STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155291	A. BUILDING -- B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	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	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: 04/17/23 Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310 At this Emergency Preparedness survey, Eagle Valley Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 66. Quality Review completed on 04/20/23	E 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Life Safety Recertification and State Licensure with Emergency Preparedness Survey conducted 4/17/23. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set			

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

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	forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below.			

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	You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and			

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	Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 04/17/23 from 10:35 a.m. to 1:05 p.m., documentation for monthly generator load testing for 5 of the last 12 months was not available for review. Based on an interview at the time of record review, the Maintenance Director stated he had been at the facility four months and confirmed that no further load testing documentation for May, June, August, September, October 2022 was available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	E 0041	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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 Supervisor/Designee will ensure that monthly emergency generator load testing is conducted and a complete written record of monthly generator load testing is maintained to ensure implementation of the emergency power system, inspection, testing and maintenance requirements. Monthly generator testing under load last conducted 4/30/23. **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, staff and visitors	05/12/2023

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			have the potential to be affected by the alleged deficient practice. Maintenance Supervisor/Designee will ensure that emergency generator load testing is conducted, and sets are inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Supervisor/Designee will be responsible for conducting weekly environmental rounds to ensure emergency generator load test is conducted and sets are inspected weekly, exercised under 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 put into place:** Maintenance Supervisor/Designee will be responsible for completing an Environmental Rounding QAPI tool to verify emergency generator load test are conducted and sets are inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load. This will be checked weekly for 4	

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			weeks and monthly for 6 months. The results of these audits will be reviewed by QAPI committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** 5/12/23	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/17/23 Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310 At this Life Safety Code survey, Eagle Valley Meadows 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 one story facility was determined to be of Type V (111) 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	K 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Life Safety Recertification and State Licensure with Emergency Preparedness Survey conducted 4/17/23. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	

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	battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 66 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached storage sheds providing facility services which were not sprinklered. Quality Review completed on 04/20/23			
K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 3 of 3 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect staff. Findings include: Based on record review on 04/17/23 at 12:02 p.m. with the Maintenance Director, the	K 0291	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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/Designee to document an annual 90-minute test of the Battery-Operated Emergency Light Test of the	05/08/2023

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	Battery-Operated Emergency Light Test documentation indicated the facility has three battery operated emergency lights. Documentation of an annual 90-minute test within the last 12 months was not available for review at the time of the survey. Based on interview at the time of record review, the Maintenance Director confirmed that an annual 90-minute test had not been conducted for the battery-operated emergency lights in the facility. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		facility's three battery operated emergency lights on 5/8/23. **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 and visitors have the potential to be affected by the alleged deficient practice. Maintenance Supervisor/Designee will ensure documentation and testing of an annual 90-minute test of the Battery-Operated Emergency Light Test of the facility's three battery operated emergency lights is completed annually. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Supervisor/Designee 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 three battery operated emergency lights is completed annually. Maintenance Supervisor/Designee to complete quarterly audit tool to ensure that an annual 90-minute test of the Battery-Operated Emergency Light Test of the facility's three battery operated emergency lights is completed annually. Area will then be	

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			monitored by the QAPI process. **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:** Maintenance Supervisor/Designee will be responsible for completing an Environmental Rounding QAPI tool to verify an annual 90-minute test of the Battery-Operated Emergency Light Test of the facility's three battery operated emergency light is completed annually quarterly. This will be checked quarterly for one year. The results of these audits will be reviewed by QAPI committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** 5/12/23	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.			

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas such as shower room being used for trash & soiled linen storage was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the shower room near resident room 156. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 04/17/23 at 1:55 p.m. the corridor door to the shower room across the hall from resident room 156 was	K 0321	**K-321 Hazardous Areas - Enclosure** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. **What corrective action(s) will be accomplished for those**	05/12/2023

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	equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. There was a 32-gallon trash receptacle and a PVC framed soiled linen cart being stored in the shower room. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** Th corridor door to the shower room equipped with a self-closing latch into the door frame is now secure. The 32-gallon trash receptacle and PVC framed soiled linen cart is no longer stored in the shower room completed 4/17/23. **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:** Residents of D-Hall, staff and visitors in vicinity of the shower room had the potential to be affected by the alleged deficient practice. Audit to be completed of shower room corridor doors and storage of items weekly for four weeks and monthly for six months. **What measures will be put into 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 and proper storage of trash receptacles and linen carts to be completed by DNS/Designee. DNS/Designee will complete an inservice with staff across shifts for all staff to ensure staff education on securing the shower room doors and proper storage of	

