Preparation and/or execution of	
	Survey Date: 09/12/24		this plan of correction does not	
	F 31, M 1 000040		constitute admission or agreement	
	Facility Number: 000243		by the provider of the truth of the	
	Provider Number: 155352		facts alleged or conclusions set	
	AIM Number: 100289830		forth in the statement of	
	A A A A B B A B B A B B B A B B B B B B		deficiencies. The plan of correction	
	At this Emergency Preparedness survey, Elkhart		is prepared and/or executed solely	
	Meadows was found in compliance with		because it is required by the	
	Emergency Preparedness Requirements for		provisions of federal and state law.	
	Medicare and Medicaid Participating Providers		We respectfully request a desk	
	and Suppliers, 42 CFR 483.73		review for compliance instead of a	
			post visit review on or before	
	The facility has 58 certified beds. At the time of		10/2/24.	
	the survey, the census was 54.			
	Quality Review completed on 09/13/24			
K 0000				
Bldg. 01				
	A Life Safety Code Survey was conducted by the	K 0000	The facility requests that this plan	
	Indiana Department of Health in accordance with		of correction be considered its	
	42 CFR 483.90(a).		credible allegation of compliance.	
			Preparation and/or execution of	
	Survey Date: 09/12/24		this plan of correction does not	
	_		constitute admission or agreement	
	Facility Number: 000243		by the provider of the truth of the	
	Provider Number: 155352		facts alleged or conclusions set	
	AIM Number: 100289830		forth in the statement of	
			deficiencies. The plan of correction	
	At this Life Safety Code survey, Elkhart		is prepared and/or executed solely	
	Meadows was found not in compliance with		because it is required by the	
	Requirements for Participation in		provisions of federal and state law.	

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

TITLE

(X6) DATE

Evan Wiedeman **Executive Director** 09/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 PLAN OF CORRECTION IDENTIFICATION NUMBER 155352		A. BUILDING <u>01</u> B. WING		COMPLETED 09/12/2024				
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa			We respectfully request a des review for compliance instead post visit review on or before 10/2/24.				
	Type III (200) const sprinklered. The fac- with smoke detection open to the corridor detectors are provid	ty was determined to be of cruction and was fully cility has a fire alarm system on in the corridors and in areas s. Battery operated smoke ed in the resident sleeping has a capacity of 58 with a ime of this survey.						
	access were sprinkle facility services wer unattached garage a							
K 0211 SS=E Bldg. 01	Quality Review con NFPA 101 Means of Egress -							
Blug. V I	Based on observation and interview, the facility failed to ensure 1 of 1 activity closet doors were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect 5 residents in the activity room. Findings include:		K 0211	K211 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility reached out to vendor is going to complete work order add a release from the latch to in the activity room closet doo work order to be completed by vendor on 10/2/24.	who er to ock r,			
	Director, Facilities I	on with the Maintenance Manager, and the 1/12/24 at 11:23 a.m., the		How other residents having the potential to be affected by the same deficient practice was a same to the same deficient practice was a same deficient practice.	ру			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMI	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIE	R	2600 N	ADDRESS, CITY, STATE, ZIP O MOREHOUSE AVE ART, IN 46517	COD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0363	activity closet door from the outside ar inside to open the o could trap a person the outside. Based observation, the Ad Manager agreed th locked with a device inside when locked	was locked with a latch-lock of there was no release from the cloor if locked. This condition inside the closet if locked from on interview at the time of diministrator and the Facilities activity closet door was be that could not open from the close wiewed with the Administrator, and the Maintenance Director		be identified and what corrective action(s) we taken; The deficient practice 5 residents in the active Facility reached out to is going to complete we add a release from the in the activity room clowork order to be composed work order to be composed will be made ensure that the deficition practice does not recomposed will be made ensuring activity close able to open from the locked. How the corrective as will be monitored to be deficient practice will recur, i.e., what qualified assurance program we into place; and by whether systemic changes deficiency will be composed will complete daily ensure compliance is report results to QAPI an action plan in place compliance is not met.	could affect vity room. vendor who vork order to e latch lock oset door, oleted by be put systemic e to ient cur; ortance of et door is inside if action(s) ensure the I not ity will be put nat date s for each mpleted; y rounds to met and will team with e if	
SS=D Bldg. 01	Corridor - Doors					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155352		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2024			
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) II PREFI	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF THE STATE OF T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	Based on observati failed to ensure 1 or doors were provide keeping the door of closing, latching, a smoke. This defici residents in room 1 Findings include: Based on observati Director, Facilities Administrator on 0 corridor door to res open with a trashea frame when tested. of observation, the corridor door woul removed the trashea The finding was re	on with the Maintenance Manager, and the 9/12/24 at 11:31 a.m., the sident room 10 was propped an and did not latch into the Based on interview at the time Facilities Manager stated the d not latch into the frame and an. viewed with the Administrator, and the Maintenance Director	K 0363	K363 What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice; MD removed the prop from the door. MD changed the inner conthe door. The door shuts a latches properly now. How other residents having the potential to be affected by the same deficient practice obe identified and what corrective action(s) will be taken; The deficient practice could a 2 of the residents in room 10. removed the prop from the docand replaced the inner core of door. The door shuts and latch properly now. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MD educated on importance of ensuring that all resident room corridor doors were provided means suitable for keeping the door closed, had no impedime closing, latching, and would rethe passage of smoke. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality	II n e core ind Dy will ffect MD for in the hes c ffect MD for in the hes c		

