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	08/15/2023

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: 08/15/23 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 44. Quality Review completed on 08/22/23	E 0000	This is the plan of correction for our life safety and we will like to request a paper compliance	
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: 08/15/23 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	This is the plan of correction for our life safety and we will like to request a paper compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Ngene	HFA	09/01/2023

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 detached wooden building in the rear that is not sprinklered only used for storage. The facility has a capacity of 53 and had a census of 44 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 08/22/23			
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			

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	nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous areas, such as combustible storage rooms over 50 square feet was provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect as many as 16 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made on 08/15/23 during a tour of the facility with the Director of Maintenance (DOM) and the Director of Property Management (DoPM) at 12:45 p.m., the Medical Records room (Room # 201) that measured approximately 190 square feet contained	K 0321	Plan of Correction **K321** A plan of correction ("POC") for the deficiencies must be received by the Division by September 3, 2023. An accepted POC must contain the following: • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **No residents were affected by this deficiency and a new self-enclosure has been installed on the door where that medical record is.** • how other residents having the potential to be affected	08/28/2023

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	numerous paper documents and records creating a hazardous environment. The entry door to this room from the corridor was not provided with a self-closing device. Based on an interview at the time of the observation, the DoPM acknowledged the room as hazardous and stated that he would have a self-closing device added to the door as soon as possible. During the exit conference on 08/15/23/with the facility Administrator, the DOM, and the DoPM at 2:31 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		by the same deficient practice will be identified and what corrective action(s) will be taken. ¿ **All residents have the potential to be affected** **¿ Education was provided by the administrator to the maintenance director on august 28th for the door to stay closed and to make sure the self-enclosure unit is working all the time.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. ¿ **Education was provided by the administrator to the maintenance director on august 28th to check all the offices and make sure they do not have more items in there than needed.** **¿ The maintenances director will observe self-enclosure on other doors daily on alternating shifts. Follow-up education and/or disciplinary action will be provided when non-compliance is noted.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **To ensure compliance, the administrator or designee is**	

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			responsible to audit the entire facility. **The self-enclosure on the doors will be checked twice a week for eight weeks, then once a week for eight weeks and monthly for eight more weeks.** **The Results of the checks will be reviewed by the CQI committee overseen by the ED.** **If 95% compliance is not achieved an action plan will be developed to ensure compliance.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. The latest completion date on an acceptable POC will be considered the date the facility has alleged compliance. **07/28/2023**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			

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	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet 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. Less than or equal to 300 cubic feet 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. Cylinders must be handled with precautions as specified in 11.6.2. 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." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 helium cylinder, a	K 0923	Plan of Correction **K923**	08/28/2023

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	nonflammable gas, was properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect as many as 16 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made on 08/15/23 during a tour of the facility with the Director of Maintenance (DOM) and the Director of Property Management (DoPM) at 12:45 p.m., one 9 ¼ inch diameter helium cylinder was laying on top of a metallic shelf approximately 5 feet (60 inches) from the floor in the oxygen storage and transfilling room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the DoPM agreed that the helium cylinder was sitting on a shelf of the oxygen storage and transfilling room and was not properly chained or supported in a proper cylinder stand or cart. During the exit conference on 08/15/23/with the facility Administrator, the DOM, and the DoPM at 2:31 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		A plan of correction ("POC") for the deficiencies must be received by the Division by September 3, 2023. An accepted POC must contain the following: • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **No residents were affected by this deficiency and the cylinder has been removed from the shelf.** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. ¿ **All other cylinders in the room have been secured with a chain for safety.** ¿ **Education was provided by the administrator to the maintenance director and the activities on august 28th to make sure they do not have cylinders in the oxygen room that are not chained and secured.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. ¿ **Education was provided by the administrator to the maintenance director on August 28th to check all the rooms and make sure they do**	

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			not have any cylinders in the rooms that are not chained and secured. **¿. Follow-up education and/or disciplinary action will be provided when non-compliance is noted.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **To ensure compliance, the administrator or designee is responsible to audit the entire building.** **Oxygen room will be checked twice a week for eight weeks, then once a week for eight weeks and monthly for eight more weeks.** **The Results of the checks will be reviewed by the CQI committee overseen by the ED.** **If 95% compliance is not achieved an action plan will be developed to ensure compliance.** • by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of	

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			correction with the updated plan of correction date. The latest completion date on an acceptable POC will be considered the date the facility has alleged compliance. **07/28/2023**	