STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155072	B. WING		04/19/2023	
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP COD LEBANY ST H GROVE, IN 46107		
DEECH (				- GROVE, IN 40107		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 04/19 Facility Number: 0 Provider Number: 100 At this Emergency Grove Meadows was Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 133 the survey, the cens	20/23 200029 155072 275200 Preparedness survey, Beech as found in compliance with edness Requirements for caid Participating Providers EFR 483.73.	E 0000	K 000 This plan of correction constituth this facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission or agreement with the deficiencie conclusions contained in the L Safety Code Recertification and Emergency Preparedness Sur Report. Beech Grove Meadow respectfully requests consideration for a desk reviet this plan of correction in lieu of post survey revisit for K321,341,35 355, and K363,. The facility is	of solan of solan of solan of solan of solan of solan	
K 0000				requesting IDR for K923 and I	<b>1930.</b>	
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).  Survey Date: 04/19/23  Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200  At this Life Safety Code survey, Beech Grove		K 0000	K 000 This plan of correction constituthis facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission or agreement with the deficiencie conclusions contained in the L Safety	of s olan of es or	
	At this Life Safety	Code survey, Beech Grove	- 1	Code Recertification and	I	

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED 04/19/2023
	PROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CO. 2002 ALBANY ST BEECH GROVE, IN 46107	D
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATIO	N TAG DEFICIENCY)	ULD BE 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.  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.  All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which is not sprinklered.  Quality Review completed on 04/20/23	post survey revisit for K321,3 355, and K363,. The fac requesting IDR for K923	review of lieu of 41,353, ility is
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 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 tha do not exceed 48 inches from the bottom of		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155072	B. W	ING		04/19/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .			LBANY ST		
BEECH (	GROVE MEADOWS	6			I GROVE, IN 46107		
	T						<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	the door.	and many langtions of					
		and zone locations of that are deficient in					
	REMARKS.	mat are delicient in					
	19.3.2.1, 19.3.5.9						
	19.5.2.1, 19.5.5.9						
	Area	Automatic Sprinkler					
	Separation	·					
	•	-Fired Heater Rooms					
		er than 100 square feet)					
	c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64						
	gallons)						
	e. Trash Collection	n Rooms					
	(exceeding 64 gal	· · · · · · · · · · · · · · · · · · ·					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	-	classified as Severe					
	Hazard - see K32		17.0	201	KOOA The feelilite we would be		05/10/2022
		on and interview, the facility f over 11 hazardous areas such	K 0	321	K321-The facility requests Paper		05/19/2023
		rooms were separated from			Compliance for this citation.	i	
		oke resistant partitions and			What corrective action(s) will be accomplished for those	ı	
		be self closing or automatic			residents, staff and visitors		
		ce with 7.2.1.8. This deficient			found to have been affected	hv	
	_	et over 20 residents, staff and			the deficient practice?	~ ;	
	_	ity of the northwest nurse's			There were no residents, staff	or	
	station.	•			visitors cited for this alleged	-	
					deficient practice.		
	Findings include:				How will you identify other		
					residents having the potentia	al	
	Based on observation				to be affected by the same		
	_	visor and the Maintenance			deficient practice and what		
	_	our of the facility from 1:15 p.m.			corrective action will be take		
	to 3:00 p.m. on 04/19/23, a two inch in diameter				Staff and visitors that are in the		
	hole was noted in the west wall of the natural gas				vicinity of the northwest nurses	s'	
	fired water heater room by the northwest nurse's				station and potentially 20		
		ras by the corridor door.			residents that reside in the vici	inity	
	Based on interview				of the northwest nurse station	1	
	observations, the M	aintenance Director agreed	1		have the potential to be affected	ed	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/19/2023	
	ROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP COD ALBANY ST H GROVE, IN 46107		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0341	the aforementioned separated from othe partitions.  These findings were Senior Maintenance	hazardous area was not r spaces by smoke resistant e reviewed with the visiting		by this alleged deficient pract What measures will be put is place or what systemic changes you will make to ensure that the deficient practice does not recur? The hole near the corridor do was immediately repaired wite rated material. The Maintenan Department will be educated the Preventative Maintenance Program by the Executive Director/designee. How the corrective action(signature) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? The Maint. Director/designee complete a monthly Preventa Maint. audit tool for 6 months Executive Director/designee review the Preventative Maintenance Manual audit to monthly. The results of these audits will be reviewed in Qua Assurance Meeting monthly from the or until 100% complia is achieved. The QA Committ will identify any trends or patt and make recommendations revise the plan of correction a indicated. The systemic changes will to completed on or before 5/19	or h fire nce on e  ) the  but  will tive . The will ol ality for 6 ance tee tee teens to as	
