PRINTED: 02/26/2025

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/05/2025	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS				2002 A	ADDRESS, CITY, STATE, ZIP COD LBANY ST I GROVE, IN 46107			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000								
Bldg			E 0	000				
	Facility Number: (Provider Number: AIM Number: 100	155072						
	Grove Meadows w Emergency Prepare	Preparedness survey, Beech as found in compliance with edness Requirements for icaid Participating Providers CFR 483.73.						
	The facility has 133 the survey, the cens	3 certified beds. At the time of sus was 90.						
	Quality Review con	mpleted on 02/07/25						
K 0000								
Bldg. 01	A Life Safety Code	e Recertification and State	K 0	000	We are requesting desk revie	w		

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

At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with

Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR

> TITLE (X6) DATE

Jeremiah Johnson **Executive Director** 02/21/2025

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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483.90(a).

Survey Date: 02/05/25

Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAY		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	BUILDING <u>01</u> COMPLE	
		155072	B. WING		02/05/2025
NAME OF B	AD CLUBED OD CLUBELIED		STRE	EET ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER		200	2 ALBANY ST	
BEECH (GROVE MEADOWS	3	BEE	ECH GROVE, IN 46107	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	EDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL			IATE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Requirements for P	articipation in , 42 CFR Subpart 483.90(a),			
		re and the 2012 Edition of the			
		etion Association (NFPA) 101,			
		LSC), Chapter 19, Existing			
		ancies and 410 IAC 16.2.			
	_	ity with a partial basement was			
		Type V (000) construction and			
		The facility has a fire alarm			
	-	detection in the corridors and			
	-	the corridor. The facility has			
	battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 133				
		90 at the time of this survey.			
		your and announced and control.			
	All areas where resi	idents have customary access			
	were sprinklered. T	The facility has one detached			
	building providing	facility storage services which			
	is not sprinklered.				
	Quality Review con	npleted on 02/07/25			
K 0211	NFPA 101				
SS=E	Means of Egress	- General			
Bldg. 01	J				
	Based on observation	on and interview, the facility	K 0211	What corrective action(s) will	be 02/21/2025
		f 7 means of egress were		accomplished for those resid	ents
		ained free of all obstructions		found to have been affected	by the
	-	full instant use in the case of		deficient practice;	
	_	ency. This deficient practice		No Residents were found to	be
	needing to exit the f	residents, staff and visitors if		effected. The Hoyer lift was removed from the area to cre	nata
	needing to exit tile i	actify.		proper means of egress.	,aic
	Findings include:			How other residents having t	he
	<i>G</i> 2 •			potential to be affected by the	
	Based on observation	ons with the Maintenance		same deficient practice will b	
	Supervisor and the	Maintenance Assistant during		identified and what corrective	;
		from 12:40 p.m. to 2:45 p.m. on		action(s) will be taken;	
	02/05/25, a hoyer li	ft was stored in the corridor		All residents have the potenti	ial to

