PRINTED: 05/12/2023

EPARTMEN ENTERS FO	FORM APPROVED OMB NO. 0938-039	
STATEMEI AND PLAN	(X3) DATE SURVEY COMPLETED 04/17/2023	
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS		
(X4) ID PREFIX TAG	(X5) COMPLETION DATE	1
E 0000 Bldg E 0041 SS=F Bldg	Se Fe	
SS=F		

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

The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set

> TITLE (X6) DATE

Nicole Holder **Executive Director** 05/05/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: MZAC21 Facility ID: 000188 If continuation sheet Page 1 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	l í	UILDING	NSTRUCTION	(X3) DATE COMPL 04/17	ETED
	PROVIDER OR SUPPLIER			3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD APOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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
	§482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built o structure or buildir 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the em inspection, testing requirements four Facilities Code, N Code.  482.15(e)(3), §483 Emergency gener and LTC facilities] source to power e have a plan for ho power systems op emergency, unles  *[For hospitals at §483.73(g), and C The standards inc this section are ap reference by the D Federal Register i	e located in accordance with rements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. Health Care in the Health Care					
	, ,	part 51. You may obtain the sources listed below.					

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet

Page 2 of 26

	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G	COM	TE SURVEY  MPLETED  17/2023
	F PROVIDER OR SUPPLIED		301	EET ADDRESS, CITY, STATE, ZIP 7 VALLEY FARMS RD IANAPOLIS, IN 46214	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
	You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at N/go to:  http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the charannounce the charannounce the charannounce the charannounce the charannounce (i) National Fire Fatterymarch Parannounce, MA 0216 1.617.770.3000.  (i) NFPA 99, Hearannounce, MA 0216 1.617.770.3000.  (ii) NFPA 99, Hearannounce, MA 0216 1.617.770.3000.  (iii) Technical internation (iii) TIA 12-3 to NI 2012.  (iv) TIA 12-3 to NI 2013.  (v) TIA 12-5 to NI 2013.  (vi) TIA 12-6 to NI 2014.  (viii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to NI 11, 2011.  (ix) TIA 12-2 to NI 30, 2012.  (x) TIA 12-3 to NI 22, 2013.  (xi) TIA 12-4 to NI 22, 2013.	a copy at the CMS urce Center, 7500 Security ore, MD or at the National bords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a federal Register to anges. Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. tim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 1, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012				

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 3 of 26

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155291		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/17/2023	
	ROVIDER OR SUPPLIER		3017	T ADDRESS, CITY, STATE, ZIP COD VALLEY FARMS RD ANAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION (Stamps, 2010, addition)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Standby Power Sy including TIAs to c 2009.  Based on record rev failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). affect all occupants  Findings include:  Based on record rev Director on 04/17/2 documentation for r for 5 of the last 12 r review. Based on ar review, the Mainter been at the facility of that no further load May, June, August, available for review.  This finding was reviewed.	ystems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could deficient practice co		This plan of correction constitution facility's written allegation compliance for the deficiencic cited. The submission of this of correction is not an admission agreement with the deficiency or conclusions contained in the linear li	itutes 05/12/2023 n of es s plan sion encies he h's alley sts ew of of will en signee esting enerator e derivative the en signee esting enerator e derivative en enerator e derivative en enerator e derivative en enerator e enerator
				identified and what correcti action(s) will be taken: All residents, staff and visitor	

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 4 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction =-	COMP	E SURVEY PLETED 7/2023
NAME OF P	ROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP	COD	
EAGLE V	ALLEY MEADOW	3		'ALLEY FARMS RD NAPOLIS, IN 46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				have the potential to be by the alleged deficient Maintenance Supervision will ensure that emergence generator load testing conducted, and sets at weekly, exercised und minutes monthly and complete written recording generator load.  What measures will be place or what system changes will be made ensure that the defice practice does not recomplete written and inspected weekly, exercised weekly, exercised weekly, exercised weekly, exercised weekly environmental ensure emergency getest is conducted and inspected weekly, exercised weekly, under load 30 minutes and maintain complete and maintain complete record of monthly generator of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly generator in the provided and maintain complete record of monthly genera	pe affected at practice. sor/Designee gency is are inspected der load 30 maintain ard of monthly pe put into nic e to ient cur: sor/Designee a conducting rounds to enerator load sets are ercised under hly and itten record load. ction(s) ensure the I not ity will be put sor/Designee a completing unding QAPI cy generator ed and sets exercised is monthly e written lerator load.	