SS=F Bldg. 01	NFPA 101 Fire Alarm System Fire Alarm System					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/19/2023	
	PROVIDER OR SUPPLIE		2002 A	ADDRESS, CITY, STATE, ZIP COD NLBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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	
	and components accordance with I Code, and NFPA Code to provide a part of the buildin occupied, detection is also in appliance circuit properties alarm system transmission path integrity.  18.3.4.1, 19.3.4.1 Based on observation failed to maintain I accordance with N Code, 2010 Edition location of the dedition of the	ns are monitored for  1, 9.6, 9.6.1.8  2) on and interview, the facility 2) of 1 fire alarm systems in 2) FPA 72, National Fire Alarm 2) Section 10.5.5.2.1 states, the 2) stated branch circuit 2) in shall be permanently 2) introl unit. Section 10.5.5.2.2 2) in systems the circuit 2) in shall be identified as "FIRE 2)." Section 10.5.5.2.3 states for 2) the circuit disconnecting means 2) irking. Section 10.5.5.2.4 states 2) ecting means shall be 2) authorized personnel. Section 2) dedicated branch circuit(s) and 2) are protected against physical 2) cient practice could affect all	K 0341	K341-The facility requests Pa Compliance for this citation. What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected the deficient practice? There were no residents, staff visitors cited for this alleged deficient practice. How will you identify other residents having the potenti to be affected by the same deficient practice and what corrective action will be take All residents, staff and visitors are in the facility have the pot to be affected by this alleged deficient practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The fire alarm circuit breaker	by for  al en? s that ential	

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155072		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/19/2023		
	PROVIDER OR SUPPLIER			2002 AL	ADDRESS, CITY, STATE, ZIP COD LBANY ST GROVE, IN 46107		
(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)	TE	(X5) COMPLETION DATE
	electrical panel ider basement electrical not identified with r breaker was not loci time of the observat Director agreed the breaker was not idea access to the breaker These findings were Senior Maintenance Maintenance Direct 3.1-19(b)	e reviewed with the visiting			located behind the dryers was immediately marked with a reclabel indicating "Fire Alarm Cirand access to the breaker was locked. The Maint. Direct will be educated on the Fire Alarms Systems by the Executive Director/designee.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?  The Maint. Director/designee who 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 months or until 100% compliant is achieved. The QA Committed will identify any trends or pattern and make recommendations to revise the plan of correction as indicated.  The systemic changes will be completed on or before 5/19/19.	d recuit" is per 6 me ee	
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a					

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155072	B. W	ING		04/19	/2023
	DOLUBER OF STREET	`		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	ζ.		2002 AI	LBANY ST		
BEECH (	GROVE MEADOWS	5		BEECH	I GROVE, IN 46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE
		nd readily available.					
	a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 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						
			177.0	2.52	16050 #4 TL 6 33		0.5/1.0/0.003
			K 0353		K353-#1 The facility requests	tion	05/19/2023
	systems in accordance with NFPA 25. LSC 9.7.5				Paper Compliance for this cita		
		er systems shall be inspected,			What corrective action(s) will be accomplished for those		
		ned in accordance with NFPA			residents, staff and visitors		
	· ·	e Inspection, Testing, and			found to have been affected	hv	
		ater-Based Fire Protection			the deficient practice?	Бу	
		5, 2011 Edition, Section 4.1.4.1			There were no residents, staff	or	
		owner or designated			visitors cited for this alleged	OI.	
		correct or repair deficiencies			deficient practice. The 3-year	trip	
	_	t are found during the			test on both dry systems failed	-	
	_	maintenance required by this			inspection due to an obstructi		
		ons and repairs shall be			both inspector test lines. IEI		
	performed by quali	fied maintenance personnel or			proposes to provide all labor a	and	
	a qualified contract	or. NFPA 25, 4.3.1 requires			travel to perform an obstruction	n	
		de for all inspections, tests,			investigation on the inspector	test	
		f the system components and			lines.		