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/05/2025
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP COD LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	36 inches into the eplastic three drawer supplies was stored resident sleeping Relift and projected 18 wide corridor. Base the observations, the agreed items were scorridor opposite or and Room 112 and means of egress was free of all obstructions instant use in the care the Maintenance A at the time of the observations were	e reviewed with the Executive enance Supervisor and the		be effected. No other obstruct have been found to block the means of egress. What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not receive the staff have been in-serviced or ensuring corridors are continuously maintained free cobstructions. A Maintenance at tool will be completed monthly one year to ensure all means egress are being maintained visual inspection by the Execu Director or designee has been completed to ensure all means egress are being maintained. How the corrective action(s) we monitored to ensure the deficit practice will not recur, i.e., which quality assurance program will put into place; and a Maintenance audit tool, ensuring corridors are continuously maintained free cobstructions, will be completed monthly for one year with resurreported to the Quality Assurance Performance Improvement (Quality Committee overseen by the Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action.	or o
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure			
Diag. 01	Based on observation	on and interview, the facility	K 0321	What corrective action(s) will l	oe 02/21/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMP.			ETED
		155072	B. W	B. WING 02/05/2025			/2025
		<u> </u>		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t .			LBANY ST		
BEECH (GROVE MEADOWS	3			I GROVE, IN 46107		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f over 12 hazardous areas such			accomplished for those reside		
		rooms were separated from			found to have been affected b	y the	
		oke resistant partitions and			deficient practice;		
		be self closing or automatic			No Residents were found to be		
	_	ce with 7.2.1.8. This deficient			effected. Squeegee propping	-	
	1 ~	et over 20 residents, staff and			door was removed. Latch that		
	visitors in the main	Dining Room.			malfunctioned was replaced.		
					How other residents having th	е	
	Findings include:				potential to be affected by the		
					same deficient practice will be		
		ons with the Maintenance			identified and what corrective		
	_	Maintenance Assistant during			action(s) will be taken;		
		from 12:40 p.m. to 2:45 p.m. on			All residents have the potentia		
		or door to the kitchen in the			be effected. Squeegee remove		
	_	by the Dietary Office was			and latch replaced. Staff educ	ated	
		f closing device and latching			not to prop open doors.		
		oor failed to fully self close and			What measures will be put into		
		rame when tested to close			place and what systemic chan	_	
	_	e latching mechanism on the			will be made to ensure that the		
	_	trude into the latching plate on			deficient practice does not rec		
		n tested to close. In addition,			Culinary staff Educated about	not	
		the kitchen in the main Dining			propping open doors, A		
		g fire door was propped in a			Maintenance audit tool will be		
		ion with a squeegee which			completed monthly for one year		
	_	from fully self closing and			ensure all doors properly latch		
	1	or frame when tested to close.			are not propped open · A visual	aı	
		squeegee was run through the			inspection by the Executive	2	
		wall mounted portable K Class			Director or designee has been	11	
	_	xt to the door to keep the The kitchen contained one			completed to ensure all doors		
		ter heater. The main Dining			properly close How the corrective action(s) w	ill be	
		the corridor. Based on			monitored to ensure the defici		
	1 -	e of the observations, the					
	Maintenance Super	•			practice will not recur, i.e., who		
	_	ardous area was not separated			quality assurance program wil	ı n c	
		y smoke resistant partitions			put into place; and		
	and doors.	y smoke resistant partitions			A Maintenance audit tool, ensuring doors latch properly	and	
	and doors.		1			anu	
	These findings war	e reviewed with the Executive			are not propped open, will be	or	
		enance Supervisor and the			completed monthly for one year		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2025	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD BANY ST		
BEECH (GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	Assurance Performance		DATE
	Maintenance Assist conference.	ant during the exit			Improvement (QAPI) Committe	00	
	conference.				overseen by the Executive	CC	
	3.1-19(b)				Director. Any non-compliance staff will result in staff education and/or disciplinary action		
14 0000							
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors						
g	Based on observation	on and interview, the facility	K 036	53	What corrective action(s) will be	ре	02/21/2025
	failed to ensure 2 of	over 50 corridor doors to			accomplished for those reside		
		oms had no impediment to			found to have been affected b	y the	
	-	g into the door frame and			deficient practice;		
		sage of smoke. This deficient			The latching mechinism on the		
	practice could affec	t over 30 residents, staff and			door to resident room 111 was	3	
	visitors.				repaired. The trash can propin	-	
					open the door to 133 was mov		
	Findings include:				so that it no longer propped or	oen	
	D 1 1 2	tot of the first			the door. No residents were		
		ons with the Maintenance			affected		
	_	Maintenance Assistant during			How other residents having th		
		from 12:40 p.m. to 2:45 p.m. on or door to resident sleeping			potential to be affected by the		
	·	latch into the door frame when			same deficient practice will be identified and what corrective		
		iple times. The latching			action(s) will be taken;		
		loor failed to protrude into the			All residents have the potentia	ıl to	
		e door frame. In addition, the			be affected. The latching	11 10	
	• •	ident sleeping Room 133 was			mechinism on the door to residue	dent	
		open position with a trash			room 111 was repaired. The tr		
		oor up against the door.			can proping open the door to		
	Based on interview				was moved so that it no longe		
		aintenance Supervisor agreed			propped open the door.		
		two corridor doors each had			What measures will be put into)	
		tching into the door frame and			place and what systemic chan		
	would not resist the				will be made to ensure that the	-	
					deficient practice does not rec		
	These findings were	e reviewed with the Executive			A Maintenance audit tool will b		
		enance Supervisor and the			completed monthly for one year		
	Maintenance Assist	-			ensure all doors properly latch		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER 155072	A. BUILDING B. WING	01	COMPLETED 02/05/2025
	PROVIDER OR SUPPLIER		2002 AI	ADDRESS, CITY, STATE, ZIP COD LBANY ST I GROVE, IN 46107	
BLLCIT	- INCAL MILADOVAC	,	, I belon		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b)			are not propped open · A visual inspection by the Executive Director or designee has been completed to ensure all doors properly close How the corrective action(s) we monitored to ensure the deficing practice will not recur, i.e., who quality assurance program will put into place; and A Maintenance audit tool, ensuring doors latch properly are not propped open, will be completed monthly for one year with results reported to the Quantum Assurance Performance Improvement (QAPI) Committed overseen by the Executive Director. Any non-compliance staff will result in staff education and/or disciplinary action	n vill be ent at I be and ar ality ee
K 0511 SS=D Bldg. 01	failed to ensure elect 50 resident sleeping grounded in accordation 19.5.1.1 requires util LSC 9.1.2 requires at to comply with NFP NFPA 70, 2011 Edi Requirements states located in branch cirill of Article 210. Geshall be in accordantation (A) Grounding Type	en and interview, the facility trical receptacles in 1 of over rooms were properly ance with NFPA 70. LSC lities comply with Section 9.1. electrical wiring and equipment PA 70, National Electrical Code. tion at 406.4 General Installation receptacle outlets shall be reuits in accordance with Part general installation requirements ce with 406.4(A) through (F). e. Receptacles installed on 15-ch circuits shall be of the	K 0511	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; Both defective grounds have corrected. No Residents were found to be effected. 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 have the potential be effected. Both defective grounds have been corrected.	nts y the been e

