STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155825	A. BUILDING -- B. WING	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

(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 Dates: 10/03/24 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Emergency Preparedness survey, St. Augustine Home for the Aged was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 23 certified beds. At the time of the survey, the census was 20. Quality Review completed on 10/07/24	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 Dates: 10/03/24 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Life Safety Code survey, St. Augustine	K 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven M Still	Administrator	10/18/2024

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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	Home for the Aged 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 facility, located on the 1st and 2nd of a three story building with a basement, was determined to be of Type II (222) construction and was 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 smoke detectors hard wired to the fire alarm system in all resident rooms. The facility has a capacity of 23 and had a census of 20 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/07/24		be considered the facility's allegation of compliance. Compliance is effective October 23, 2024. We respectfully request a desk review of our Plan of Correction.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet the clear width requirement for 1 of over 4 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2).	K 0232	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All furniture stored in the hallway adjacent to the Beauty Salon and Chaplain's Office has been affixed to the floor. This work was performed on October 16, 2024. (See photos entitled K232 Affixed Furniture 1&2)	10/23/2024

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	(c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect over 5 residents, staff and visitors. Findings include: Based on observations with the Facilities Operations Manager and the Assistant Facilities Operations Manager during a tour of the facility from 12:55 p.m. to 2:35 p.m. on 10/03/24, one wood table was stored in the corridor outside the Salon on the first floor. The table was not affixed to the floor or to the wall and projected one foot into the eight foot wide corridor. In addition, benches were stored in the corridor outside the Chaplains Office across from the Salon on the first floor. The benches were not affixed to the floor or to the wall and each bench extended 18 inches into the eight foot wide corridor. Based on interview at the time of the observations, the Facilities		**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 using the Beauty Shop have the potential to be affected by this practice. All furniture stored in the hallway adjacent to the Beauty Shop and Chaplain's Office has been affixed to the floor. (See photos entitled K232 Affixed Furniture 1&2) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Department Heads will be informed as to the requirement of furniture permanently stored in the hallways to be affixed to the wall or floor. They will be asked to report any permanently stored furniture that is not affixed to the floor or wall to the Administrator for follow up action. This will be done at the staff meetings on October 21 and 28. It will also be presented at the next monthly QAPI Committee meeting on November 12, 2024. **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.**	

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	Operations Manager and the Assistant Facilities Operations Manager stated comprehensive care residents have customary access to the Salon on the first floor and agreed furniture was stored in the corridor at the aforementioned locations which was not affixed to the floor or to the wall. These findings were reviewed with the Administrator, the Facilities Operations Manager and the Assistant Facilities Operations Manager during the exit conference. 3.1-19(b)		The Activity Director will note and report any furniture permanently stored in the hallway adjacent to the Beauty Shop and Chaplain's Office. Her office is located on that same hallway. Facility Operations Manager will monitor for compliance. **By what date the systemic changes for each deficiency will be complete.** October 23, 2024	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A second Fire Alarm System Inspection is scheduled with our contractor, Koorsen, on October 22, 2024. Additionally, the facility has signed a new agreement with our contractor to provide fire system inspections and maintenance for 2025 to include two (2) semi-annual Fire Alarm System Inspections. (See K345 Signed Koorsen Contract for 2025) **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	10/23/2024

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	Based on review of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 04/20/23 and "Alarm System Inspection" documentation dated 04/11/24 with the Facilities Operations Manager and the Assistant Facilities Operations Manager during record review from 9:40 a.m. to 12:25 p.m. on 10/03/24, visual semi-annual fire alarm system inspection documentation six months after 04/20/23 was not available for review. Based on interview at the time of record review, the Facilities Operations Manager and the Assistant Facilities Operations Manager agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 04/20/23 was not available for review. These findings were reviewed with the Administrator, the Facilities Operations Manager and the Assistant Facilities Operations Manager during the exit conference. 3.1-19(b)		be affected by this practice. A second Fire Alarm System Inspection is scheduled with our contractor, Koorsen, on October 22, 2024. Additionally, the facility has signed a new agreement with our contractor to provide fire system inspections and maintenance for 2025 to include two (2) semi-annual Fire Alarm System Inspections. (See K345 Signed Koorsen Contract for 2025) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** A new agreement has been signed with our contractor to perform semi-annual Fire Alarm System Inspections for 2025 and going forward. (See new K345 Signed Koorsen Contract for 2025) **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 plac**e. The Assistant Facilities Operations Manager or designee is responsible for monitoring the performance and timeliness of the contracted services. The second Fire Alarm System Inspection will be presented to the next monthly meeting of the QAPI Committee for confirmation of performance.	