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 5 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONS		CONSTRUCTION (X3) DATE SURVEY		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155291	B. WIN	IG		04/17/	2023
			<del></del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	3	INDIANAPOLIS, IN 46214				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					weeks and monthly for 6 mont The results of these audits will reviewed by QAPI committee overseen by the Executive Director. If a threshold of 95% not achieved, an action plan we be developed to ensure compliance. By what date the systemic changes will be completed: 5/12/23	be is	
K 0000							
Bldg. 01							
	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 04/17  Facility Number: 04 Provider Number: 1002  At this Life Safety C Meadows was found Requirements for Pa Medicare/Medicaid, Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa  This one story facili Type V (111) constr	00188 155291 266310 Code survey, Eagle Valley d not in compliance with	K 00	00	This plan of correction constituthis facility's written allegation compliance for the deficiencies cited. The submission of this post correction is not an admission agreement with the deficient or conclusions contained in the Indiana Department of Health's Safety Recertification and Stat Licensure with Emergency Preparedness Survey conduct 4/17/23. Eagle Valley Meadow respectfully requests consideration for a desk review this plan of correction in lieu or post survey revisit.	of s plan on cies e s Life de de ws	
	with smoke detection	cility has a fire alarm system on in the corridors and in all rridor. The facility has					

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 6 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155291		(X2) MULTIPLE C A. BUILDING B. WING	<del></del>		
	ROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD /ALLEY FARMS RD NAPOLIS, IN 46214	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0291 SS=D Bldg. 01	All areas where resi were sprinklered. T storage sheds provid were not sprinklered  Quality Review com  NFPA 101  Emergency Lightin Emergency Lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1  Based on record rev failed to ensure 3 of tested annually for 9 to ensure the light w periods of power ou visual inspections as Section 7.9.3.1.1 (1) shall be conducted in weeks and a maxim for not less than 30 testing shall be cond of 1 1/2 hours if the battery powered and inspections and tests for inspection by the jurisdiction. This de staff.  Findings include:	ng ng ng g of at least 1-1/2-hour ed automatically in .9.  Tiew and interview, the facility is 3 battery backup lights were no minutes over the past year would provide lighting during stages and a written record of and tests was provided.  The requires functional testing monthly, with a minimum of 3 num of 5 weeks between tests, seconds, (3) Functional ducted annually for a minimum emergency lighting system is in (5) Written records of visual is shall be kept by the owner end authority having efficient practice could affect hier words of 04/17/23 at 12:02 p.m.	K 0291	This plan of correction constituthis facility's written allegation compliance for the deficienciecited. The submission of this of correction is not an admission agreement with the deficientor conclusions contained in the Indiana Department of Health' Inspection Report. Eagle Valle Meadows respectfully request consideration for a desk review this plan of correction in lieu of post survey revisit.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:  Maintenance Director/Designed document an annual 90-minutest of the Battery-Operated Emergency Light Test of the	of s plan on ccies e s ey s w of f

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet

Page 7 of 26

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	TION IDENTIFICATION NUMBER A. BUILDING <u>01</u>		01	COMPLETED
		155291	B. WING	<u> </u>	04/17/2023
			CED FEE	TARRESS CITY OF THE SID COR	
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD	
FACIE,	/ALLEY/ MEADOVA	10		VALLEY FARMS RD	
EAGLE \	ALLEY MEADOW	<b>'S</b>	INDIA	NAPOLIS, IN 46214	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Battery-Operated l	Emergency Light Test		facility's three battery operate	d
	documentation ind	icated the facility has three		emergency lights on 5/8/23.	
	battery operated en	nergency lights.			
	Documentation of	an annual 90-minute test within		How other residents having	the
	the last 12 months	was not available for review at		potential to be affected by the	ne
	the time of the sur	vey. Based on interview at the		same deficient practice will	be
	time of record revi	ew, the Maintenance Director		identified and what corrective	re e
	confirmed that an	annual 90-minute test had not		action(s) will be taken:	
	been conducted for	r the battery-operated		All staff and visitors have the	
	emergency lights i	n the facility.		potential to be affected by the	
				alleged deficient practice.	
		eviewed with the Executive		Maintenance Supervisor/Desi	gnee
		tenance Director at the exit		will ensure documentation an	d
	conference.			testing of an annual 90-minut	e test
				of the Battery-Operated	
	3.1-19(b)			Emergency Light Test of the	
				facility's three battery operate	
				emergency lights is complete	d
				annually.	
				What measures will be put in	nto
				place or what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not recur:	
				Maintenance Supervisor/Desi	-
				will be responsible for ensuring	-
				documentation and testing of	an
				annual 90-minute test of the Battery-Operated Emergency	
				Light Test of the facility's thre battery operated emergency I	
				is completed annually.	ignis
				Maintenance Supervisor/Desi	anee
				to complete quarterly audit to	-
				ensure that an annual 90-min	
				test of the Battery-Operated	uio
				Emergency Light Test of the	
				facility's three battery operate	d
				emergency lights is complete	
				annually. Area will then be	<b>-</b>
I	1		1	annually. Allea will then be	