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			trash receptacles and linen carts to be completed by 5/12/23. **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:** Housekeeping Supervisor/Designee will be responsible for completing POC QA tool weekly x 4 weeks then monthly x 6 months, with results reported to 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 compliance. **By what date the systemic changes will be completed:** 5/12/23	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 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 records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on review of "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems 5th Year" documentation dated 06/11/20 during record review with the Maintenance Director from 10:35 a.m. to 1:05 p.m. on 04/17/23; the Deficiency Summary stated 'The FDC check valve is corroded on both sides of the check and will not move freely'. Based on interview at the time of record review, the Maintenance Director stated he had been at the	K 0353	**K-353 Sprinkler System – Maintenance and Testing** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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:** Requesting a Temporary Waiver to allow for completion of necessary corrective actions for alleged deficient practice allowing corrective action to be completed by 6/1/23 **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, staff and visitors	06/01/2023

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EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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	facility four months and there is no documentation for the repair of the FDC check valve on or after 06/11/20 available for review at the time of the survey. b. Based on review of "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems Third Year" documentation dated 06/01/22 during record review with the Maintenance Director on 04/17/23, the Deficiency Summary stated "System failed air leak test by 20lbs in an hour. 3-Year trip test FAILED inspection". A purchase agreement/proposal for air leak service dated 06/02/20 from the facility's sprinkler vendor was provided at the time of the survey, however it was unsigned by the facility. Based on interview at the time of record review, the Maintenance Director stated that documentation indicating repairs being conducted on or after 06/01/20 for the aforementioned air leak was not available for review at the time of the survey. 2. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the		have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility is fully sprinklered with fire detection system. Requesting a Temporary Waiver to allow for completion of necessary corrective actions for alleged deficient practice. **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:** Maintenance Director to complete regular rounding and follow up with vendors to ensure repairs occur to correct alleged deficiencies. Maintenance to conduct regular checks as provided by TELS system to ensure documentation and proper checks occur. Upon completion of repairs a copy of said invoice to be provided to ISDH. **By what date the systemic changes will be completed:** 6/1/23	

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	authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of monthly valve documentation for the most recent twelve-month period with the Maintenance Director during record review from 10:30 a.m. to 1:05 p.m. on 04/17/23, monthly inspection documentation for all sprinkler system control valves for five months of the most recent 12-month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been at the facility for four months and confirmed there is not additional control valve inspection documentation available for review. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 21 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable	K 0355	**K-355 Portable Fire Extinguishers** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission	05/12/2023

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	Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect at least 10 residents, staff, and visitors while in Memory Care dining room and the salon. Findings include: Based on observations on 04/17/23 between 1:05 p.m. and 2:10 p.m. during a tour of the facility with the Maintenance Director, the ABC type portable fire extinguisher in the Memory Care dining room and salon had affixed maintenance tags documenting the date the most recent annual maintenance was performed as February 2022. All other fire extinguishers in the facility had affixed maintenance tags documenting the date the most recent annual maintenance was performed as March 30, 2023. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve-month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3-1.19(b)		or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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:** Annual maintenance documented and completed for portable fire extinguishers in accordance with NFPA 10 in Memory Care Dining room and the salon corrected on 4/18/23. **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:** The alleged deficient practice could affect at least 10 residents, staff, and visitors while in Memory Care Dining room and the salon. Audit was completed of all portable extinguishers to ensure appropriate documentation in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/Designee	

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			will ensure affixed maintenance tags to all portable fire extinguishers will be inspected monthly and documentation will reflect upon environmental rounding. **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:** Maintenance Director/Designee will complete a QAPI Tool for Environmental Rounds to ensure all portable fire extinguishers have been inspected monthly and documentation on affixed maintenance tags is current. This will be utilized bi-weekly x 4 weeks then monthly x 6 months, with results reported to 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 compliance. **By what date the systemic changes will be completed:** 5/12/23	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick			