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ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	1B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155072	B. W	ING		02/05	/2025
		100072		_		02,00	72020
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	ROVIDER OR SOLI EIEI			2002 A	LBANY ST		
BEECH (GROVE MEADOWS	8		BEECH	I GROVE, IN 46107		
(VA) ID	CLDOLADY	GTATEMENT OF DEPLOYENCE		ID	T		(37.5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ceptacles shall be installed only			What measures will be put int	o	
	on circuits of the vo	oltage class and current for			place and what systemic char	iges	
	which they are rate	d, except as provided in Table			will be made to ensure that the	е	
	210.21(B)(2) and T	Table 210.21(B)(3).			deficient practice does not rec	ur	
	Exception: Nongro	unding-type receptacles			A Maintenance audit tool will I	эе	
	installed in accorda	nce with 406.4(D).			completed monthly for one ye	ar to	
		ed. Receptacles and cord			ensure all electric recepticles		
	1 1	re equipment grounding			properly ground·		
		shall have those contacts			How the corrective action(s) w	vill be	
		ipment grounding conductor.			monitored to ensure the defici		
	_	eceptacles mounted on portable			practice will not recur, i.e., wh		
		ed generators in accordance			quality assurance program wil		
	with 250.34.	ed generators in accordance			put into place; and	i be	
		eplacement receptacles as					
	^				A Maintenance audit tool,	_	
	permitted by 406.4				ensuring all electric recepticle	5	
	1 1	ounding. The equipment			are properly ground, will be		
		or contacts of receptacles and			completed monthly for one ye		
		all be grounded by connection			with results reported to the Qu	ıality	
		ounding conductor of the			Assurance Performance		
		e receptacle or cord connector.			Improvement (QAPI) Committ	ee	
	The branch-circuit	wiring method shall include or			overseen by the Executive		
	provide an equipme	ent grounding conductor to			Director. Any non-compliance	with	
	which the equipmen	nt grounding conductor			staff will result in staff education	on	
	contacts of the rece	ptacle or cord connector are			and/or disciplinary action		
	connected.						
	Informational Note	No. 1: See 250.118 for					
	acceptable grounding	ng means.					
		No. 2: For extensions of					
	existing branch circ						
		rice could affect two residents					
		t sleeping Room 328.					
	and starr in residen	t steeping Room 526.					
	Findings include:						
	Based on observation	ons with the Maintenance					
		Maintenance Assistant during					
	_						
	1	from 12:40 p.m. to 2:45 p.m. on					
	· ·	e six electrical receptacles in the					
	wall mounted outle	t box installed at the head of			1		

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the resident bed nearest the window in resident

