| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING -- B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 04/19/23<br><br>Facility Number: 000029<br>Provider Number: 155072<br>AIM Number: 100275200<br><br>At this Emergency Preparedness survey, Beech Grove Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 133 certified beds. At the time of the survey, the census was 71.<br><br>Quality Review completed on 04/20/23 | E 0000 | K 000<br>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of<br>correction is not an admission of or<br>agreement with the deficiencies or conclusions contained in the Life Safety<br>Code Recertification and Emergency Preparedness Survey Report. Beech Grove Meadows respectfully requests<br>consideration for a desk review of this plan of correction in lieu of post<br>survey revisit for K321,341,353, 355, and K363,. The facility is requesting IDR for K923 and K930. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 04/19/23<br><br>Facility Number: 000029<br>Provider Number: 155072<br>AIM Number: 100275200<br><br>At this Life Safety Code survey, Beech Grove | K 0000 | K 000<br>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of<br>correction is not an admission of or<br>agreement with the deficiencies or conclusions contained in the Life Safety<br>Code Recertification and | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | 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 and 410 IAC 16.2.<br><br>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. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 133 and had a census of 71 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which is not sprinklered.<br><br>Quality Review completed on 04/20/23 | | Emergency Preparedness Survey Report. Beech Grove Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post<br>survey revisit for K321,341,353, 355, and K363,. The facility is requesting IDR for K923 and K930. | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to ensure 1 of over 11 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the northwest nurse's station.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, a two inch in diameter hole was noted in the west wall of the natural gas fired water heater room by the northwest nurse's station. The hole was by the corridor door.<br>Based on interview at the time of the observations, the Maintenance Director agreed | K 0321 | K321-The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or visitors cited for this alleged deficient practice.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>Staff and visitors that are in the vicinity of the northwest nurses' station and potentially 20 residents that reside in the vicinity of the northwest nurse station have the potential to be affected | 05/19/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | by this alleged deficient practice.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The hole near the corridor door was immediately repaired with fire rated material. The Maintenance Department will be educated on the Preventative Maintenance Program by the Executive Director/designee.<br>**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?**<br>The Maint. Director/designee will complete a monthly Preventative Maint. audit tool for 6 months. The Executive Director/designee will review the Preventative Maintenance Manual audit tool monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be completed on or before 5/19/23.** | |
| K 0341<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Installation<br>Fire Alarm System - Installation | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the fire alarm system | K 0341 | K341-The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or visitors cited for this alleged deficient practice.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff and visitors that are in the facility have the potential to be affected by this alleged deficient practice.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The fire alarm circuit breaker | 05/19/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | circuit breaker located in the wall mounted electrical panel identified as "ER-1" in the basement electrical room behind the dryers was not identified with red marking and access to the breaker was not locked. Based on interview at the time of the observations, the Maintenance Director agreed the fire alarm system circuit breaker was not identified with red marking and access to the breaker was not locked.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | located behind the dryers was immediately marked with a red label indicating “Fire Alarm Circuit” and access to the breaker was locked. The Maint. Direct will be educated on the Fire Alarms Systems by the Executive Director/designee.<br>**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?**<br>The Maint. Director/designee will complete a Fire Alarm Breaker audit monthly for 6 months. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be completed on or before 5/19/23.** | |
| K 0353<br>SS=F<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Records of system design, maintenance, inspection and testing are maintained in a | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |
| | 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 07/28/22 with the Senior Maintenance Supervisor and the Maintenance Director during record review from | K 0353 | K353-#1 The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or visitors cited for this alleged deficient practice. The 3-year trip test on both dry systems failed inspection due to an obstruction in both inspector test lines. IEI proposes to provide all labor and travel to perform an obstruction investigation on the inspector test lines.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff and visitors that are in the facility have the potential to be affected by this alleged deficient practice.