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 8 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/17/2023
	PROVIDER OR SUPPLIE		3017 V	ADDRESS, CITY, STATE, ZIP C	OD
EAGLE \	ALLEY MEADOW	S	INDIAN	IAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE APPROPRIATE COMPLETION DATE
				monitored by the QAPI How the corrective ac will be monitored to e deficient practice will recur, i.e., what qualit assurance program w into place: Maintenance Supervis will be responsible for an Environmental Rou tool to verify an annual test of the Battery-Ope Emergency Light Test facility's three battery emergency light is com annually quarterly. This will be checked qu one year. The results audits will be reviewed committee overseen by Executive Director. If a of 95% is not achieved plan will be developed compliance. By what date the syst changes will be comp 5/12/23	insure the not  y ill be put  or/Designee completing nding QAPI 190-minute erated of the operated npleted  uarterly for of these by QAPI y the a threshold I, an action to ensure
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire ext accordance with approved automa option is used, th from other space				

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 9 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 04/17/2023				
		155291	B. WING			04/17/	2023
	PROVIDER OR SUPPLIER		3	3017 VA	DDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD APOLIS, IN 46214		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32: Based on observation)	and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in  Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) hance, and Paint Shops boms (exceeding 64  In Rooms lons) brage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility	K 032	1	K-321 Hazardous Areas -		05/12/2023
	failed to ensure 1 of shower room being storage was separated smoke resistant part be self-closing or at with LSC 7.2.1.8. If affect 20 residents, vicinity of the show 156.  Findings include:  Based on observation Director during a to 1:55 p.m. the corrid	f 1 hazardous areas such as used for trash & soiled linen ed from other spaces by titions and doors. Doors shall atomatic closing in accordance This deficient practice could staff and visitors in the ver room near resident room  on with the Maintenance our of the facility on 04/17/23 at lor door to the shower room a resident room 156 was	K 032		Enclosure This plan of correction constituthis facility's written allegation compliance for the deficiencies cited. The submission of this of correction is not an admission agreement with the deficient or conclusions contained in the Indiana Department of Health' Inspection Report. Eagle Valle Meadows respectfully request consideration for a desk review this plan of correction in lieu of post survey revisit.  What corrective action(s) will be accomplished for those	of s plan on icies e s ey s w of f	03/12/2023

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 10 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO			COMPLE	TED
		155291	B. W	ING		04/17/2	2023
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS				APOLIS, IN 46214		
EAGLE V	ALLET WEADOW	3		INDIAN	AFOLIS, IN 402 14		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	equipped with a self-closing device but the door				residents found to have been	ո	
	-	and latch into the door frame			affected by the deficient		
		eparate times. There was a			practice:		
	-	eptacle and a PVC framed soiled			Th corridor door to the shower	r	
	-	red in the shower room. Based			room equipped with a self-clos	sing	
		time of observation, the	1		latch into the door frame is no	w	
		tor confirmed the corridor door			secure. The 32-gallon trash		
		ed hazardous area failed to			receptacle and PVC framed so		
	self-close and latch	into the door frame.			linen cart is no longer stored i	n the	
			1		shower room completed 4/17/	23.	
		viewed with the Executive					
		enance Director at the exit			How other residents having		
	conference.				potential to be affected by th		
					same deficient practice will b		
	3.1-19(b)				identified and what correctiv	е	
					action(s) will be taken:		
					Residents of D-Hall, staff and		
					visitors in vicinity of the showe	er	
					room had the potential to be		
					affected by the alleged deficie	nt	
					practice.		
					Audit to be completed of show		
					room corridor doors and stora	~	
					items weekly for four weeks a	nd	
					monthly for six months.	.	
					What measures will be put in	ito	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Inservice all nursing staff on	,	
					securing shower room doors a	ai iü	
					proper storage of trash	ho	
					receptacles and linen carts to		
					completed by DNS/Designee.		
					DNS/Designee will complete a inservice with staff across shif		
					Inservice with staff across shift for all staff to ensure staff	is	
			1				
			1		education on securing the sho		
			1		room doors and proper storag	е от	

