STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING -- B. WING	10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAIRWAY VILLAGE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/19/22 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 At this Emergency Preparedness survey, Fairway Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 53 certified beds. At the time of the survey, the census was 38. Quality Review completed on 10/21/22	E 0000		
K 0000 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: 10/19/22 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 At this Life Safety Code survey, Fairway Village was found not in compliance with Requirements	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Hicks	Executive Director	11/03/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 on all levels in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 53 and had a census of 38 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed. Quality Review completed on 10/21/22			
K 0223 SS=D Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and			

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	* Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of over 2 self closing doors in the basement would self close and latch into the door frame to form a smoke resistant barrier. This deficient practice could affect over 2 staff in the basement. Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, the Breakroom door in the basement was equipped with a self closing device and was held in the fully open position with a wall mounted magnetic holding device set to release with fire alarm system activation. A plastic tub and cardboard boxes were placed on the floor up against the door in the swing of the path of the door and would cause the door to not self close and latch into the door frame. Based on interview at the time of the observations, the Maintenance Supervisor agreed the items stored on the floor up against the door would prevent the door from self closing and latching into the door frame if the fire alarm system was activated. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0223	**K223 Doors with Self-Closing Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. Self closing lock and latch will be installed in order for door to close appropriately forming a smoke resistant barrier in the basement **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Maintenance will perform installation on door and ED/designee will monitor completion and function **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Director will be in serviced by Director of Property Management by 11.3.22 **How the corrective action(s) will be monitored to ensure the deficient practice will not**	11/15/2022

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			recur, i.e., what quality assurance program will be put into place? To ensure compliance, the ED/Designee will perform walking rounds in the basement with the Maintenance Supervisor using the QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observations and interview, the facility failed to ensure 1 of 5 exit discharges was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the patio enclosure on the west side of the building.	K 0271	**K271 Discharge from Exits** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to	11/15/2022

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	Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, the west exit door for the main dining room was marked as a facility exit with an exit sign. The exit discharge for the west exit door from the main dining room is an outside patio on the west side of the facility. The patio is enclosed with fencing and has one gate at the north end of the enclosure. The facility's bus was parked in the path of the exit discharge for the gate for the enclosure and completely blocked the main path of egress. The facility's emergency generator, parked cars and concrete berms for the parking spaces for the cars blocked any alternative path for the exit discharge for the patio gate. Based on interview at the time of the observations, the Director of Property Management and the Maintenance Supervisor agreed the bus, the parked cars and the concrete berms in the exit discharge would provide an impediment to full instant use in the case of fire or other emergency. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)		be affected by the alleged deficient practice. Center's transportation bus will be relocated to a different parking spot preventing it from blocking the emergency exit pathway **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Driver will move bus to the parking space at the end of the lot at all times **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Bus driver will be in-service by the ED/designee on where to park bus as to not block pathway for exit by 11.3.22 **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?** To ensure compliance, the ED/Designee will perform walking rounds throughout the parking lot daily as well as monitoring on the camera	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 1 of 1 Dutch doors to the kitchen from the main dining room latched into the door frame. LSC 19.3.6.3.13 states Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria: (1) Both the upper leaf and lower leaf are equipped with a latching device. (2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. (3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect over 20 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, the upper leaf for the Dutch door serving as the entrance door to the kitchen from the main dining room was equipped with a door handle and a latching device to latch the leaf into the door frame but the latching mechanism did not protrude into the latching plate on the door frame when tested to close multiple times. The upper leaf was not equipped with latching hardware to latch the upper leaf into the lower leaf. The main dining room was open to the corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed the upper leaf for	K 0363	**K363 Corridor - Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents, visitors and staff have the potential to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, visitors and staff have the potential to be affected by the alleged deficient practice. Locking mechanism on Dutch door between dining room and kitchen will be replaced to meet regulated requirements 11/16/22 The locking mechanism for room 102 will be replaced so it will no longer be necessary to prop door open by any object, the door handle will be replaced by 11/15/22 The door to room 207 will be repaired to assure the latch will fit into the door frame and adhere to regulation by 11/15/22 **What measures will be put into place or what systemic changes you will make to**	11/15/2022