<br>**What measures will be put into place or what systemic changes you will make to** | 05/19/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | 8:50 a.m. to 1:15 p.m. on 04/19/23, deficiencies were noted during the quarterly inspection of the facility's dry sprinkler systems under Section II.B.3.1 and Section II.B.4.a.4 of the 07/28/22 inspection report. The "Deficiency Summary" section of the 07/28/22 inspection report stated the "(2) systems are sharing (1) air maintenance device (AMD). This needs to be corrected by adding a second AMD. This has been previously quoted to customer" in response to "Automatic air maintenance devices passed?" In addition, the "Deficiency Summary" section of the 07/28/22 inspection report stated, "Water was delivered on one system and was too clogged to deliver on the second system" in response to "Dry-pipe full flow trip test: Results comparable to previous tests?" The "General Comments" section of the 07/28/22 inspection report stated "3-Year trip test NOT completed and FAILED". Based on telephone interview with the sprinkler system inspection contractor at 1:00 p.m. on 04/19/22, the inspection contractor stated he provided the facility with a quote to conduct an obstruction investigation of the sprinkler system(s) on 08/11/22 but had not heard back from the facility on or after 08/11/22. The inspection contractor stated a subsequent 3-year trip test had not been performed on or after 07/28/22 and the sprinkler system(s) AMD repair or replacement had also not been conducted. The inspection contractor stated he would provide the facility with an updated quote for any investigation or repairs needed. The Senior Maintenance Supervisor and the Maintenance Director provided "Purchase Agreement" documentation dated 04/19/23 from the inspection contractor and signed by the facility 04/19/23 to correct deficiencies noted during the 07/28/22 inspection following the telephone interview.<br><br>These findings were reviewed with the visiting | | **ensure that the deficient practice does not recur?**<br>IEI to remove and replace all exposed sprinkler piping and sprinkler heads on the main level. Lines and mains will run where the existing system is located. After installation of the new piping a new trip test will be conducted to ensure in good condition.<br>**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?**<br>Life Safety QA will be completed monthly for 6 months by the Maintenance Director or designee. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be determined by the contractors' scope of work.**<br>K353-#2 The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, a blue water line was resting on top of horizontal sprinkler piping in the basement electrical room behind the dryers in the Laundry. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping was used to support non-system components in the basement electrical room.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | visitors cited for this alleged deficient practice.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff and visitors that are in the facility have the potential to be affected by this alleged deficient practice. The water line was immediately secured from the sprinkler line.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The Maint. Direct will be educated on the Sprinkler system by the Executive Director/designee.<br>**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?**<br>Sprinkler system QA will be completed monthly for 6 months by the Maintenance Director or designee. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | | | **The systemic changes will be completed on or before 5/19/23.** | |
| K 0355 SS=F Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>1. Based on observation and interview, the facility failed to ensure 1 of 19 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the ABC type portable fire extinguishers located in the sprinkler riser room closet had an affixed maintenance tag by an | K 0355 | K355-#1The facility requests Paper Compliance for this citation.<br><br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or visitors cited for this alleged deficient practice.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff and visitors that are in the facility have the potential to be affected by this alleged deficient practice. The facility fire extinguisher contractor was immediately contacted and the extinguisher in the “sprinkler riser room” was scheduled for inspection.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient** | 05/19/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | inspection contractor indicating the date the most recent annual maintenance was performed was February 2022. Based on interview at the time of the observations, the Maintenance Director agreed it had been greater than twelve months since the most recent annual maintenance was documented on the aforementioned portable fire extinguisher.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 19 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of | | **practice does not recur?**<br>The Maint. Direct will be educated on the Standard for Portable Fire Extinguishers by the Executive Director/designee.<br>**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?**<br>The Maint. Director/designee will complete a fire extinguisher audit monthly for 6 months. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be corrected by 5/19/23.**<br>K355-#2The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>There were no residents, staff or visitors cited for this alleged deficient practice.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | service and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 2 staff in the basement.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the wall mounted portable ABC type portable fire extinguisher located in the elevator machine room in the basement had an affixed maintenance collar and sticker indicating the most recent 6-year maintenance was performed in October 2016. The fire extinguisher inspection contractor also affixed a maintenance tag to the fire extinguisher indicating the most recent annual inspection was performed in February 2023. Based on interview at the time of the observations, the Maintenance Director stated the inspection contractor should have switched out the portable fire extinguisher this past February with an extinguisher meeting 6-year maintenance requirements and agreed the aforementioned portable fire extinguisher was documented as overdue for 6-year maintenance.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | All residents, staff and visitors that are in the facility have the potential to be affected by this alleged deficient practice. The facility fire extinguisher contractor was immediately contacted and the extinguisher in the “elevator machine room” was scheduled for inspection.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The Maint. Direct will be educated on the Standard for Portable Fire Extinguishers by the Executive Director/designee.<br>**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?**<br>The Maint. Director/designee will complete a fire extinguisher audit monthly for 6 months. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be corrected by 5/19/23.** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>Based on observation and interview, the facility failed to ensure 1 of over 10 resident room corridor doors in the adjoining Assisted Living area had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 13.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the adjoining Assisted Living area does not have separation from the health care occupancy. Resident sleeping Room 13 is in the Assisted Living area. A wedge was placed on the floor under the corridor door to resident sleeping Room 13 to prop the door in the fully open position. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door had an impediment to closing and latching into the door frame and would not resist the passage of smoke.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0363 | K363-The facility requests Paper Compliance for this citation.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>The alleged deficient practice could affect over 10 residents, staff, and visitors in the vicinity of room 13 on the assisted living.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff, and visitors in the vicinity of room 13 on the assisted living have the potential to be affected by this alleged deficient practice. The Maintenance Director and assisted living staff will be educated on corridor doors as it is related to fire safety.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The Maintenance Director and assisted living staff will be educated on corridor doors as it is related to fire safety.<br>**How the corrective action(s) will be monitored to ensure the** | 05/19/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | | | **deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The Maint. Director/designee will complete a door latching audit monthly for 6 months. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br>**The systemic changes will be corrected by 5/19/23.** | |
| K 0923<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.<br>Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen in the adjoining Assisted Living area were properly secured from falling.<br>NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.<br>This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 1. | K 0923 | K923-The facility requests paper compliance for this alleged deficiency.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>The alleged deficient practice could affect over 10 residents, staff, and visitors in the vicinity of room 1 on the assisted living. Storage rack/s were supplied to the resident in apartment #1 to ensure that all oxygen cylinders were properly stored and secured. | 06/09/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the adjoining Assisted Living area does not have separation from the health care occupancy. Resident sleeping Room 1 is in the Assisted Living area. One of one 'E' type oxygen cylinders was freestanding on the floor in Room 1 and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Director agreed the oxygen cylinder was not properly chained or supported in a proper cylinder stand or cart.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff, and visitors in the vacancy of AL room #1 have the potential to be affected by this alleged deficient practice. All designated assisted living staff will be educated on ensuring that oxygen cylinders are secured at all times while in the residents' apartments.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The maintenance director/designee will conduct monthly inspections of resident apartments to ensure cylinders are being secured. If found to be unsecure, they will be addressed immediately.<br>**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?**<br>The Maint. Director/designee will complete a secured oxygen storage audit monthly for 6 months. The results of these audits will be reviewed by the Executive Director/designee in Quality Assurance Meeting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | | | monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **The systemic changes will be completed by 6/9/23.** | |
| K 0930 SS=A Bldg. 01 | NFPA 101<br>Gas Equipment - Liquid Oxygen Equipment<br>Gas Equipment - Liquid Oxygen Equipment<br>The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99).<br>11.7 (NFPA 99)<br>Based on observation and interview, the facility failed to protect 1 of over 10 resident rooms in the adjoining Assisted Living area from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4, but NFPA has released a Tentative Interim Amendment (TIA) for that section and CMS will be issuing further guidance on that code section. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient | K 0930 | K930-The facility requests paper compliance for this alleged deficiency.<br>**What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected by the deficient practice?**<br>The alleged deficient practice could affect over 10 residents, staff, and visitors in the vicinity of apartment #1 on assisted living. Please see attached waiver request for construction of a room that meets the oxygen transfilling requirements.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents, staff, and visitors in | 11/30/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155072 | A. BUILDING 01<br>B. WING | 04/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BEECH GROVE MEADOWS | 2002 ALBANY ST<br>BEECH GROVE, IN 46107 |

| (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 |
|---|---|---|---|---|
| | practice could affect over 1 resident, staff and visitors in the vicinity of Room 4.<br><br>Findings include:<br><br>Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a tour of the facility from 1:15 p.m. to 3:00 p.m. on 04/19/23, the adjoining Assisted Living area does not have separation from the health care occupancy. Resident sleeping Room 4 is in the Assisted Living area. Two liquid oxygen containers were stored in resident sleeping Room 4. Room 4 was not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the room was not self-closing or automatic closing but was equipped with a minimum 1-hour fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Senior Maintenance Supervisor and the Maintenance Director agreed two liquid oxygen containers were stored in Room 4 and the room was not maintained with a minimum fire resistance rating of 1 hour.<br><br>These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | the vacancy of assisted living apartment #4 have the potential to be affected by this alleged deficient practice. Facility to submit temporary waiver requesting 120 business days to complete the construction of a room that meets the requirements for transferring liquid oxygen.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>The facility will work with a contractor to have a room that meets transferring oxygen requirements. Additional fire drills will be conducted during the construction period and in service on fire safety for all designated assisted living staff.<br>**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?**<br>One time in-service for designated Assisted Living staff will be conducted on oxygen filling safety.<br>**The systemic changes will be determined by the contractors' scope of work. Anticipated date of completion no later than 11/30/23.** | |