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/17/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI ALLEY FARMS RD	)
EAGLE V	ALLEY MEADOWS	3		NAPOLIS, IN 46214	
(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 CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE COMPLETION PROPRIATE DATE
				trash receptacles and lin to be completed by 5/12/How the corrective action will be monitored to ensideficient practice will no recur, i.e., what quality assurance program will into place: Housekeeping Supervisor/Designee will responsible for completin QA tool weekly x 4 week monthly x 6 months, with reported to the Quality A and Performance Improve Committee overseen by Executive Director If a threshold of 95% is nachieved, an action plan developed to ensure consideration.  By what date the system changes will be completed to the process of the complete states and the complete states are changes will be completed to the complete states are considered as the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes will be completed to the complete states are changes ar	interview of the second
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkler are inspected, tes accordance with Naspection, Testing Water-based Fire Records of system inspection and tes secure location are	Maintenance and Testing Maintenance and Testing r and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available. System last checked  system test			

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 12 of 26

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155291	B. Wl	ING	_	04/17/	/2023
	PROVIDER OR SUPPLIER			3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD IAPOLIS, IN 46214		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	c) Water system	supply source					
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record facility failed to ma systems in accordar requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wa Systems. NFPA 25	, and NFPA 25 review and interview, the intain automatic sprinkler nee with NFPA 25. LSC 9.7.5 er systems shall be inspected, ned in accordance with NFPA e Inspection, Testing, and iter-Based Fire Protection f, 2011 Edition, Section 4.1.4.1	K 0	353	K-353 Sprinkler System – Maintenance and Testing This plan of correction constituthis facility's written allegation compliance for the deficiencie cited. The submission of this of correction is not an admission agreement with the deficient	of s plan on cies	06/01/2023
	Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires				or conclusions contained in the Indiana Department of Health' Inspection Report. Eagle Valle Meadows respectfully request consideration for a desk review this plan of correction in lieu of post survey revisit.	s ey s w of f	
		de for all inspections, tests,  the system components and			What corrective action(s) will be accomplished for those	ļ	
	shall be made availa	able to the authority having			residents found to have been	1	
		quest. This deficient practice			affected by the deficient		
		dents, staff, and visitors in the			practice:		
	facility.  Findings include:				Requesting a Temporary Waiv allow for completion of necess corrective actions for alleged		
		of "Form for Inspection,			deficient practice allowing		
		nance of Dry Pipe Fire			corrective action to be comple	ted	
		5th Year" documentation dated			by 6/1/23		
		ord review with the tor from 10:35 a.m. to 1:05 p.m.			How other residents having	ho	
		eficiency Summary stated 'The			How other residents having to potential to be affected by the		
		corroded on both sides of the			same deficient practice will be		
		move freely'. Based on			identified and what correctiv		
		e of record review, the			action(s) will be taken:	-	
		tor stated he had been at the			All residents, staff and visitors		

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 13 of 26

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/17/2023
	ROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD IAPOLIS, IN 46214	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	valve on or after 06	he repair of the FDC check /11/20 available for review at		have the potential to be affect by the alleged deficient praction	ce.
	the time of the surve b. Based on review Testing and Mainte Sprinkler Systems and Mainte Sprinkler Systems and Maintenance Direct Summary stated "Sy 20lbs in an hour. 3-inspection". A pure air leak service date sprinkler vendor was survey, however it based on interview the Maintenance Didocumentation indicon or after 06/01/20 was not available for survey.  2. Based on record afacility failed to documentation in accordacility failed to documentation in accordacility failed to document facility failed to document for the Maintenance of Wasystems, 2011 Editing auges on dry pipe inspected weekly to water pressures are 5.1.2 states valves a connections shall be maintained in accordant facility. It is stated to the maintained in accordant facility failed to document for the Maintenance of Wasystems, 2011 Editing auges on dry pipe inspected weekly to water pressures are 5.1.2 states valves a connection, testing a valve components and the state of the fail of the fail of the failed	of "Form for Inspection, mance of Dry Pipe Fire Third Year" documentation ng record review with the or on 04/17/23, the Deficiency yetem failed air leak test by Year trip test FAILED hase agreement/proposal for d 06/02/20 from the facility's as provided at the time of the was unsigned by the facility. at the time of record review, rector stated that cating repairs being conducted of or the aforementioned air leak for review at the time of the review and interview, the reument sprinkler system dance with NFPA 25. NFPA Inspection, Testing, and ter-Based Fire Protection ion, Section 5.2.4.2 states sprinkler systems shall be ensure that normal air and being maintained. Section		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility is fully sprinklered with detection system. Requesting a Temporary Wair allow for completion of necess corrective actions for alleged deficient practice.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Maintenance Director to compregular rounding and follow upvendors to ensure repairs occorrect alleged deficiencies. Maintenance to conduct regul checks as provided by TELS system to ensure documentat and proper checks occur. Upon completion of repairs a of said invoice to be provided ISDH. By what date the systemic changes will be completed: 6/1/23	on fire  ver to sary  the  ut  blete b with ur to ar ion copy
	and maintenance of components and sha	the system and its all be made available to the			