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	the Dutch door to the kitchen did not latch into the door frame when tested to close multiple times. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of over 25 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, the following was noted: (1) the corridor door to resident sleeping Room 102 was propped in the fully open position with a folding chair placed up against the door. (2) the top hinge for the corridor door to resident sleeping room 103 was loose from the door frame which caused the door to hit the door frame on the handle side of the door and caused the door to fail to latch into the door frame when tested to close multiple times. (3) the corridor door to resident sleeping Room 207 failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned three corridor doors each had an impediment to closing and latching into the		**ensure that the deficient practice does not recur?** Weekly observational rounds testing all corridor doors will be conducted by Maintenance Supervisor to assure compliance and proper functioning **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?** To ensure compliance, the Maintenance Supervisor is responsible for the completion of the monthly QAPI times 6 and then quarterly to encompass all areas achieve continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	door frame and would not resist the passage of smoke. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the	K 0372	**K372 Subdivision of Building Spaces – Smoke Barrier** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Potential to affect over 20 residents by the alleged deficient practice **How will you identify other residents having the potential to be affected by the same**	11/15/2022

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	spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Housekeeping closet by the south nurse's station. Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, the attic access door in the Housekeeping closet by the south nurse's station was left in the fully open position which exposed the attic above and did not serve to maintain the fire resistance rating of the ceiling smoke barrier. Based on interview at the time of the observations, the Maintenance Supervisor agreed the open attic access door did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**deficient practice and what corrective action will be taken?** Over 20 residents could potentially be affected by the alleged deficient practice Attic access door in the housekeeping closet by South nurses station will be closed and kept in a closed position always Housekeeping staff and housekeeping lead will be inserviced by the Maintenance Supervisor on the regulation and the necessity for it to remain closed on or before 10/15/22 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Daily observational rounds to assure attic door is closed will be completed by the Maintenance Supervisor/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?** To ensure compliance, the Maintenance Supervisor/Designee will be responsible for utilizing the QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be	

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			reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the basement were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 2 staff in the vicinity of the Storage Room in the basement. Findings include: Based on observations with the Director of Property Management and the Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:45 p.m. on 10/19/22, one of one ceiling mounted electrical junction boxes in the Storage Room in the basement was without a cover which	K 0511	**K 511Utilities – Gas and Electric** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. A cover will be replaced covering the one ceiling mounted electrical junction box in the storage room that was missing **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Maintenance Supervisor will replace missing cover on or before	11/15/2022

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	exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)		11/15/22 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/designee will in-service Maintenance Supervisor on regulation by 11/11/22 Daily observational rounds completed by the Maintenance Supervisor to assure all covers are in place will occur **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?** To ensure compliance, the Maintenance Supervisor will utilize the QAPI tool weekly 3 times per week The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is			

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(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
	aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Director of Property Management and the Maintenance Supervisor during record review from 8:55 a.m. to 11:30 a.m. on 10/19/22, documentation of a third shift fire drill in the third quarter (July, August, September) 2022 was not available for review. Based on interview at the time of record review, Maintenance Supervisor stated the facility operates three shifts per day and agreed documentation for a third shift fire drill in the third quarter 2022 was not available for review. This finding was reviewed with the Director of Property Management and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0712	**K712 Fire Drills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Maintenance Supervisor will perform drills on each shift at variable times monthly on each shift and document in TELS **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED/designee will routinely monitor TELS each month to assure compliance Maintenance Supervisor will also show ED/designee the signature list of participants from each drill starting on 11.12.22 . **How the corrective action(s)**	11/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING 01 B. WING	10/19/2022

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, Maintenance Supervisor is responsible for the completion of the Fire drills QAPI tool monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	