		able to the authority having			How will you identify other		
		equest. This deficient practice			residents having the potenti	al	
	could affect all resi	dents, staff, and visitors.			to be affected by the same		
	F' 1' ' 1 1				deficient practice and what	_	
	Findings include:				corrective action will be take		
	Rased on review of	the sprinkler system			All residents, staff and visitors		
		or's "Form for Inspection,			are in the facility have the pot to be affected by this alleged	cuudi	1
	_	enance of Dry Pipe Fire			deficient practice.		
		documentation dated 07/28/22			What measures will be put in	nto	
		intenance Supervisor and the			place or what systemic		
		tor during record review from			changes you will make to		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155072	B. W	ING		04/19/	2023
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DEFOLL					LBANY ST		
BEECH (	GROVE MEADOWS			BEECH GROVE, IN 46107			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тс	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	8:50 a.m. to 1:15 p.	m. on 04/19/23, deficiencies			ensure that the deficient		
	_	he quarterly inspection of the			practice does not recur?		
	_	ler systems under Section			IEI to remove and replace all		
		i II.B.4.a.4 of the 07/28/22			exposed sprinkler piping and		
		The "Deficiency Summary"			sprinkler heads on the main le	evel	
		/22 inspection report stated			Lines and mains will run when		
		sharing (1) air maintenance			existing system is located. Aft		
	device (AMD). This needs to be corrected by				installation of the new piping a		
	adding a second AMD. This has been previously				new trip test will be conducted		
	quoted to customer" in response to "Automatic				ensure in good condition.	1.0	
	air maintenance devices passed?" In addition, the				How the corrective action(s)		
	"Deficiency Summary" section of the 07/28/22				will be monitored to ensure to	ho	
	inspection report stated, "Water was delivered on				deficient practice will not		
		s too clogged to deliver on the			recur, i.e., what quality		
	•	esponse to "Dry-pipe full flow			assurance program will be p		
	-	mparable to previous tests?"			into place?	ui	
	-	ments" section of the 07/28/22			Life Safety QA will be complet	·od	
		ated "3-Year trip test NOT			monthly for 6 months by the	leu	
		LED". Based on telephone			Maintenance Director or design	ınaa	
	-	sprinkler system inspection			The results of these audits wil		
		.m. on 04/19/22, the inspection			reviewed by the Executive	i be	
	-	provided the facility with a			Director/designee in Quality		
		obstruction investigation of			-	or 6	
	•	n(s) on 08/11/22 but had not	Assurance Meeting monthly for 6				
		e facility on or after 08/11/22.		months or until 100% compliance			
		ractor stated a subsequent			is achieved. The QA Committee		
	-	-			will identify any trends or patter		
		not been performed on or after			and make recommendations t		
	-	rinkler system(s) AMD repair			revise the plan of correction a	s	
	_	also not been conducted. The			indicated.		
	•	or stated he would provide the			The systemic changes will b		
	facility with an upd	-			determined by the contracto	rs'	
		airs needed. The Senior			scope of work.		
	_	visor and the Maintenance			K353-#2 The facility requests		
	•	Purchase Agreement"			Paper Compliance for this cita		
		d 04/19/23 from the inspection			What corrective action(s) wil	ı	
	contractor and signed by the facility 04/19/23 to				be accomplished for those		
		noted during the 07/28/22			residents, staff and visitors		
	inspection following	g the telephone interview.			found to have been affected	by	
					the deficient practice?		
	These findings were	e reviewed with the visiting			There were no residents, staff	or	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155072	B. W	ING		04/19/	/2023
			<u> </u>	CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DEFOLIA					LBANY ST		
DEECH (	GROVE MEADOWS			BEECH GROVE, IN 46107			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		e Supervisor and the			visitors cited for this alleged		
	Maintenance Director during the exit conference.				deficient practice.		
					How will you identify other		
	3.1-19(b)				residents having the potential	al	
					to be affected by the same		
		ation and interview, the facility			deficient practice and what		
	failed to maintain 1 of 1 sprinkler system in				corrective action will be take		
		SC 9.7.5. LSC 9.7.5 requires all			All residents, staff and visitors		
	automatic sprinkler systems shall be inspected				are in the facility have the pote	ential	
	and maintained in accordance with NFPA 25,				to be affected by this alleged		
	Standard for the Inspection, Testing, and				deficient practice. The water li		
	Maintenance of Water-Based Fire Protection				was immediately secured from	n the	
	Systems. NFPA 25, 2011 edition, Section 5.2.2.2				sprinkler line.		
		iping shall not be subjected to			What measures will be put in	nto	
	· ·	naterials either resting on the			place or what systemic		
		he pipe. This deficient practice			changes you will make to		
	could affect all occi	upants.			ensure that the deficient		
			practice does not recur?				
