STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING -- B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/12/24 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Emergency Preparedness survey, Elkhart Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 58 certified beds. At the time of the survey, the census was 54. Quality Review completed on 09/13/24	E 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before 10/2/24.	
K 0000 Bldg. 01	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/12/24 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Life Safety Code survey, Elkhart Meadows was found not in compliance with Requirements for Participation in	K 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Battery operated smoke detectors are provided in the resident sleeping rooms. The facility has a capacity of 58 with a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the unattached garage and a shed. Quality Review completed on 09/13/24		We respectfully request a desk review for compliance instead of a post visit review on or before 10/2/24.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 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: Based on observation with the Maintenance Director, Facilities Manager, and the Administrator on 09/12/24 at 11:23 a.m., the	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 who is going to complete work order to add a release from the latch lock in the activity room closet door, work order to be completed by vendor on 10/2/24. **How other residents having the potential to be affected by the same deficient practice will**	10/02/2024

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	activity closet door was locked with a latch-lock from the outside and there was no release from the inside to open the door if locked. This condition could trap a person inside the closet if locked from the outside. Based on interview at the time of observation, the Administrator and the Facilities Manager agreed the activity closet door was locked with a device that could not open from the inside when locked. The finding was reviewed with the Administrator, Facilities Manager, and the Maintenance Director during the exit conference. 3.1-19(b)		**be identified and what corrective action(s) will be taken;** The deficient practice could affect 5 residents in the activity room. Facility reached out to vendor who is going to complete work order to add a release from the latch lock in the activity room closet door, work order to be completed by vendor on 10/2/24. **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 activity closet door is able to open from the inside if locked. **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; and by what date the systemic changes for each deficiency will be completed;** MD will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 10/2/24	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors			

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	Based on observation and interview, the facility failed to ensure 1 of 30 resident room corridor doors 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 2 residents in room 10. Findings include: Based on observation with the Maintenance Director, Facilities Manager, and the Administrator on 09/12/24 at 11:31 a.m., the corridor door to resident room 10 was propped open with a trashcan and did not latch into the frame when tested. Based on interview at the time of observation, the Facilities Manager stated the corridor door would not latch into the frame and removed the trashcan. The finding was reviewed with the Administrator, Facilities Manager, and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K363** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD removed the prop from the door. MD changed the inner core on the door. The door shuts and latches properly now. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** The deficient practice could affect 2 of the residents in room 10. MD removed the prop from the door and replaced the inner core on the door. The door shuts and latches 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 with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	09/28/2024

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			assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed; MD will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 9/28/24	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 22 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director, Facilities Manager, and the Administrator on 09/12/24 at 11:47 a.m., a cardboard box containing supplies and plastic oxygen supplies was stored on a shelf within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Based on	K 0923	**K923** **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 will be identified and what corrective action(s) will be taken;** The deficient practice could affect 22 residents in one smoke compartment. All combustibles were removed from the oxygen storage and trans-filling room and moved to different storage area. **What measures will be put into place and what systemic changes will be made to**	09/28/2024

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	interview at the time of observation, the Facilities Manager agreed combustible materials were stored within five feet of stationary liquid oxygen containers. The finding was reviewed with the Administrator, Facilities Manager, and the Maintenance Director during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur;** MD educated on importance of ensuring a minimum distance of at least 5 feet separated combustible materials from oxygen storage equipment in oxygen storage areas. **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; and by what date the systemic changes for each deficiency will be completed;** MD will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 9/28/24	