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 14 of 26

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD IAPOLIS, IN 46214	
(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
		risdiction upon request. This ould affect all residents, staff,			
	for the most recent of Maintenance Direct 10:30 a.m. to 1:05 proceed inspection document control valves for find 12-month period was Based on interview the Maintenance Dithe facility for four not additional control documentation available.	-			
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 2 of had documented and accordance with NF portable fire extinguinstalled, inspected,	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility 621 portable fire extinguishers	K 0355	K-355 Portable Fire Extinguishers This plan of correction constituthis facility's written allegation compliance for the deficiencie cited. The submission of this of correction is not an admission.	of s plan

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 15 of 26

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155291	B. WING		04/17/2023
			CTREET	ADDRESS CITY STATE ZIR COD	
NAME OF P	ROVIDER OR SUPPLIER	L		ADDRESS, CITY, STATE, ZIP COD	
EACLE)	/ALLEV MEADON/			ALLEY FARMS RD	
EAGLE V	'ALLEY MEADOWS		INDIAN	IAPOLIS, IN 46214	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Fire Extinguishers,	2010 Edition, Section 7.3.1.1.1		or agreement with the deficien	icies
	states fire extinguis	hers shall be subject to		or conclusions contained in the	e
	maintenance at inte	rvals of not more than one		Indiana Department of Health'	s
	year, at the time of	hydrostatic test, or when		Inspection Report. Eagle Valle	ey
	specifically indicate	ed by an inspection or		Meadows respectfully request	-
	electronic notification	on. Section 7.3.3 states each		consideration for a desk review	
	fire extinguisher sha	all have a tag or label securely		this plan of correction in lieu o	f
	attached that indicate	tes the month and year the		post survey revisit.	
		erformed, identifies the person		What corrective action(s) wil	ı
	_	k, and identifies the name of		be accomplished for those	
	-	ing the work. This deficient		residents found to have beer	լ
		t at least 10 residents, staff,		affected by the deficient	
	-	n Memory Care dining room		practice:	
	and the salon.			Annual maintenance documer	nted
				and completed for portable fire	
	Findings include:			extinguishers in accordance w	
	i mamgs merace.			NFPA 10 in Memory Care Din	
	Based on observation	ons on 04/17/23 between 1:05		room and the salon corrected	·
		during a tour of the facility with		4/18/23.	
		rector, the ABC type portable		4/10/23.	
		the Memory Care dining room		How other residents having t	the
	_	ed maintenance tags		How other residents having t	
		te the most recent annual		potential to be affected by th	
	_	erformed as February 2022. All		same deficient practice will be	
	•	ners in the facility had affixed		identified and what correctiv	e
		ocumenting the date the most		action(s) will be taken:	
	_	C		The alleged deficient practice	,
		enance was performed as		could affect at least 10 resider	
		sed on interview at the time of		staff, and visitors while in Men	-
		intenance Director confirmed		Care Dining room and the sale	on.
		portable fire extinguisher did		l	
		ed annual maintenance within		Audit was completed of all	
	the most recent twe	ive-month period.		portable extinguishers to ensu	re
		t distant		appropriate documentation in	
		viewed with the Executive		place.	
		enance Director during the exit		What measures will be put in	ito
	conference.			place or what systemic	
				changes will be made to	
	3-1.19(b)			ensure that the deficient	
				practice does not recur:	
				Maintenance Director/Designe	e e

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

Event ID:

MZAC21

Facility ID: 000188

If continuation sheet

Page 16 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
EAGLE V	ALLEY MEADOWS	3		ALLEY FARMS RD NAPOLIS, IN 46214	
(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 APPROPRI DEFICIENCY)	DATE
				will ensure affixed maintenantags to all portable fire extinguishers will be inspected monthly and documentation varieties upon environmental rounding.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place:  Maintenance Director/Design will complete a QAPI Tool for Environmental Rounds to ensuall portable fire extinguishers been inspected monthly and documentation on affixed maintenance tags is current. Will be utilized bi-weekly x 4 weeks then monthly x 6 month with results reported to the Quant Assurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will adeveloped to ensure compliant By what date the systemic changes will be completed: 5/12/23	the  the  ut  ee  ure have  This hs, uality rseen
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING	lding Spaces - Smoke lding Spaces - Smoke arriers are 1-3/4-inch thick			

