STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING -- B. WING	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

(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: 10/25/23 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Emergency Preparedness survey, Elkhart Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 58 certified beds. At the time of the survey, the census was 48. Quality Review completed on 10/31/23	E 0000	The facility requests that this plan of correction be considered it's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before 11/12/2023.	
K 0000 Bldg. 01	A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/25/23 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Life Safety Code survey, Elkhart Meadows was found not in compliance with Requirements for Participation in	K 0000	The facility requests that this plan of correction be considered it's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Evan Wiedeman	Executive Director	11/12/2023

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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	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. This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Battery operated smoke detectors are provided in the resident sleeping rooms. The facility has a capacity of 58 with a census of 48 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except the unattached garage and a shed. Quality Review completed on 10/31/23		We respectfully request a desk review for compliance instead of a post visit review on or before 11/12/2023.	
K 0372 SS=F 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	K 0372	**K372**	11/12/2023

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	failed to ensure penetrations through 3 of 3 smoke barrier walls smoke barriers 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 affects all staff residents. Findings include: Based on observations with the Maintenance Director on 10/25/23 at 1:00 p.m., above the drop ceiling of all three smoke walls had unsealed gaps around pipes and wires. Based on interview at the time of observations, the Maintenance Director agreed there were unsealed penetrations in all smoke barrier walls. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD sealed penetrations through 3 of 3 smoke barrier walls. **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 who reside in the facility have the potential to be effected by the deficient practice. MD sealed penetrations through 3 of 3 smoke barrier walls. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of ensuring any penetrations are identified and sealed immediately. **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 by what date the systemic changes for each deficiency will be completed;** MD will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if	

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			compliance is not met.	
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 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and staff in the smoking area.	K 0741	K741 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	11/12/2023

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	Findings include: Based on observation with the Maintenance Director on 10/25/23 at 12:18 p.m., in the staff smoking area there were over 50 cigarette butts disposed on the ground. Also, the butt containers had lids that were not self-closing and had butts on top of the lids. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the staff smoking area and the butt containers did not have self-closing lids. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		MD removed butt containers that did not have self-closing lids, and removed cigarette butts disposed of on the ground. **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 staff/staff in the smoking area have the potential to be effected by the deficient practice. MD removed butt containers that did not have self-closing lids, and removed cigarette butts disposed of on the ground. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff educated on smoking in designated smoking area and to dispose of cigarette butts in self-closing butt containers. **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 by what date the systemic changes for each deficiency will be completed;** MD will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if	

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			compliance is not met.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			

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	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation with the Maintenance Director on 10/25/23 at 12:08 p.m., the generator was not equipped with a remote emergency stop station. Based on interview at the time of observation, the Maintenance Director agreed a remote emergency stop button was not provided. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0918	K918 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD had generator company come out and install a remote emergency stop button outside of the room housing the prime mover. **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 as well as all staff and visitors have the potential to be effected by the deficient practice. MD had generator company come out and install a remote emergency stop button outside of the room housing the prime mover. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Emergency stop button installed outside of room housing the prime mover. MD educated on importance of remote stop button being outside the room housing the prime mover. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	11/12/2023

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			recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed; Maintenance director will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 10/25/23 at 12:04 p.m., the oxygen	K 0927	K927 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD covered hole in wall behind broken wall covering with a one hour fire-resistive construction. **How other residents having the potential to be affected by the same deficient practice will be identified and what**	11/12/2023

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	trans-filling room was not protected with a one-hour fire-resistive construction due to a one-foot hole in the wall behind a broken wall covering. Based on an interview at the time of observation, the Maintenance Director agreed there was an unsealed hole in the wall of the oxygen trans-filling room. 3.1-19(b)		**corrective action(s) will be taken;** The deficient practice could effect 20 residents in one smoke compartment. MD covered hole in wall behind broken wall covering with a one hour fire-resistive construction. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD covered hole in wall behind broken wall covering with a one hour fire-resistive construction. MD educated on oxygen transfilling rooms being separated from other areas in the facility in a room that is protected with a one hour fire resistive construction. **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 by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met.	