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			The Facilities Operations Manager will monitor for compliance. **By what date the systemic changes for each deficiency will be complete.** October 23, 2024	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Based on observation and interview, the facility failed to ensure trash receptacles stored in 1 of 1 Biohazard storage rooms were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Biohazard Storage room by Sister's Office on the second floor. Findings include: Based on observations with the Facilities Operations Manager and the Assistant Facilities Operations Manager during a tour of the facility from 12:55 p.m. to 2:35 p.m. on 10/03/24, one unattended 55 gallon capacity receptacle was partially filled with trash in the Biohazard Storage room by Sister's Office on the second floor. The lid for the container stated it was a 55 gallon capacity receptacle. The corridor door to the room was not self closing or automatic closing. Based on interview at the time of the observations, the Facilities Operations Manager and the Assistant Facilities Operations Manager agreed the aforementioned receptacle was not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the	K 0754	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 55-gallon trash container was removed from the bio-hazard storage room and replaced with a 32-gallon container on October 8, 2024. (See K754 New Bio-Hazard Waste Can) **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?** Other residents are unaffected due to proximity to the bio-hazard storage room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Facilities Operations Director or designee will monitor the bio-hazard storage room, during	10/23/2024

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	Administrator, the Facilities Operations Manager and the Assistant Facilities Operations Manager during the exit conference. 3.1-19(b)		morning rounds, to ensure the 32-gallon container remains and is not replaced with an inappropriately sized container. **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 plac**e. The Facilities Operations Director will be responsible for compliance. He will present his findings to the QAPI Committee for the next three (3) monthly meetings. **By what date the systemic changes for each deficiency will be complete.** October 23, 2024	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for 12 month of the most recent 12 month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Generator Log has been updated to include columns to record the Load Test and Cool-down times going forward. This was completed and implemented on October 10, 2024. The generator is tested weekly as indicated on the attached Generator Log. (See	10/23/2024

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	not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Generator Log" documentation for the most recent twelve month period with the Facilities Operations Manager and the Assistant Facilities Operations Manager during record review from 9:40 a.m. to 12:25 p.m. on 10/03/24, monthly load testing documentation for the facility's diesel fuel fired emergency generator for the most recent twelve month period did not document the loading that maintained the minimum exhaust gas temperatures as recommended by the manufacturer or that the load test was conducted under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. Based on interview at the time of record review, the Facilities Operations Manager and the Assistant Facilities Operations Manager stated a replacement diesel fired emergency generator was installed at the facility approximately two years ago, the facility runs the generator under load each week and agreed generator load testing documentation for the most recent twelve month period did not include the load percent achieved for the test. Based on		K918 St Augustine Generator Log) **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 this practice. The Generator Log has been updated to include columns to record the Load Test and Cool-down times going forward. This was completed and implemented on October 10, 2024. The generator is tested weekly as indicated on the attached Generator Log. (See K918 St Augustine Generator Log) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Generator Log has been updated to include columns to record the Load Test and Cool-down times going forward. This was completed and implemented on October 10, 2024. The generator is tested weekly, and performance is recorded on the attached Generator Log by the Assistant Facilities Operations Manager. (See K918 St Augustine Generator Log)	

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	observations with the Facilities Operations Manager and the Assistant Facilities Operations Manager during a tour of the facility from 12:55 p.m. to 2:35 p.m. on 10/03/24, the facility has one diesel fuel fired emergency generator located outside the building on the west side of the property. The manufacturer's nameplate indicated the generator was manufactured July 2022 and it was rated at 100 kW. These findings were reviewed with the Administrator, the Facilities Operations Manager and the Assistant Facilities Operations Manager during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for 12 of 12 months. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.4 which requires emergency generators providing power to emergency lighting systems to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. NFPA 110, Section 6.2.10 Time Delay on Engine Shutdown requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown to allow for engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. NFPA 110, Section 8.3.4 states a permanent record of the Emergency Power Supply Systems (EPSS) inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors.		**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 plac**e. The Facilities Operations Manager will present the results of the weekly generator tests to the QAPI Committee at its next three (3) monthly meetings. Facilities Operations Manager is responsible for compliance. **By what date the systemic changes for each deficiency will be complete.** October 23, 2024	

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	Findings include: Based on review of "Generator Log" documentation for the most recent twelve month period with the Facilities Operations Manager and the Assistant Facilities Operations Manager during record review from 9:40 a.m. to 12:25 p.m. on 10/03/24, monthly load testing documentation for the most recent twelve month did not include cool down time. Based on interview at the time of record review, the Facilities Operations Manager and the Assistant Facilities Operations Manager stated a replacement diesel fired emergency generator was installed at the facility approximately two years ago, the facility runs the generator under load each week and agreed cool down time was not recorded in load testing documentation for the most recent twelve month period. Based on observations with the Facilities Operations Manager and the Assistant Facilities Operations Manager during a tour of the facility from 12:55 p.m. to 2:35 p.m. on 10/03/24, the facility has one diesel fuel fired emergency generator located outside the building on the west side of the property. The manufacturer's nameplate indicated the generator was manufactured July 2022 and it was rated at 100 kW. These findings were reviewed with the Administrator, the Facilities Operations Manager and the Assistant Facilities Operations Manager during the exit conference. 3.1-19(b)			