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 17 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155291	B. W	ING		04/17	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ALLEY FARMS RD		
EAGLE V	ALLEY MEADOWS	8	INDIANAPOLIS, IN 46214				
			1		· I		avs.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG	solid bonded woo	R LSC IDENTIFYING INFORMATION	+	TAG	DEI TOLENC I I		DATE
		a-core acors or or esists fire for 20 minutes.					
		ve plates of unlimited height					
		ors are permitted to have					
		assemblies per 8.5. Doors					
		automatic-closing, do not					
	_	and are not required to swing					
		egress travel. Door opening					
		um clear width of 32 inches					
	for swinging or ho						
	19.3.7.6, 19.3.7.8,						
		on and interview, the facility	K 0	374	K-374 Subdivision of Buildin	g	05/12/2023
	failed to ensure 1 of	f 6 sets of corridor doors would			Spaces – Smoke Barrier Doo	-	
	close to form a smo	ke resistant barrier. LSC			This plan of correction constitu	utes	
	19.3.7.8 requires do	oors in smoke barriers shall			this facility's written allegation	of	
	comply with LSC S	Section 8.5.4. LSC 8.5.4.1			compliance for the deficiencie	s	
	requires doors in sn	noke barrier shall close the			cited. The submission of this	plan	
		ly the minimum clearance			of correction is not an admissi	on	
		r operation. This deficient			or agreement with the deficier	ncies	
	-	et 30 residents, staff and			or conclusions contained in th		
	visitors in the Main	Dining Room.			Indiana Department of Health		
					Inspection Report. Eagle Vall	-	
	Findings include:				Meadows respectfully request		
	. n. 1 1 1	tot of the tra			consideration for a desk revie		
		ons with the Maintenance			this plan of correction in lieu o	Ť	
	_	our of the facility from 1:05 a.m.			post survey revisit.		
		17/23, the set of corridor doors			What corrective action(s) will be accomplished for those	ı	
	-	entrance to the Main Dining n the same direction, are held			be accomplished for those	•	
	_	eleasing devices which release			residents found to have been affected by the deficient	1	
		em activation. When tested on			practice:		
		sions, the door set failed to			The set of corridor doors to the	<b>A</b>	
	_	to the frame to form a smoke			Main Dining Room now latch	C	
		sed on interview at the time of			completely and form a smoke		
		e Maintenance Director			resident barrier – corrected or		
	· ·	ntioned corridor door set did			4/18/23.	•	
		y and form a smoke resident					
	barrier.	•			How other residents having	the	
					potential to be affected by th		
	This finding was re	viewed with the Executive			same deficient practice will l		
	l ~		1		· '		I .

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 18 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155291	A. BUILDING B. WING	01	COMPLETED 04/17/2023
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD	
EAGLE V	ALLEY MEADOWS	3		IAPOLIS, IN 46214	
(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
	Director and Mainte conference.  3.1-19(b)	enance Director at the exit		identified and what corrective action(s) will be taken: This alleged deficient practice the potential to affect 30 reside staff and visitors in the Main Dining Room. Audit of all corridor doors completed to ensure proper closure without incident completed. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designe will conduct weekly audits of corridor doors to ensure proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Staff inservice to review how the report issue to maintenance if noticed that doors do not proped close/seal to be completed by Maintenance Director/Designed Will conduct weekly audits of corridor doors to ensure proped seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident barrier for 4 weeks and then monthly for 6 months using PCQA tool, with results reported to the proper seal to form a smoke resident proper	had ents,  to  te  te  tr  CC  the  ut  co  erly  ee.  ee  er

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 19 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155291	A. BUILDING B. WING	01	COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS RD JAPOLIS, IN 46214	
(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
				the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure complian By what date the systemic changes will be completed: 5/12/23	
K 0741 SS=E Bldg. 01	shall include not lead provisions:  (1) Smoking shall ward, or compartmaliquids, combustible used or stored and location, and such signs that read NC posted with the interest smoking.  (2) In health care of smoking is prohibite prominently placed secondary signs we smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the passupervision.  (5) Ashtrays of not safe design shall be where smoking is (6) Metal contained	ons ons shall be adopted and oss than the following oe prohibited in any room, ment where flammable e gases, or oxygen is d in any other hazardous area shall be posted with o SMOKING or shall be ernational symbol for no occupancies where ded and signs are d at all major entrances, with language that prohibits obe required. tients classified as not one prohibited. ont of 18.7.4(3) shall not atient is under direct			

