STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	10/07/2024

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

(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 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/12/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 10/07/24 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this PSR survey, Elkhart Meadows was found not in compliance with Requirements for Participation in 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 52 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 10/10/24	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. We respectfully request a desk review for compliance instead of a post visit review on or before 10/24/24.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Evan Wiedeman	Executive Director	10/24/2024

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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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 was 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 and the Executive Director on 10/07/24 at 12:39 p.m., the 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. Additionally, there was a sliding lock at the top of the door. Based on interview at the time of observation, the Executive Director and the Maintenance Director agreed the activity closet door was locked with a device that could not open from the inside when locked. Based on an interview with the Executive Director at the time of observation, supplies were on order to correct the citation but had not yet arrived. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. This deficiency was cited on 09/12/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0211	**K211** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Vendor completed work order to remove the latch-lock from the outside of the activity closet door, release and door handle added to inside of closet door. Sliding lock on top of the door removed. **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 5 residents in the activity room. Vendor completed work order to remove the latch-lock from the outside of the activity closet door, release and door handle added to inside of closet door. Sliding lock on top of the door removed. **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)**	10/24/2024

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	3.1-19(b)		**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 10/24/24	