	Findings include:				The Maint. Direct will be educ		
				on the Sprinkler system by the			
	Based on observation				Executive Director/designee.		
	_	visor and the Maintenance			How the corrective action(s)		
	_	our of the facility from 1:15 p.m.	will be monitored to ensure the				
	_	19/23, a blue water line was			deficient practice will not		
		orizontal sprinkler piping in the			recur, i.e., what quality		
		room behind the dryers in the			assurance program will be p	ut	
		interview at the time of the			into place?		
		Iaintenance Director agreed			Sprinkler system QA will be		
		s used to support non-system			completed monthly for 6 mont		
	components in the b	basement electrical room.			by the Maintenance Director of		
	TE1 (* 1)	the annual of the			designee. The results of these	)	
	_	e reviewed with the visiting			audits will be reviewed by the		
		e Supervisor and the			Executive Director/designee in	า	
	Maintenance Direct	tor during the exit conference.			Quality Assurance Meeting		
	21.10(1)				monthly for 6 months or until		
	3.1-19(b)				100% compliance is achieved		
					QA Committee will identify any	y	
					trends or patterns and make		
					recommendations to revise the		
					plan of correction as indicated	l.	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED			
THIE TELL	or coluction.	155072		B. WING			04/19/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST BEECH GROVE, IN 46107				
(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		
W 0055	NEDA 404				The systemic changes will be completed on or before 5/19/			
K 0355 SS=F Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5.	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.	K 03	355	K355-#1The facility requests		05/19/2023	
	had documented am accordance with NF portable fire extinguinstalled, inspected, with NFPA 10. NF Fire Extinguishers, states fire extinguish maintenance at interyear, at the time of specifically indicate electronic notification fire extinguisher shatached that indicate maintenance was performing the world the agency performing the world the agency performing the could affect visitors.  Findings include:  Based on observation Maintenance Super Director during a to to 3:00 p.m. on 04/1 fire extinguishers lost	PA 10. LSC 9.7.4.1 states and maintained in accordance PA 10, Standard for Portable 2010 Edition, Section 7.3.1.1.1 there shall be subject to reals of not more than one hydrostatic test, or when ed by an inspection or on. Section 7.3.3 states each all have a tag or label securely test the month and year the erformed, identifies the person k, and identifies the name of ting the work. This deficient t all residents, staff, and			What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected the deficient practice? There were no residents, staff visitors cited for this alleged deficient practice. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents, staff and visitors are in the facility have the pote to be affected by this alleged deficient practice. The facility fextinguisher contractor was immediately contacted and the extinguisher in the "sprinkler riroom" was scheduled for inspection. What measures will be put in place or what systemic changes you will make to ensure that the deficient	by for  al that ential fire e		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1MM221 Facility ID: 000029

If continuation sheet Page 10 of 19

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155072	B. W	ING		04/19/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LBANY ST		
BEECH (	GROVE MEADOWS	S			I GROVE, IN 46107		
	1				1		,
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	inspection contractor indicating the date the most				practice does not recur?		
		tenance was performed was			The Maint. Direct will be educ		
	1	ised on interview at the time of			on the Standard for Portable		
		ne Maintenance Director			Extinguishers by the Executiv	⁄e	
	_	greater than twelve months			Director/designee.		
		nt annual maintenance was			How the corrective action(s		
	documented on the aforementioned portable fire				will be monitored to ensure	tne	
	extinguisher.				deficient practice will not		
	These findings were reviewed with the visiting				recur, i.e., what quality	4	
	Senior Maintenance Supervisor and the				assurance program will be p	out	
		tor during the exit conference.			into place?		
	wantenance Director during the exit conference.				The Maint. Director/designee		
	3.1-19(b)				complete a fire extinguisher a		
	3.1-19(0)				monthly for 6 months. The re		
	2 Pagad on absorpt	ation and interview, the facility			of these audits will be review	-	
		of 19 portable fire extinguishers			the Executive Director/design	iee iri	
		ear maintenance documented			Quality Assurance Meeting		
	•	n accordance with NFPA 10.			monthly for 6 months or until		
		ition, Section 7.3.1.1.2 states fire		100% compliance is achieved. The			
		be internally examined at			QA Committee will identify any trends or patterns and make		
	_	ding those specified in Table			recommendations to revise the	10	
		7.3.1.2.1 states every six years,		plan of correction as indicated.			