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155072	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/05/2025
	PROVIDER OR SUPPLIER		2002	ET ADDRESS, CITY, STATE, ZIP COD P. ALBANY ST CH GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	sleeping Room 328 ground" when tested listed circuit tester t interview at the time Maintenance Super showed the aforeme locations needed rep These findings were Director, the Maintenance Assist conference. 3.1-19(b) NFPA 101 Electrical Equipme Extens Based on observation failed to ensure extens strips were not used wiring. LSC 19.5.1 Section 9.1. LSC 9 and equipment to co Electrical Code, 200	were found to have an "open d with an Ideal Industries UL esting device. Based on e of the observations, the visor agreed the testing device entioned electrical receptacle pair.	K 0920	What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice; No residents were found to have been affected by the deficient practice. The CD player was unplugged from the power str	be 02/21/2025 ents by the ave t
	flexible cords and c substitute for fixed Section 4.5.7 states equipment or safegu shall be designed, in accordance with all NFPA 99, Standard edition, defines pati of a health care faci intended to be exam- vicinity is defined a intended for the exa- patients, extending	ables shall not be used as a wiring of a structure. LSC any building service hard provided for life safety hastalled and approved in applicable NFPA standards. for Health Care Facilities, 2012 ent care areas as any portion lity wherein patients are hined or treated. Patient care is a space, within a location mination and treatment of 6 ft (1.8 m) beyond the normal chair, table, treadmill, or other		room 205 so that only patient related electrical equipment valuaged into the power strip. regridgerator in room 210 was plugged directly into the power outlet in the wall. 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 have the potential be affected by the practice. To player was unplugged from	t care was The s er he e e al to The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>01</u>			COMPLETED	
		155072	B. W	ING		02/05/	2025	
	STREET ADDRESS, CITY, STATE, ZIP COD							
NAME OF F	PROVIDER OR SUPPLIER	8			LBANY ST			
BEECH (SPOVE MEADOWS				GROVE, IN 46107			
BEECH	GROVE MEADOWS	5		BEECH	GROVE, IN 40107			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	device that supports	s the patient during			power strip in room 205 so tha	at		
		eatment. A patient care vicinity			only patient care related electi	rical		
		o 7 ft 6 in. (2.3 m) above the			equipment was plugged into the	ne		
		ection 10.4.2.3 states household			power strip. The regridgerator	in		
		not commonly equipped with			room 210 was plugged directly	y		
		ors in their power cords shall			into the power outlet in the wa	II.		
		ed they are not located within			No other instances of this			
	1 -	nity. This deficient practice			deficiency were found to be			
	could affect over 10	residents, staff and visitors.			corrected.			
					What measures will be put into	0		
	Findings include:				place and what systemic chan	iges		
					will be made to ensure that the	е		
		ons with the Maintenance			deficient practice does not rec	ur		
	_	Maintenance Assistant during			A Maintenance audit tool will b	oe		
	-	from 12:40 p.m. to 2:45 p.m. on			completed monthly for one year			
	02/05/25, the follow	_			ensure Power strips in a patie	nt		
		nearest the window, a CPAP			care vicinity are only used for			
		player were plugged into a			components of movable			
		on the floor under the head of			patient-care-related electrical			
		sleeping Room 205. The UL			equipment (PCREE) assemble	es		
	listing of the power	-			that have been assembled by			
	_	s plugged into a power strip six			qualified personnel and meet	the		
		nt bed nearest the window in			conditions of 10.2.3.6. Power			
		oom 210. The UL listing of the			strips in the patient care vicinit	-		
	power strip could no				may not be used for non-PCR	EE		
	Based on interview				(e.g., personal electronics),			
		aintenance Supervisor agreed			except in long-term care resid			
		eing used for PCREE and			rooms that do not use PCREE			
		patient care vicinity and as a			How the corrective action(s) w			
		wiring in the aforementioned			monitored to ensure the defici-			
	two locations in the	facility.			practice will not recur, i.e., who			
					quality assurance program wil	l be		
	1	e reviewed with the Executive			put into place; and			
	· · · · · · · · · · · · · · · · · · ·	enance Supervisor and the			A Maintenance audit tool,			
	Maintenance Assist	ant during the exit			ensuring all Power strips are			
	conference.				properly used, will be complet			
					monthly for one year with resu			
	3.1-19(b)				reported to the Quality Assura			
					Performance Improvement (Q	API)		
					Committee overseen by the			

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

Event ID:

HPMK21 Facility ID: 000029

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	01	COMPLETED		
		155072	B. WIN	B. WING			02/05/2025	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS				2002 AL	ADDRESS, CITY, STATE, ZIP COD BANY ST GROVE, IN 46107			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P			JLD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action			

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