STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 01 B. WING	04/24/2023

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/27/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/24/23 Facility Number: 013280 Provider Number: 155826 AIM Number: 201270670 At this PSR Life Safety Code survey, Evergreen 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 82 at the time of this PSR visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/01/23	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	Administrator	05/12/2023

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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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 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.	K 0372	**Requesting desk review** **K- 372** **What corrective actions will be accomplished for those residents found to have been affected? The facility contracted with R. Underwood Construction to install Fire Wall** **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? R Underwood Construction supplied the scope of work that is attached to this POC to state**	05/25/2023

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	Findings include: Based on observation and interview with the Administrator on 04/24/23 between 9:05 a.m. and 11:00 a.m., the Administrator stated that no work had been done to the smoke barrier wall which was observed during the original survey, located in the attic near RR 200 and the dialysis wall which 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. The Administrator, on a conference call with a facility consultant during the PSR, stated the corridor leading from the smoke doors through the second-floor corridor to the stairwell exit was rated and created a "fire box" evacuation route of sorts. The consultant on the phone stated that the wall in the attic was not a fire wall, smoke wall, or draft stop. Based on email correspondence with the Senior Project Architect and the Life Safety Code Supervisor on 04/25/23 at 1:51 p.m., the Senior Project Architect failed to confirm the second floor one hour smoke barrier wall near the dialysis room terminated at a one-hour smoke barrier ceiling. This finding was acknowledged by the Administrator at the time of interview and again at the exit conference with both the Administrator and Maintenance Director from another facility present. This deficiency was cited on 02/27/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**work to be done.** **1. Stage work area in 2nd floor dining room started on 5/8/2023** **2. Frame scaffolding in attic area to allow for access to roof line started on 5/8/2023** **3. Provide and install 5/8" fire code drywall on both sides of attic wall started on 5/9/2023** **4. Install 3M fire caulk to all penetrations** **5. Remove all temporary scaffolding** **6. Cleanup and remove temporary wall from dining 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? This tag is within compliance with documents uploaded. Pictures of work being started to completion will be done and sent to Life Safety Supervisor until wok completed.**	

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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 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:	K 0741	**Requesting desk review 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**	05/25/2023

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	Based on observation and interview with the Administrator on 04/24/23 between 9:05 a.m. and 11:00 a.m., in the gravel area near the generator, immediately outside exit nearest the generator, there were over 100 cigarette butts disposed on the ground in and around the gravel. This location was not a designated smoking area and the Administrator stated that "No Smoking" signs had been placed around this area and that currently it was her understanding that no one was smoking in this location. The Administrator stated during the original survey in the initial interview that staff are to smoke off site or in their cars. This finding was acknowledged by the Administrator at the time of discovery and again at the exit conference with both the Administrator and Maintenance Director from another facility present. This deficiency was cited on 02/27/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**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.** **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. Results**	

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			of monitoring will be reviewed during the facility's Quality assurance meeting x6 months.	