STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155826	A. BUILDING -- B. WING	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/27/23 Facility Number: 013280 Provider Number: 155826 AIM Number: 201270670 At this Emergency Preparedness survey, Evergreen Crossing and the Lofts was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 109 certified beds. At the time of the survey, the census was 79. Quality Review completed on 03/06/23	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: 02/27/23 Facility Number: 013280 Provider Number: 155826 AIM Number: 201270670 At this Life Safety Code survey, Evergreen	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	Administrator	03/27/2023

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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	Crossing and the Lofts 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 two-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 79 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 03/06/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or			

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	other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS			

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	Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through the service hall exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the facility. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the double exit doors, marked as a facility exit from the main corridor into the service hallway, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the double exit doors. The Maintenance Director stated that perhaps they would remove the exit sign and asked if that would be okay. He was advised that required exits cannot be eliminated without cause and review. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director	K 0222	**REQUESTING A DESK REVIEW FOR THIS SURVEY** **K-222 Egress Doors** **What corrective actions will be accomplished for those residents found to have been affected?** New Era (door company) was contacted to repair door. This door already has 15 egress at the time of the survey. The code discussed in the 2567 is for wander guard not for opening the door. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents, Staff and families could have been effected however none were effected. This door was already equipped with 15 second egress. Signage was added to the door Maintenance Assistant was educated to check all 15 sec. egress doors for properly functioning. **What measures will be put into**	03/22/2023

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	present. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Assistant was educated to check all 15 sec. egress doors for properly functioning. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee to complete auditing of all Egress Doors Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	
K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in			

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	accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure 1 of 1 window and frame met the proper requirements for window glazing and frame fire resistance in a vertical open space in accordance with LSC 8.3.3. Section 8.3.3.12 states new fire protection-rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. 8.3.3.6 Glazing in fire window assemblies, other than in existing fire window installations of wired glass and other fire-rated glazing material, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 257or ANSI/UL 9. Fire protection-rated glazing in fire door assemblies, other than in existing fire-rated door assemblies, shall be of a design that has been tested to meet the conditions of acceptance of NFPA252, ANSI/UL 10B, or 10C. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the second floor contained a window in the dialysis unit which overlooked the first-floor atrium entry area, which was consistent with other corridor windows in the facility that were aluminum frame construction. The window and frame lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material or if the aluminum frame	K 0311	We received a variance from the State at the second floor window overlooking the lobby to allow for close spaced sprinkler heads on either side of the opening in lieu of the glass being rated to meet the intention of NFPA 101. I've attached the approval letter we received from the State and have highlighted the applicable note of approval. **K- 311** **What corrective actions will be accomplished for those residents found to have been affected? The facility received a variance from Home land Security and the ISDH at the time of the construction. Variance is attached under uploaded documents K311** **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? No residents affected** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	03/22/2023

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	met the fire resistance requirements for a vertical opening. Based on interview at the time of observation, the Administrator and Maintenance Director sought guidance via telephone conversations with other individuals not present for the survey but were unable to verify the rating of the aforementioned window or frame and agreed the window and frame was not marked with a fire-rated identifier. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		**Variance and info is uploaded with POC** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? This tag is within compliance with documents uploaded.**	
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 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			

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	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 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 10 residents, as well as staff and visitors. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., during a tour of the facility, (1) Resident Room # 122 contained 2 pallets with 44 cardboard boxes per pallet. The room was greater than 50 square feet and the corridor door did not self-close and latch into the doorframe. And (2) the Mechanical Room next to room #116 equipped with a self-closing device failed to self-close and latch. This deficient practice was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)	K 0321	**K-321 Hazardous areas** **What corrective actions will be accomplished for those residents found to have been affected?** Room 122 was cleaned out and all pallets were removed. The Mechanical room next to room #116 was repaired and latches. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents, Staff and families could have been effected however none were effected. Maintenance Assistant was educated to check all doors for properly functioning. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Assistant was educated to check all doors for	03/22/2023

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			properly functioning. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee to complete auditing of all Doors Auditing will occur 4x's monthly x's 5 months. Auditing of all vacant rooms to ensure nothing will be stored in them will also be audited 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2			

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	* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy area. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy area.	K 0324	**K-324 Cooking Facilities** **What corrective actions will be accomplished for those residents found to have been affected?** The emergency shut off switch was installed in the therapy kitchen for the range. The missing dip tray was ordered for the kitchen range hood and has been installed. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No residents were affected 6 staff members could have been affected however none were. Therapy Staff educated on the emergency shut off switch in therapy kitchen. Maintenance Assistant/ Certified Dietary Manager/dietary staff was educated to ensure all drip trays are in place.	03/22/2023