		extinguishers that require a			The systemic changes will be		
	•	test shall be emptied and			corrected by 5/19/23.	<del>, c</del>	
		plicable internal examination			K355-#2The facility requests		
		ed in the manufacturer's			Paper Compliance for this cit	ation	
	^	this standard. Sections 7.3.3.1			What corrective action(s) w		
		te fire extinguishers that pass			be accomplished for those		
		ar requirement shall have the			residents, staff and visitors		
		nation recorded on a durable			found to have been affected	bv	
		that is a minimum size of 2			the deficient practice?	-,	
	_	es. The label shall be affixed to			There were no residents, stat	f or	
	•	include the month and year the			visitors cited for this alleged		
		erformed. The label shall			deficient practice.		
	include the initials of the person performing the				How will you identify other		
	maintenance and the name of the agency				residents having the potent	ial	
	performing the maintenance. A verification of				to be affected by the same		
	-	be located around the neck of			deficient practice and what		1
		ating the month and year of			corrective action will be tak	en?	1

DENTIFICATION NUMBER  BECH GROVE MEADOWS  SIRRET ADDRESS. CITY. STATE, ZIP COD 2002 ALBANY ST BECH GROVE MEADOWS  SIRRET ADDRESS. CITY. STATE, ZIP COD 2002 ALBANY ST BECH GROVE, IN 46107  SCHOOL SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG  SERVICE and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 2 staff in the basement.  Findings include:  Findings include:  Based on observations with the Senior Maintenance Supervisor and the Maintenance Director during a toor of the facility from 1:15 pan. 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 mispection contractor also affixed a maintenance ling to the fire extinguisher the protector stated the inspection contractor also affixed a maintenance or requirements and agreed the aforementational, both the potential of the facility from 1:15 pan. To 3:00 p.m. on 04/19/23, the wall mounted portable ABC type portable fire extinguisher calculation 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 mis- inspection contractor also affixed a maintenance or that the deficient practice of the contractor of the facility fire extinguisher contractor was immediately contracted and the elevator machine room in the basement had an affixed maintenance rolls and sticker indicating the most recent 6-year maintenance was withede out the portable fire extinguisher was documented as overdue for 6-year maintenance requirements and agreed the aforementationed portable fire extinguisher was documented as overdue for 6-year maintenance.  These findings were reviewed with the visiting Serior Maintenance Supervisor and the Maintenance Director during the exit conference.	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
STREET ADDRESS, CITY, STATE, JIP COD 2002 ALBANY ST BEECH GROVE MEADOWS  (XA) JD SUMMARY STATIMENT OF DEFICIENCIE FREETX TAG SERVICE and the name of the agency performing the maintenance or recharge. This deficient practice could affect over 2 staff in the basement.  Findings include:  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 4/19/23, the wall mounted portable ABC type portable fire extinguisher located in the elevator machine room in the basement had an affixed maintenance collar and sicker indicating the most recent 6-year maintenance tag to the fire extinguisher indeating the most recent of so affixed a maintenance tag to the fire extinguisher infecting 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 was documented as overdue for 6-year maintenance.  These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Eupervisor and the Maintenance Director during the exit conference.  3.1-19(b)  SIMMARY STATEMENT SUBCRETY  ID PREETX  TAG  PREETX  TAG  PREETX  TAG  PREETX  TAG  All residents, staff and visitors that are in the facility fire extinguisher practice the facility fire extinguisher or thread the exitinguisher of the exitinguisher of the exitinguisher of the exitinguisher of the exitinguisher in the "elevator machine room" was scheduled for inspection.  What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  The Maint Director Wile be educated on the Standard for Portable Fire Extinguishers by the Executive Director/designee.  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?  The Maint Director/designee	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
BEECH GROVE MEADOWS  Ox41D  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MILST his PRECEDED BY PLLL TAG  REGULATORY OR LISC IDENTIFYING INFORMATION TAG  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 ARC type portable fire extinguisher indicating the most recent 6-year maintenance was performed in October 2016. The fire extinguisher indicating the most recent favorage and the maintenance calgar and sticker indicating the most recent annual inspection contractor should have witched out the portable fire extinguisher meeting 6-year maintenance collar and the switched out the portable fire extinguisher meeting 6-year maintenance comments as ordered are maintenance commented as overdue for 6-year maintenance. These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.  3.1-19(b)  DATE  MRECH GROVE, IN 46107  PREFIX TAG  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 in the "elevator machine room" was scheduled for inspection.  What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  The Maint, Director/designee.  How the corrective action(s) will be monitored to ensure the deficient practice will not rocur, i.e., what quality assurance program will be put into place?  The Maint, Director/designee will complete a fire extinguisher was documented as overdue for extractive breactor/designee will complete a fire extinguisher an			155072	B. W	ING		04/19/	/2023