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CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155352		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 09/12/2024			ΈD		
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
K 0923 SS=E	NFPA 101 Gas Equipment - 0	Cylinder and Container			assurance program will be pointo place; and by what date the systemic changes for each deficiency will be completed. MD will complete daily rounds ensure compliance is met and report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 9/28	ch ; to will th	
Bldg. 01	failed to ensure a m feet separated comb storage equipment i NFPA 99, 11.3.2.3 oxygen shall be sep one of the following feet. (2) a minimum required storage loc automatic sprinkler NFPA 13, Standard Systems. (3) Enclos construction having rating of ½ hour. Thaffect 22 residents i Findings include: Based on observation Director, Facilities Administrator on 05 cardboard box conta oxygen supplies wa feet of stationary lice	on and interview, the facility inimum distance of at least five oustible materials from oxygen in 1 of 1 oxygen storage areas, requires oxidizing gases such as arated from combustibles by g: (1) a minimum distance of 20 in distance of 5 feet if the ation is protected by an system in accordance with for the Installation of Sprinkler and cabinet of noncombustible a minimum fire protection his deficient practice could in one smoke compartment. On with the Maintenance Manager, and the 20/12/24 at 11:47 a.m., a mining supplies and plastic is stored on a shelf within five quid oxygen containers in the trans-filling room. Based on	K 0	923	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All combustibles were removed from the oxygen storage and trans-filling room and moved to different storage area. How other residents having the potential to be affected by the same deficient practice who identified and what corrective action(s) will be taken; The deficient practice could affected from the oxygen storage and trans-filling room a moved to different storage are what measures will be put into place and what systemic changes will be made to	d o y vill fect s n and a.	09/28/2024

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	· /	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		<u>01</u>	COMPLETED			
155352			B. WING 09/12/2024						
NAME OF P	ROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD						
					IOREHOUSE AVE				
ELKHAR'	T MEADOWS			ELKHART, IN 46517					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	D BE COMPLE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE		
		ne of observation, the Facilities			ensure that the deficient				
		mbustible materials were			practice does not recur;				
	stored within five f	eet of stationary liquid oxygen			MD educated on importance of				
	containers.			ensuring a minimum distance of at					
	The finding was reviewed with the Administrator,			least 5 feet separated combustible materials from oxygen storage					
	•	and the Maintenance Director	equipment in oxygen storage						
	during the exit conference.		areas.						
	during the exit conference.				areas.				
	3.1-19(b)				How the corrective action(s	s)			
					will be monitored to ensure	•			
					deficient practice will not				
					recur, i.e., what quality				
					assurance program will be p	put			
					into place; and by what date				
					the systemic changes for ea				
					deficiency will be completed	•			
					MD will complete daily round				
					ensure compliance is met an				
				report results to QAPI team v	vitN				
					an action plan in place if compliance is not met.				
					compliance is not met.				
					Deficiencies corrected by 9/2	8/24			

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