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet

Page 20 of 26

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3		(X3) DATE	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155291	B. W	NG		04/17	/2023
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
E401E1	/ALLEY/ NAE A DOM/				ALLEY FARMS RD		
EAGLE \	ALLEY MEADOWS	5		INDIAN	IAPOLIS, IN 46214		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	shall be readily av	vailable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4						
		on and interview, the facility	K 0	741	F-741 Smoking Regulations		05/12/2023
		1 non-smoking policies. This	100	, 11	This plan of correction constitu	ıtes	03/12/2023
		ould affect staff outside the			this facility's written allegation		
	kitchen exit door.	oura urreet starr outstae the			compliance for the deficiencies		
	Michon Can door.				cited. The submission of this		
	Findings include:				of correction is not an admissi		
	i mamga merade.						
	Raced on observation	ons during a tour of the facility			or agreement with the deficient or conclusions contained in the		
		ce Director on 04/17/23 at 1:37					
					Indiana Department of Health'		
		ide the kitchen exit door was			Inspection Report. Eagle Valle	-	
		50 cigarette butts discarded			Meadows respectfully request		
	_	de of the exit. Based on			consideration for a desk review		
		e of observation, the			this plan of correction in lieu o	Ī	
		tor stated that is not a smoking			post survey revisit.	_	
		the presence of discarded			What corrective action(s) wil	l	
		de the exit. Based on			be accomplished for those		
		Executive Director, she stated			residents found to have beer	1	
	the facility is non-s	moking.			affected by the deficient		
					practice:		
	_	viewed with the Executive			Cigarette butts have been rem		
		enance Director at the exit			from kitchen exit door and pro		
	conference.				disposed of corrected on 4/18/	/23.	
	3.1-19(b)				All staff will be educated regar	dina	
					smoking policy.	3	
					How other residents having t	the	
					potential to be affected by th		
					same deficient practice will b		
					identified and what correctiv		
					action(s) will be taken:		
					Staff outside the kitchen exit d	oor	
					have the potential to be affected		
					by the alleged deficient practic		
					ED/Designee to conduct an		
					in-service with all staff regarding	na	
					smoking policy.		

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 21 of 26

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155291	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/17/2023
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP COD 'ALLEY FARMS RD NAPOLIS, IN 46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) BE COMPLETION DATE
				What measures will be purplace or what systemic changes will be made to ensure that the deficient practice does not recur: ED/Designee to conduct ar in-service with all staff regards smoking policy. Building rounding to be corweekly using Environmentate How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: Maintenance Director/Designation of the place of the extinguished been inspected monthly and documentation on affixed maintenance tags is current will be utilized weekly x 4 with the monthly x 6 months, we results reported to the Quantenance and Performance Improvement Committee of by the Executive Director If a threshold of 95% is not achieved, an action plan with developed to ensure computations will be complete 5/12/23	mpleted al tool. (s) re the  e put  gnee for ensure rs have ad  at. This veeks with lity be verseen  ill be liance. ic
K 0918 SS=F Bldg. 01	1	s - Essential Electric Syste s - Essential Electric nce and Testing			

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 22 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>01</u>	COMPLETED
		155291	B. WING		04/17/2023
			CTD	EET ADDRESS CITY STATE ZID COD	
NAME OF P	PROVIDER OR SUPPLIER	1		EET ADDRESS, CITY, STATE, ZIP COD	
EAGLE)	/ALLEY/ ME A DO)///			7 VALLEY FARMS RD	
EAGLE V	ALLEY MEADOWS		IND	DIANAPOLIS, IN 46214	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG		DATE
	The generator or	other alternate power			
	source and assoc	iated equipment is capable			
	of supplying service	ce within 10 seconds. If the			
	10-second criterio	n is not met during the			
	monthly test, a pro	ocess shall be provided to			
	annually confirm t	his capability for the life			
	safety and critical	branches. Maintenance			
	and testing of the	generator and transfer			
	switches are perfo	ormed in accordance with			
	NFPA 110.				
	Generator sets are	e inspected weekly,			
	exercised under lo	oad 30 minutes 12 times a			
	year in 20-40 day	intervals, and exercised			
	once every 36 mo	nths for 4 continuous hours.			
		der load conditions include			
	a complete simula				
		ual transfer of all EES			
		nducted by competent			
	1 '	nance and testing of stored			
	1	rces (Type 3 EES) are in			
		NFPA 111. Main and feeder			
		e inspected annually, and a			
		dically exercising the			
		tablished according to			
		uirements. Written records			
		nd testing are maintained			
		ble. EES electrical panels			
		arked, readily identifiable,			
	1	n normal power circuits.			
	1	ssibility of damage of the			
		source is a design			
	consideration for r				
		(NFPA 99), NFPA 110,			
	NFPA 111, 700.10	,	IZ 0010	K 049 Floatsiaal Contains	05/10/2022
		view and interview, the facility	K 0918	K-918 Electrical Systems	- 05/12/2023
		complete written record of		Essential Electric System	
		oad testing for five of the last r 6.4.4.1.1.4(a) of 2012 NFPA 99		Maintenance and Testing	itutoo
	_	sting of the generator serving		This plan of correction const	
				this facility's written allegatio	
	me emergency elect	trical system to be in	1	compliance for the deficience	es