BEECH GROVE MEADOWS  Ox41D  SUMMARY STATEMENT OF DEFICIENCE PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MLST his PRECEDED BY FULL TAG  RIGILATORY OR LISCIDENTIFYING INFORMATION  Findings include:  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 ARC type portable fire extinguisher indicating the most recent fayer maintenance was performed in October 2016. The fire extinguisher indicating the most recent dayer an attendance was performed in October 2016. The fire extinguisher indicating the most recent dayer and the maintenance calgar and sticker indicating the most recent dayer maintenance was performed in October 2016. The fire extinguisher indicating the most recent annual inspection contractor should have switched out the portable fire extinguisher meeting 6-year maintenance requirements and agreed the aforementioned portable fire extinguisher meeting 6-year maintenance color and the Maintenance Color and the Maintenance Director during the exit conference.  These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.  3.1-19(b)  DATE  PREFIX TAG  PREFIX								
DEECH GROVE, IN 46107  EXAMARY STATEMENT OF DEFICIENCE  WE WANARY STATEMENT OF DEFICIENCE  (I-ACH DEFICINCY MUST BIT PRECEDED BY BULL  TAG  Service and the name of the agency performing the maintenance or cerbarge. This deficient practice could affect over 2 staff in the basement.  Findings include:  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 was documented as overdue for 6-year maintenance.  These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.  These findings were reviewed with the visiting Senior Maintenance Supervisor and the Maintenance Director during the exit conference.  The findings include:  Dr. REFEXT TAG  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 contractor was amenine room. What measures will be put into place or what systemic Development and the facility have the extinguisher place or what systemic Development and the facility have t	NAME OF P	ROVIDER OR SUPPLIER						
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1MM221 Facility ID: 000029

PRINTED: 06/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/19/2023		
	PROVIDER OR SUPPLIER		•	2002 AL	DDRESS, CITY, STATE, ZIP COD BANY ST GROVE, IN 46107	•	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPRO	PRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
		corridor openings in other					
	· ·	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		g fire for at least 20					
		fully sprinklered smoke					
		only required to resist the					
	I	e. Corridor doors and doors					
	to rooms containir	_					
		rials have positive latching					
		atches are prohibited by					
	_	hese requirements do not					
		spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
	_	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	if provided with a	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	-	rs. Hold open devices that					
		door is pushed or pulled are					
	·	ed protective plates of					
		re permitted. Dutch doors					
		3 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	•					
		fire window assemblies are					
	i i	n sprinklered compartments					
		ctions in area or fire					
	resistance of glass	s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1MM221 Facility ID: 000029

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06/22/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/19/2023 155072 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST BEECH GROVE MEADOWS BEECH GROVE, IN 46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 05/19/2023 K363-The facility requests Paper failed to ensure 1 of over 10 resident room corridor Compliance for this citation. doors in the adjoining Assisted Living area had What corrective action(s) will no impediment to closing and latching into the be accomplished for those door frame and would resist the passage of residents, staff and visitors smoke. This deficient practice could affect over found to have been affected by 10 residents, staff and visitors in the vicinity of the deficient practice? Room 13. The alleged deficient practice could affect over 10 residents, Findings include: staff, and visitors in the vicinity of room 13 on the assisted living. Based on observations with the Senior Maintenance Supervisor and the Maintenance How will you identify other Director during a tour of the facility from 1:15 p.m. residents having the potential to 3:00 p.m. on 04/19/23, the adjoining Assisted to be affected by the same Living area does not have separation from the deficient practice and what health care occupancy. Resident sleeping Room corrective action will be taken? 13 is in the Assisted Living area. A wedge was All residents, staff, and visitors in placed on the floor under the corridor door to the vicinity of room 13 on the resident sleeping Room 13 to prop the door in the assisted living have the potential fully open position. Based on interview at the to be affected by this alleged time of the observations, the Maintenance deficient practice. The Director agreed the aforementioned corridor door Maintenance Director and had an impediment to closing and latching into assisted living staff will be the door frame and would not resist the passage educated on corridor doors as it is of smoke. related to fire safety. What measures will be put into These findings were reviewed with the visiting place or what systemic Senior Maintenance Supervisor and the changes you will make to Maintenance Director during the exit conference. ensure that the deficient practice does not recur? 3.1-19(b)The Maintenance Director and assisted living staff will be educated on corridor doors as it is

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related to fire safety.

