STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING -- B. WING	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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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: 02/05/25 Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200 At this Emergency Preparedness survey, Beech Grove Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 133 certified beds. At the time of the survey, the census was 90. Quality Review completed on 02/07/25	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: 02/05/25 Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200 At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with	K 0000	We are requesting desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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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	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 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 in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 133 and had a census of 90 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which is not sprinklered. Quality Review completed on 02/07/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 02/05/25, a hoyer lift was stored in the corridor	K 0211	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No Residents were found to be effected. The Hoyer lift was removed from the area to create proper means of egress. 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 to	02/21/2025

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	outside resident sleeping Room 111 and projected 36 inches into the eight foot wide corridor. A plastic three drawer wheeled cart for isolation supplies was stored in the corridor outside resident sleeping Room 112 opposite the Hoyer lift and projected 18 inches into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed items were stored on each side of the corridor opposite one another outside Room 111 and Room 112 and agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. The Maintenance Assistant moved the Hoyer lift at the time of the observations. These findings were reviewed with the Executive Director, the Maintenance Supervisor and the Maintenance Assistant during the exit conference. 3.1-19(b)		be effected. No other obstructions have been found to block the means of egress. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Staff have been in-serviced on ensuring corridors are continuously maintained free of all obstructions A Maintenance audit tool will be completed monthly for one year to ensure all means of egress are being maintained · A visual inspection by the Executive Director or designee has been completed to ensure all means of egress are being maintained 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 A Maintenance audit tool, ensuring corridors are continuously maintained free of all obstructions, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility	K 0321	What corrective action(s) will be	02/21/2025

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	failed to ensure 1 of over 12 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include: Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 02/05/25, the corridor door to the kitchen in the main Dining Room by the Dietary Office was equipped with a self closing device and latching hardware but the door failed to fully self close and latch into the door frame when tested to close multiple times. The latching mechanism on the door would not protrude into the latching plate on the door frame when tested to close. In addition, the corridor door to the kitchen in the main Dining Room by the rolling fire door was propped in a partially open position with a squeegee which prevented the door from fully self closing and latching into the door frame when tested to close. The handle for the squeegee was run through the hose mount on the wall mounted portable K Class fire extinguisher next to the door to keep the squeegee in place. The kitchen contained one natural gas fired water heater. The main Dining Room was open to the corridor. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Supervisor and the		accomplished for those residents found to have been affected by the deficient practice; No Residents were found to be effected. Squeegee propping open door was removed. Latch that malfunctioned was replaced. 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 to be effected. Squeegee removed and latch replaced. Staff educated not to prop open doors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Culinary staff Educated about not propping open doors, A Maintenance audit tool will be completed monthly for one year to ensure all doors properly latch and 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) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and A Maintenance audit tool, ensuring doors latch properly and are not propped open, will be completed monthly for one year with results reported to the Quality	

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	Maintenance Assistant during the exit conference. 3.1-19(b)		Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 02/05/25, the corridor door to resident sleeping Room 111 failed to latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. In addition, the corridor door to resident sleeping Room 133 was propped in the fully open position with a trash can placed on the floor up against the door. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned two corridor doors each had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Supervisor and the Maintenance Assistant during the exit	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The latching mechinism on the door to resident room 111 was repaired. The trash can proping open the door to 133 was moved so that it no longer propped open the door. No residents were affected 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 to be affected. The latching mechinism on the door to resident room 111 was repaired. The trash can proping open the door to 133 was moved so that it no longer propped open the door. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur A Maintenance audit tool will be completed monthly for one year to ensure all doors properly latch and	02/21/2025

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	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) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and A Maintenance audit tool, ensuring doors latch properly and are not propped open, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of over 50 resident sleeping rooms were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type.	K 0511	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Both defective grounds have been 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 to be effected. Both defective grounds have been corrected.	02/21/2025

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	Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect two residents and staff in resident sleeping Room 328. Findings include: Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 02/05/25, two of the six electrical receptacles in the wall mounted outlet box installed at the head of the resident bed nearest the window in resident		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur A Maintenance audit tool will be completed monthly for one year to ensure all electric recepticles are properly ground· 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 A Maintenance audit tool, ensuring all electric recepticles are properly ground, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action	

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	sleeping Room 328 were found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Supervisor agreed the testing device showed the aforementioned electrical receptacle locations needed repair. These findings were reviewed with the Executive Director, the Maintenance Supervisor and the Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other	K 0920	What corrective action(s) will be accomplished for those residents 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 strip in room 205 so that only patient care related electrical equipment was plugged into the power strip. The 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 to be affected by the practice. The CD player was unplugged from the	02/21/2025

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	device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and the Maintenance Assistant during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 02/05/25, the following was noted: a. the resident bed nearest the window, a CPAP machine and a CD player were plugged into a power strip placed on the floor under the head of the bed in resident sleeping Room 205. The UL listing of the power strip was 1363A. b. a refrigerator was plugged into a power strip six feet from the resident bed nearest the window in resident sleeping Room 210. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Supervisor agreed a power strip was being used for PCREE and non-PCREE in the patient care vicinity and as a substitute for fixed wiring in the aforementioned two locations in the facility. These findings were reviewed with the Executive Director, the Maintenance Supervisor and the Maintenance Assistant during the exit conference. 3.1-19(b)		power strip in room 205 so that only patient care related electrical equipment was plugged into the power strip. The regridgerator in room 210 was plugged directly into the power outlet in the wall. No other instances of this deficiency were found to be corrected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur A Maintenance audit tool will be completed monthly for one year to ensure Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. 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 A Maintenance audit tool, ensuring all Power strips are properly used, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the	

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			Executive Director. Any non-compliance with staff will result in staff education and/or disciplinary action	