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	Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., there was a cooking range in the therapy area that was separated from the corridor, but staff were unable to deactivate the cooktop from power. The aforementioned range was powered on and not in use at the time of observation. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated the location of the shut off switch or if there was a shut off switch was not known. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff and visitors. Findings include:		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Therapy Staff and Maintenance assistant educated on the emergency shut off switch in therapy kitchen. Maintenance Assistant Certified Dietary Manager was educated to ensure all drip trays are in place. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee/ CDM to complete auditing of all Drip trays Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	

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	Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the design of the kitchen hood requires two drip trays, one on each side. Only the left side contained a drip tray, the right side was missing its metal drip tray underneath the kitchen range hood system. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and 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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were	K 0353	**K-353 Sprinkler System-Maintenance and**	03/22/2023

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	provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., there was one spare sprinkler cabinet in the riser room that included spare sprinklers. During a tour of the facility 2 sidewall standard response sprinklers were observed in the facility however the spare sprinkler cabinet did not contain any standard response sidewall sprinkler heads. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinet did not have spare standard response sidewall sprinklers. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present.		**Testing** **What corrective actions will be accomplished for those residents found to have been affected?** The Vendor was called out immediately to bring the required standard response sidewall sprinkler heads **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents had the potential to be affected however no residents were affected. Maintenance Assistant was educated on ensuring the amount of supply on hand at all times for the extra sprinkler heads is met. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Assistant was educated on ensuring the amount of supply on hand at all times for the extra sprinkler heads is met **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee/ to complete auditing of sprinkler cabinet to ensure the spare	

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	3.1-19(b)		sprinklers are on hand at all times. Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	
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			

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	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 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 30 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 2 staff. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the (1) "Med Suite II" closet door in the therapy area failed to close and latch positively into the door frame. And (2) the corridor office door across from the elevator on the second floor had a ½ inch hole and would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned door did not close and latch into the door frame and each door would not resist the passage of smoke.	K 0363	**K-363- Corridor Doors** **What corrective actions will be accomplished for those residents found to have been affected?** The latch to medical suite 11 closet door in therapy area was repaired. An audit was completed on all doors to ensure proper closure. The ½ hold in the corridor office door across from the elevator on the 2nd floor was repaired to ensure resist the passage of smoke. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No residents were effected, No staff were effected. Maintenance	03/22/2023

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	This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		Director was educated that all doors need to latch into door frames and to ensure no holes are in any doors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director was educated that all doors need to latch into door frames and to ensure no holes are in any doors **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee to complete auditing of all doors to make sure they latch. Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	
K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	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 1 of more than 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff on the second floor. Findings include:	K 0372	K-372 American Structure Point Architecture & Interiors Group of Indianapolis, (contracted during the 2019 2nd floor renovation floor occupancy), confirmed the smoke compartment by the Dialysis room is constructed of a 1 hour “Rated Ceiling LID” to separate the occupied space from the attic space and is not associated with the particle wood wall in the attic. The drywall wall “Rated Ceiling LID” is located above the suspended ceiling from smoke doors to exit egress stairwell; encapsulating the hallway egress; identified on drawing Smoke compartment B2 – Corridor 1 hour rated for egress. Since the facility has a NFPA-13 sprinkler system, it does not require attic draft stopping and are not aware of any requirements for a rated / smoke barrier to have to go to the roof in	03/22/2023

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	Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the smoke barrier wall in the attic near RR 200 and the dialysis wall did not extend completely through the attic space. It appeared to be more of a draft stop, constructed of particle board and not a smoke wall. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		that area. Attachment will be uploaded showing info G101 i right corner of attachment	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility did not maintain 2 of 2 sets of barrier doors in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2 and 8.5.6. This deficient practice could affect	K 0374	**K-374- Subdivision of Building Spaces** **What corrective actions will be accomplished for those residents found to have been**	03/22/2023

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	approximately 20 residents. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the (1) set of double latching door in the corridor near RR 158 and (2) the set of double latching door in the corridor leading into suites 216-230, near RR 230, did not latch when tested 3 times. The Maintenance Director stated that the latching mechanisms appeared to be sticking and not allowing each door in the double door sets (which he identified as fire doors) to latch positively into the door frame. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		**affected?** The set of double latching doors near RR 158 and the set of double latching door near RR 230 were repaired. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The potential for approximately 20 residents could have been affected however No residents were effected. Maintenance Director was educated that all doors need to latch into door frames. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director was educated that all doors need to latch into door frames. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee to complete auditing of all doors to make sure they latch. Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months.	

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			Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	
K 0511 SS=E 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 over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors	K 0511	**K-511- Gas and Electric** **What corrective actions will be accomplished for those residents found to have been affected?** The Ice machine connected to a receptacle on Heritage connected within 2 feet of the sink was replaced with a GFCI outlet. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Any resident near the ice machine could have been affected but no residents were affected. Maintenance Assistant was educated that GFCI's are needed anywhere near water areas. **What measures will be put into**	03/22/2023

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	Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Assistant was educated that GFCI's are needed anywhere near water areas. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** Maintenance assistant/Designee to complete auditing of GFI's in nursing station kitchenettes where needed. Auditing will occur 4x's monthly x's 5 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified.	

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	reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents while at the ice machine, and 2 staff in the nurse's station. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., the ice machine in the Heritage Nurses Station was connected to an electric receptacle which was within 2 feet of the sink. When tested, the aforementioned receptacle did not appear to be a GFCI outlet or on a GFCI breaker. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2,			

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	18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 8:50 a.m. and 12:20 p.m., the provided Emergency Preparedness Manual lacked information on partial or horizontal evacuation from one smoke compartment beyond a smoke or fire barrier to the next smoke compartment. The provided documentation used the term "station" but did not define to what it is referring. Based on interview during records review, the Administrator agreed the Fire Emergency Procedures that was provided for review did not contain complete instruction for Evacuation of smoke compartments. This deficient practice was acknowledged at the	K 0711	**K- 711** **What corrective actions will be accomplished for those residents found to have been affected?** **The written safety plan was in place at the time of survey and has been since 12/2019 however not all of the plan was given to surveyor.** **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents could have been affected however no residents were affected.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? To ensure the written safety plan is in both Emergency Procedure binders and Life Safety binder and readily available for everyone to view** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? Administrator to audit all binders to ensure**	03/22/2023

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	time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		**safety plan is in Emergency Procedure binders and Life Safety binder monthly for 6 months.**	
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 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 conduct fire drills on each shift for 3 of 12 shifts in 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Administrator and Maintenance Director from another facility on 02/27/23 between 8:50 a.m. and 12:20 p.m., the following shifts were missing documentation of a completed fire drill: a) First Shift in the fourth quarter of 2022. b) Second shift in the third quarter of 2022.	K 0712	K712 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility will conduct fire drills. One per shift, per month, per quarter.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 residents residing in the facility have the potential to be affected. No residents were affected by this alleged deficient practice. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	03/22/2023

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	155826	A. BUILDING 01 B. WING	02/27/2023

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EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

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	c) Third shift in the third quarter of 2022. Based on interview at the time of record review, the Administrator and Maintenance Director stated the drill documentation was not available to show the drills were conducted. This deficient practice was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		recur; Maintenance was educated on fire drills. 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; andExecutive Director or designee will monitor fire drills monthly for six months. Fire drills have been added to Tels PM program. Results will be brought to monthly QAPI	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas			

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	where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure the smoking policy was followed and smoking occurred only in the smoking area. This deficient practice could affect staff and 5 residents. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m. and 4:50 p.m., in the gravel area near the generator, immediately outside exit nearest the generator, there were over 200 cigarette butts disposed on the ground in and around the gravel. The Maintenance Supervisor stated that it was likely the result of staff as the residents do not generally smoke in this area, which is not the facility's one designated smoking area for residents. The Administrator stated during the initial interview that staff are to smoke off site or in their cars. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)	K 0741	**K-741** **What corrective actions will be accomplished for those residents found to have been affected?** **The cigarette butts located on ground outside back service hall door were cleaned and removed. No smoking sign was placed outside door** **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? No residents go outside back service hall no therefore no residents were affected. Smoking sign was placed in that area and staff were educated that is a no smoking area.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **Smoking sign was placed in that area and staff were educated that is a no smoking area.**	03/22/2023

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			How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? **Maintenance Director/Designee to complete auditing of area to ensure following no smoking area. Auditing will occur 3x's a week x's 4 weeks, 3x's monthly x's 5 months**	
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 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			

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	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 5 of 5 cylinders of nonflammable gases such as oxygen were 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 5m staff. Findings include: Based on observation and interview with the Administrator and Maintenance Director from another facility on 02/27/23 between 12:20 p.m.	K 0923	**K- 923** **What corrective actions will be accomplished for those residents found to have been affected?** **5 carbon dioxide cylinders were removed from the floor in the maintenance storage area. No residents were affected as they are not allowed entry to this area.** **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The cylinders were removed from the bldg. as they are no longer needed.**	03/22/2023

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	and 4:50 p.m., 5 carbon dioxide cylinders were standing upright on the floor in the maintenance storage area and were not properly chained or supported in a proper cylinder stand or cart. The Maintenance Director stated he was unsure what they were for, as the facility does not (to his knowledge) have a soda machine. This finding was acknowledged at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director present. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **The cylinders were removed from the bldg. as they are no longer needed. Maintenance Director was educated on items placed in maintenance storage area.** **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?** **Administrator/Designee will audit Maintenance storage area 3x's weekly x's 4 weeks, 3x's monthly x's 5 months** **Audits will be brought to QAPI and reviewed x 6 months**	