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	solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 6 sets of corridor doors would close to form a smoke resistant barrier. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 30 residents, staff and visitors in the Main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 a.m. to 2:10 p.m. on 04/17/23, the set of corridor doors serving as the main entrance to the Main Dining Room each swing in the same direction, are held open by magnetic releasing devices which release with fire alarm system activation. When tested on three separate occasions, the door set failed to completely latch into the frame to form a smoke resistant barrier. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor door set did not latch completely and form a smoke resident barrier. This finding was reviewed with the Executive	K 0374	**K-374 Subdivision of Building Spaces – Smoke Barrier Doors** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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:** The set of corridor doors to the Main Dining Room now latch completely and form a smoke resident barrier – corrected on 4/18/23. **How other residents having the potential to be affected by the same deficient practice will be**	05/12/2023

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	Director and Maintenance Director at the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken:** This alleged deficient practice had the potential to affect 30 residents, 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 into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/Designee 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 POC QA 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 put into place:** Staff inservice to review how to report issue to maintenance if noticed that doors do not properly close/seal to be completed by Maintenance Director/Designee. Maintenance Director/Designee 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 POC QA tool, with results reported to	

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			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 compliance. **By what date the systemic changes will be completed:** 5/12/23	
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			

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	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 enforce 1 of 1 non-smoking policies. This deficient practice could affect staff outside the kitchen exit door. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/17/23 at 1:37 p.m., smoking outside the kitchen exit door was evident due to over 50 cigarette butts discarded on the ground outside of the exit. Based on interview at the time of observation, the Maintenance Director stated that is not a smoking area and confirmed the presence of discarded cigarette butts outside the exit. Based on interview with the Executive Director, she stated the facility is non-smoking. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0741	**F-741 Smoking Regulations** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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:** Cigarette butts have been removed from kitchen exit door and properly disposed of corrected on 4/18/23. All staff will be educated regarding smoking policy. **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:** Staff outside the kitchen exit door have the potential to be affected by the alleged deficient practice. ED/Designee to conduct an in-service with all staff regarding smoking policy.	05/12/2023

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ED/Designee to conduct an in-service with all staff regarding smoking policy. Building rounding to be completed weekly using Environmental 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 put into place:** Maintenance Director/Designee will complete a QAPI Tool for Environmental Rounds to ensure all portable fire extinguishers have been inspected monthly and documentation on affixed maintenance tags is current. This will be utilized weekly x 4 weeks then monthly x 6 months, with results reported to 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 compliance. **By what date the systemic changes will be completed:** 5/12/23	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing			

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	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)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for five of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in	K 0918	**K-918 Electrical Systems – Essential Electric System Maintenance and Testing** This plan of correction constitutes this facility's written allegation of compliance for the deficiencies	05/12/2023

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	accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 04/17/23 from 10:35 a.m. to 1:05 p.m., documentation for monthly generator load testing for five of the last 12 months was not available for review. Based on an interview at the time of record review, the Maintenance Director stated he had been at the facility four months and confirmed that no further load testing documentation for May, June, August, September, October 2022 was available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of 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 Supervisor/Designee will ensure that monthly emergency generator load testing is conducted and a complete written record of monthly generator load testing is maintained to ensure implementation of the emergency power system, inspection, testing and maintenance requirements. Load testing completed 4/22/23 and 4/29/23 with no load and 4/30/23 under load. **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, staff and visitors have the potential to be affected by the alleged deficient practice. Maintenance Supervisor/Designee will ensure that emergency generator load testing is	

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			conducted, and sets are inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Supervisor/Designee will be responsible for conducting weekly environmental rounds to ensure emergency generator load test is conducted and sets are inspected weekly, exercised under 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 put into place:** Maintenance Supervisor/Designee will be responsible for completing an Environmental Rounding QAPI tool to verify emergency generator load test are conducted and sets are inspected weekly, exercised under load 30 minutes monthly and maintain complete written record of monthly generator load. This will be checked weekly for 4 weeks and monthly for 6 months. The results of these audits will be reviewed by QAPI committee overseen by the Executive Director. If a threshold of 95% is	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** 5/12/23	