How the corrective action(s) will be monitored to ensure the

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/22/2023
FORM APPROVED
OMB NO. 0938, 039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	r í	JILDING	onstruction 01	(X3) DATE COMPL 04/19/	ETED
	PROVIDER OR SUPPLIER			2002 AI	ADDRESS, CITY, STATE, ZIP COD LBANY ST I GROVE, IN 46107		
(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)	.TE	(X5) COMPLETION DATE
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - 0 Storag Gas Equipment - 0 Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enc noncombustible co	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2			deficient practice will not recur, i.e., what quality assurance program will be p into place?  The Maint. Director/designee complete a door latching audit monthly for 6 months. The resulting of these audits will be reviewed the Executive Director/designee Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The systemic changes will be corrected by 5/19/23.	will t sults ed by ee in . The y e	

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Less than or equal to 300 cubic feet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072			A. BUILDING <u>01</u> CON		(X3) DATE SURVEY COMPLETED 04/19/2023		
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	cylinders available patient care areas of less than or equirequired to be stored Cylinders must be as specified in 11. A precautionary si on each door or groom, where the si a minimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with inteithreshold pressure established. Empavoid confusion. Care protected from 11.3.1, 11.3.2, 11. 99)  Based on observation failed to ensure 1 of gases such as oxygous Living area were proposed in a passed on the supplier. Edition, Section 11. nonflammable gase or less than 8.5 cub comply with 11.3.3. Section 11.3.3.2 start cylinders specified accordance with 11 freestanding cylinder supported in a proposition of the supp	gn readable from 5 feet is ate of a cylinder storage ign includes the wording as FION: OXIDIZING GAS(ES) NO SMOKING." It is so cylinders are used in y are received from the ylinders are segregated When facility employs gral pressure gauge, a e considered empty is ty cylinders are marked to Cylinders stored in the open	K 0923	K923-The facility requests participate compliance for this alleged deficiency.  What corrective action(s) with the accomplished for those residents, staff and visitors found to have been affected the deficient practice?  The alleged deficient practice could affect over 10 residents staff, and visitors in the vicinit room 1 on the assisted living. Storage rack/s were supplied the resident in apartment #11 ensure that all oxygen cylinder were properly stored and second	by  s, sy of to so ers		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/19/2023		
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5)  ULLD BE PROPRIATE COMPLETION  DATE		
	Director during a to to 3:00 p.m. on 04/ Living area does not health care occupar is in the Assisted L oxygen cylinders w Room 1 and was no supported in a prop Based on interview observations, the M the oxygen cylinder supported in a prop These findings were Senior Maintenance.	visor and the Maintenance our of the facility from 1:15 p.m. 19/23, the adjoining Assisted of have separation from the acy. Resident sleeping Room 1 iving area. One of one 'E' type has freestanding on the floor in of properly chained or er cylinder stand or cart.		How will you identify or residents having the pet to be affected by the sadeficient practice and worrective action will be all residents, staff, and with the vacancy of AL room the potential to be affect alleged deficient practice designated assisted living be educated on ensuring oxygen cylinders are seall times while in the resident apartments.  What measures will be place or what systemic changes you will make ensure that the deficient practice does not recurrent to ensure cylinders are seall times while in the resident practice does not recurrent to ensure that the deficient practice does not recurrent to ensure cylinders are seall times will be ensure that the deficient practice does not recurrent to ensure cylinders are seally in the maintenance director/designee will compartments to ensure cylinders are being secured. If for unsecure, they will be an immediately.  How the corrective active will be monitored to endeficient practice will recurre to endeficient practice will recurred in the monitored to endeficient practice will recurre	otential ame what e taken? visitors in #1 have ted by this e. All ng staff will g that cured at sidents'  put into e to nt r?  onduct esident v/linders und to be ddressed  ion(s) sure the not II be put ignee will gen or 6 hese by the gnee in		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155072		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/19/2023	
	PROVIDER OR SUPPLIED		2002 A	ADDRESS, CITY, STATE, ZIP COD LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
				monthly for 6 months or until 100% compliance is achieved QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The systemic changes will b completed by 6/9/23.	y e
K 0930 SS=A Bldg. 01	Gas Equipment - The storage and reservoir contained	Liguid Oxygen Equipment Liquid Oxygen Equipment use of liquid oxygen in base ers and portable containers ons 11.7.2 through 11.7.4			
	failed to protect 1 of adjoining Assisted liquid oxygen contraction or patient of Care Facilities Code states the maximum permitted in storage location or patient of gallons), provided patient care room, or remainder of the fathorizontal assembling resistance rating of adopted building of adopted building of deficient according Section 11.7.4, but Interim Amendmer CMS will be issuing section. LSC Sectidoor assemblies in	on and interview, the facility of over 10 resident rooms in the Living area from the use of ainers stored in a patient bed care room. NFPA 99, Health e, 2012 Edition, Section 11.7.4 in total quantity of liquid oxygen e and in use in a patient bed care room shall be 120 L (31.6 that the patient bed location or or both, are separated from the cility by fire barriers and tes having a minimum fire 1 hour in accordance with the ode. Per Centers for Medicare es (CMS), this practice is to NFPA 99, 2012 Edition, NFPA has released a Tentative at (TIA) for that section and g further guidance on that code on 7.2.4.3.10 requires all fire horizontal exits shall be matic-closing. This deficient	K 0930	K930-The facility requests pay compliance for this alleged deficiency.  What corrective action(s) will be accomplished for those residents, staff and visitors found to have been affected the deficient practice?  The alleged deficient practice could affect over 10 residents, staff, and visitors in the vicinity apartment #1 on assisted livin Please see attached waiver request for construction of a rethat meets the oxygen transfill requirements.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents, staff, and visitors	by  / of g.  com ing  al

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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		
		155072	B. WING		04/19/2023		
NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
1110	<del> </del>	et over 1 resident, staff and	mo	the vacancy of assisted living	BATE		
	visitors in the vicin			apartment #4 have the potent	ial to		
	visitors in the vieni	ity of Room 4.		be affected by this alleged	iai to		
	Findings include:			deficient practice. Facility to			
	Tilldings include.			submit temporary waiver			
	Raced on observati	ons with the Senior		requesting 120 business days	to		
		visor and the Maintenance		complete the construction of a			
	_	our of the facility from 1:15 p.m.		room that meets the requirem			
	_	19/23, the adjoining Assisted		for transferring liquid oxygen.	Citio		
	-	ot have separation from the		What measures will be put in	nto		
	-	ncy. Resident sleeping Room 4		place or what systemic			
	_	iving area. Two liquid oxygen		changes you will make to			
		ored in resident sleeping Room		ensure that the deficient			
		t separated from the remainder		practice does not recur?			
		re barriers and horizontal		The facility will work with a			
		a minimum fire resistance rating		contractor to have a room that			
	_	ridor door to the room was not		meets transferring oxygen			
		omatic closing but was		requirements. Additional fire of	Irille		
		nimum 1-hour fire resistance		will be conducted during the	iiiii3		
		to the door. Based on		construction period and in ser	vice		
	-	ne of the observations, the		on fire safety for all designate			
		e Supervisor and the		assisted living staff.	ч 		
		tor agreed two liquid oxygen		How the corrective action(s)			
		ored in Room 4 and the room		will be monitored to ensure			
		with a minimum fire resistance		deficient practice will not			
rating of 1 hour.		a minimum nic resistance		recur, i.e., what quality			
				assurance program will be p	ut		
	These findings wer	re reviewed with the visiting		into place?			
	_	e Supervisor and the		One time in-service for design	nated		
		tor during the exit conference.		Assisted Living staff will be			
				conducted on oxygen filling sa	afety.		
	3.1-19(b)			The systemic changes will b	- I		
				determined by the contracto			
				scope of work. Anticipated of			
				of completion no later than			
				11/30/23.			

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