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

Event ID:

MZAC21 Facility ID: 000188

If continuation sheet Page 23 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155291	B. W	ING		04/17/	2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ALLEY FARMS RD		
EAGLE V	ALLEY MEADOW	S			APOLIS, IN 46214		
	Т				, JEIO, III IOZIT		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		FPA 110, the Standard for			cited. The submission of this	-	
		andby Powers Systems, Chapter			of correction is not an admiss		
		requires diesel generator sets in ised at least once monthly, for a			or agreement with the deficier or conclusions contained in the		
		nutes. Chapter 6.4.4.2 of NFPA			or conclusions contained in the Indiana Department of Health		
		en record of inspection,			Inspection Report. Eagle Val		
		vising period, and repairs for the			Meadows respectfully reques	-	
	1 ~	ularly maintained and available			consideration for a desk revie		
	for inspection by the				this plan of correction in lieu of		
		deficient practice could affect all			post survey revisit.	••	
	occupants.	1			What corrective action(s) wi	II .	
	•				be accomplished for those		
	Findings include:				residents found to have bee	n	
	_				affected by the deficient		
	Based on record re	view with the Maintenance			practice:		
	Director on 04/17/2	23 from 10:35 a.m. to 1:05 p.m.,			Maintenance Supervisor/Desi	gnee	
	documentation for	monthly generator load testing			will ensure that monthly		
	for five of the last	12 months was not available for			emergency generator load tes	sting	
		n interview at the time of record			is conducted and a complete		
		nance Director stated he had			written record of monthly gene	erator	
		four months and confirmed			load testing is maintained to		
		I testing documentation for			ensure implementation of the		
		, September, October 2022 was			emergency power system,		
	available for review	v.			inspection, testing and		
	TEL: C: 1:	t that rest			maintenance requirements. L		
	_	eviewed with the Executive			testing completed 4/22/23 and		
		tenance Director at the exit			4/29/23 with no load and 4/30	123	
	conference.				under load.		
	3.1-19(b)				How other residents having	tho	
	3.1-17(0)				potential to be affected by the		
					same deficient practice will		
					identified and what corrective		
					action(s) will be taken:	-	
					All residents, staff and visitors	<b>s</b>	
					have the potential to be affect		
					by the alleged deficient practi		
					Maintenance Supervisor/Desi		
					will ensure that emergency	-	
					generator load testing is		

PRINTED: 05/12/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155291	A. BUILDING 01  B. WING		COMPLETED 04/17/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE				
				conducted, and sets are inspet weekly, exercised under load a minutes monthly and maintain complete written record of more generator load.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:  Maintenance Supervisor/Design will be responsible for conduct weekly environmental rounds ensure emergency generator letest is conducted and sets are inspected weekly, exercised u load 30 minutes monthly and maintain complete written record of monthly generator load.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place:  Maintenance Supervisor/Design will be responsible for complete an Environmental Rounding Quality tool to verify emergency general load test are conducted and seare inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load test are conducted and seare inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load test are conducted and seare inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load test are conducted and seare inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load test are conducted and seare inspected weekly for weeks and monthly for 6 monthly and maintain complete written record of monthly generator load test are conducted and seare inspected weekly for weeks and monthly for 6 monthly generator load test are conducted and seare inspected weekly for weeks and monthly for 6 monthly generator load test are conducted and seare inspected weekly for weeks and monthly for 6 monthly generator load test are conducted and seare inspected weekly for weeks and monthly for 6 monthly generator load test are conducted and seare inspected weekly for weekly for the form of the form of	cted 30  Inthly  Ito  Ignee ing to oad Inder  Inthe  Inthe  Inthe			

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

Event ID:

 $MZAC21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000188$ 

If continuation sheet

Page 25 of 26

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CE

REGULATORY OR LSC IDENTIFYING INFORMATION

TAG

PRINTED: 05/12/2023 FORM APPROVED

DATE

ENTERS FOR	OM	OMB NO. 0938-039						
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED		
		155291	B. WING			04/17/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 3017 VALLEY FARMS RD				
EAGLE VALLEY MEADOWS				INDIANAPOLIS, IN 46214				
(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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	

not achieved, an action plan will

be developed to ensure

By what date the systemic changes will be completed:

compliance.

5/12/23

Event ID: MZAC21 Facility ID: 000188 Page 26 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet