STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155566	A. BUILDING -- B. WING	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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: 09/12/22 Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920 At this Emergency Preparedness survey, Warsaw Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 58. Quality Review completed on 09/14/22	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 30, 2022. We respectfully request paper compliance for this survey resolution.	
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: 09/12/22 Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920 At this Life Safety Code survey, Warsaw	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 01 B. WING	09/12/2022

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	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 III (211) construction in the original building and Type V (111) construction in the northwest, west and laundry wings and all were fully sprinklered. The buildings were not separated by a fire barrier therefore the construction type for the entire facility was V (111). The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery-operated smoke detectors in the resident rooms. The facility is partially protected by a diesel 50 kW emergency generator. The facility has a capacity of 80 beds dually certified for Medicare and Medicaid and had a census of 58 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached garage providing storage for the mowers and maintenance supplies, a shed with activity supplies, and a storage pod with wheelchairs, beds and walkers. Quality Review completed on 09/14/22		September 30, 2022. We respectfully request paper compliance for this survey resolution.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means			

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	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 storeroom doors in the laundry were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect staff that use storeroom in the laundry. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 1:10 p.m., the storeroom door in the laundry was locked with a padlock from the outside and there was no release from the inside to open the door if locked with the pad lock. This condition could trap a person inside the storeroom if locked from the outside. Based on interview at the time of observation, the Maintenance Director agreed the storeroom door was locked with a padlock and could not open from the inside when locked. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b	K 0211	K 211 It is the practice of this facility that no doors lock without the ability to be unlocked from both sides. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this alleged deficient practice. *Other residents that have the potential to be affected have been identified by:* The area in question is not accessible or accessed by residents. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Padlock was removed and hasp was removed. It was found this door did not need to be secured as it is storage for laundry and does not contain anything that needs to be secured, just linen. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all egresses meet state and federal requirements. A weekly audit of all doors building wide will be	09/13/2022

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			completed to ensure no locks have been placed that do not have means of egress from both sides. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/13/2022*	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be			

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	electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 4 of	K 0222	K222 It is the practice of this facility to	09/13/2022

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	12 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 30 residents in three exit corridors. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:40 a.m. and 1:00 p.m., exit doors numbers 2, 7, 8, and 9 were marked as a facility exit, were magnetically locked, and could be opened by entering the posted four-digit code on the access control pad, but when the posted code was entered into the keypad the doors would not open. Based on interview at the time of observation, the Maintenance Director stated the codes at the aforementioned doors had the wrong codes posted and the doors did open when the correct codes were entered. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		assure that egress doors that are coded have the correct code clearly displayed on top. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficient practice. The doors in question were not in common resident areas. *Other residents that have the potential to be affected have been identified by:* Residents have the potential to be affected if wanting to use those doors and unable to read the code on top. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* All codes were confirmed correct and reapplied to the tops of all code boxes building wide. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all egresses meet state and federal requirements. A weekly audit of all doors building wide that have coded doors will be completed to ensure no codes have been removed from the top of the code box and that they are correct. Those results will be submitted to the Administrator weekly and	

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			included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/13/2022*	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 3 of 6 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not	K 0232	K232 It is the practice of this facility to ensure hallways are free from obstructions. *The corrective action taken for those residents found to be affected by the deficient practice include:* Residents on Heritage Hall, Liberty Hall, and Freedom Hall had the potential to be affected. All of the chairs that were in the halls have been removed and returned to resident's rooms. *Other residents that have the potential to be affected have been identified by:* All residents have the opportunity to be affected by this deficient practice. *The measures of systemic*	09/22/2022

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	obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 40 residents in three halls. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:40 a.m. and 1:00 p.m., there were a total of 10 chairs in Heritage Hall, Liberty Hall, and Freedom Hall that extended about two feet into the corridor and were not affixed to the floor or to the wall when evaluated. Based on interview at the time of the observations, the Maintenance Director agreed the chairs were not securely attached to the floor or to the wall when evaluated. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		*changes that have been put into place to ensure that the deficient practice does not recur include:* Chairs are not allowed to be placed in the hallways. Staff have been in-serviced on not allowing chairs to be brought out into the halls and any that are ever left must be removed immediately. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all hallways are free of furniture that is not secured to the floor or wall and meet state and federal guidelines. A weekly audit of all halls building wide will be completed to ensure no furniture that is not secured is left in hallways. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/22/2022*	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting			

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	the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 12 exit discharge were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 20 residents that would use exit door #9. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 12:36 p.m., the exit discharge from door #9 had an asphalt walkway leading to the common way. The first 50 feet of the walkway was uneven, had holes, had weeds growing through the cracks, and about 15 feet of the walkway was covered with a half inch of moss. Based on interview at the time of observation, the Maintenance Director agreed the walkway was in poor condition and did not provide an unobstructed level walking surface. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0271	K271 It is the practice of this facility to ensure exits all have safe, even walkways. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficient practice. *Other residents that have the potential to be affected have been identified by:* This exit is not used by residents and is not an area residents frequent. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Walkway was power washed and all holes filled in to ensure a smooth hazard free egress. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all walkways are clear and pathways do not have holes or breaks in the pavement. A weekly audit of all exits building wide will be completed to ensure no areas	09/30/2022

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			become overgrown or have broken pavement. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/30/2022*	
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. 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			

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	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 laundry rooms and 1 of 1 kitchens that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 12:50 p.m. and at 1:10 p.m., the following unsealed holes and cracks were observed: a.) In the laundry room which contained fuel fired dryers had a damaged celling containing multiple unsealed cracks and drywall patches with unsealed holes and gaps. b.) In the kitchen which contained a fuel fired furnace had a damaged celling containing multiple unsealed cracks running across the ceiling. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed holes and cracks in both ceilings and stated a quote has been sent in to repair the ceilings. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0321	K321 It is the practice of this facility to ensure there are no hazardous conditions in any area of the facility. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficient practice. *Other residents that have the potential to be affected have been identified by:* Residents do not have access or enter these areas *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Both ceilings were scheduled to be repaired by a contractor and that date was moved up to 9/23/2022. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring no hazards exist in any area of the facility. A daily walkthrough audit of all areas building wide will be	09/30/2022

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			completed to ensure there are no new hazardous conditions anywhere and repairs are completed timely and correctly. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/30/2022*	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls in 1 of 1 dining rooms and 1 of 1 ADON offices met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. and 10.2.3.4 LSC 101 (2012 edition). LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.	K 0331	K331 It is the practice of this facility to ensure there are no hazardous conditions in any area of the facility. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficient practice. *Other residents that have the*	09/30/2022

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WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scaleThis deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 11:40 a.m., in the dining room and the ADON office the lower 1/3rd of the walls was covered with wood wainscoting. Based on records review at 10:05 a.m., no documentation of the flame spread rating for the wall coverings was available for review. Based on interview at the time of observation, the Maintenance Director stated the flame spread documentation for the wainscoting could not be located. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		*potential to be affected have been identified by:* Residents do not access the office that was cited. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Wainscotting in question was treated with fire retardant rated Class 1 and documentation to that effect is on file. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring no hazards exist in any area of the facility. A daily walkthrough audit of all areas building wide will be completed to ensure there are no new hazardous conditions anywhere and repairs are completed timely and correctly. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/30/2022*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 01 B. WING	09/12/2022

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K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 11:35 a.m., the time and date on the display of the fire alarm control panel indicated the dated was 9/11/22 and the time was 2215 (10:15 p.m.) when checked on 9/12/22 at 11:35 a.m. Based on interview at the time of observation, the Maintenance Director agreed the fire alarm control panel had the wrong time and date. The finding was reviewed with the Maintenance	K 0341	K 341 It is the practice of this facility that the fire panels have the correct time and date on them. *The corrective action taken for those residents found to be affected by the deficient practice include:* Residents were not affected. *Other residents that have the potential to be affected have been identified by:* Residents were not affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* **SafeCare contractor came in and updated the time and date on the fire panel.** *The corrective action taken to*	09/13/2022

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	Director and the Administrator during the exit conference. 3.1-19(b)		*monitor the performance to assure compliance through quality assurance is:* The Maintenance Director or designee is responsible for ensuring the fire panel has current date and time on it. Maintenance Director of designee will perform a weekly check of the fire panel to ensure it's still up to date for six months. Any deviation will be corrected immediately. *The date the systemic change will be completed: 9/13/2022*	
K 0353 SS=E 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 _____ 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 Based on observation and interview, the facility failed to maintain 1 of 1 ceiling constructions. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a	K 0353	K353 It is the practice of this facility to ensure there are no hazardous conditions in any area of the	09/21/2022

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	specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 15 residents in Independence Hall. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 11:43 a.m., in room #3 and in the hall outside of room #3 there were a total of 5 unsealed ½ inch holes in the ceilings. This condition could delay the activation of the sprinklers installed in ceilings. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed holes in the ceiling and by room #3. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		facility. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by a delay in the sprinkler system operating. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* All five holes were sealed with fire caulk. The contractor that is repairing the ceilings in the kitchen and laundry are also patching two areas in hallway ceilings with old damage. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring no hazards exist in any area of the facility. A daily walkthrough audit of all areas building wide will be completed to ensure there are no new hazardous conditions anywhere and repairs are completed timely and correctly. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting	

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			monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/30/2022*	
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 1. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the riser room was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect staff working in the riser room. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 11:40 a.m., an ABC portable fire extinguisher in the riser room was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor and stated the mounting bracket broke and will need to be rehung.	K 0355	K355 It is the practice of this facility to ensure that fire extinguishers are correctly charged and are hung according to state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by a improperly filled fire extinguishers or ones that are not secured properly. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* The ABC fire extinguisher was secured to the wall as required in the riser room. The K extinguisher	09/21/2022

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 portable K-class fire extinguishers had pressure gauge readings in the acceptable range. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect staff in the kitchen. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 12:30 p.m., the pressure gauge on the K-class fire extinguisher in the kitchen showed the extinguisher was overcharged. Based on interview at the time of observation, the Maintenance Director agreed the K-class fire extinguisher in the kitchen was overcharged. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		was removed and replaced with one that was properly filled. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring fire extinguishers are secured as required and filled properly. A weekly audit of fire extinguishers will be completed that includes ensuring they are properly filled and secured as the guideline dictates. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/21/2022*	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 quiet room corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 12:10 a.m., the corridor door to the quiet room on Liberty Hall had two quarter inch holes that went through the door. Based on interview at the time of observation, the Maintenance Director stated the holes were due to switching the door handle and will need to be filled. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0363	K363 It is the practice of this facility to ensure that all doors are complete and meet required fire ratings. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents in this hall have the potential to be affected. *Other residents that have the potential to be affected have been identified by:* All residents on this hall have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Holes in door to Quiet Room on Liberty Hall have been filled in with fire caulk. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all doors are complete with no holes. A weekly audit of doors will be completed that includes ensuring there are no holes or missing door handles. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months.	09/21/2022

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			Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 9/21/2022*	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation, records review, and interview; the facility failed to ensure 4 of 5 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. The State requires hot water heaters to be inspected once every two years. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:45 a.m. and 1:00 p.m., four of the hot water heaters throughout the facility had an inspection date of 04/11/19. Based on records review at 10:00 a.m., no documentation was available for review to show the four water heaters have been inspected within the last two years. Based on interview at the time of the observation	K 0500	K500 It is the practice of this facility to ensure all water heaters are inspected every two years. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents have the potential to be affected. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Documentation of inspections was found as soon as the surveyor left and is on file. It was done on time and consistently. *The corrective action taken to*	09/21/2022

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	and records review, the Maintenance Director stated a current inspection for the four water heaters could not be found and agreed the posted water heater inspections were past due. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		*monitor the performance to assure compliance through quality assurance is:* Maintenance Director will ensure that inspections continue to be done on time and recommendations followed up on. *The date the systemic change will be completed: 9/21/2022*	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 3 of 6 egress corridors were not being used as a portion of the return air plenum for heating, ventilating, and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A 2012 Edition 4.3.12.1.1 Egress corridors in nursing homes and long-term care facilities, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining arrears. This deficient practice affects 40 residences in 4 smoke compartments. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:30 a.m. to 1:00 p.m., resident rooms number 1 through number 43, storage rooms, and office areas on Independence Hall, Heritage Hall and Liberty Hall had an air supply in	K 0521	K521 It is the practice of this facility to assure that all HVAC requirements are met per regulations. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents have the potential to be affected. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* The Maintenance Director and	09/30/2022

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	each room with no return in the rooms and were using the egress corridors as a return air system. Based on an interview at the time of observations, the Maintenance Director agreed resident rooms, storage rooms, and office areas on the three halls did not contain an air return and were using the corridors as the air return. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		Maintenance Assistant will be in-serviced on this requirement. The facility has submitted a waiver in regards to the air return requirement, please see attached. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Administrator will submit this waiver annually or as required to address the air returns in this area of the facility. *The date the systemic change will be completed: 9/30/2022*	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room.	K 0522	K522 It is the practice of this facility to assure that all HVAC requirements are met per regulations. *The corrective action taken for those residents found to be affected by the deficient practice*	09/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 at 12:35 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was covered with a blanket. This condition does not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Director acknowledged the condition and removed the blanket. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		*include:* No residents were affected by this deficient practice due to this room not being accessible to residents. *Other residents that have the potential to be affected have been identified by:* No residents were affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* The blanket was removed from the fresh air intake in the laundry room and laundry staff were in-serviced on never covered these fuel-fired dryers intakes. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Maintenance Director or designee is responsible for safe operations of the laundry. A weekly audit of laundry systems that include review of the fresh air intakes will be performed for six months. The results of those audits will be presented to the Quality Assurance Process Improvement Committee at the monthly meeting. Any deficiencies will be corrected immediately. *The date the systemic change will be completed: 9/30/2022*	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens			

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	155566	A. BUILDING 01 B. WING	09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

(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
	Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 6 residents in 3 rooms. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:55 a.m. and 1:00 p.m., resident rooms 40, 47, and 67 were using extension cords or multi-plug adaptors as fixed wiring to power	K 0920	K 920 It is the practice of this facility that extension cords not be used on anything other than patient care related electrical equipment. *The corrective action taken for those residents found to be affected by the deficient practice include:* Residents with extension cords in their rooms could be affected by this deficient practice. *Other residents that have the potential to be affected have been identified by:*	09/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 01 B. WING	09/12/2022

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	electronics. Based on interview at the time of observation, the Maintenance Director acknowledged extension cords were in use in rooms 40, 47, and 67. 2. Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 09/12/22 between 11:55 a.m. and 1:00 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in Liberty Hall nurses supply room and a refrigerator and a microwave (high power draw equipment) were plugged into and supplied power by a power strip in resident room 47. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		All residents have the potential to install extension cords in their room if not monitored. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Extension cords were removed from room 40, 47, and 67. Power strips were removed from the Liberty Hall supply room and room 47. An audit of all rooms was completed immediately with no other findings of extension cords or power strips being found. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Maintenance Director or designee is responsible for ensuring extension cords are not used for anything but patient care related electrical equipment and that power strips not be used instead of hard wired in the wall sockets. A weekly audit of all resident rooms and nurses stations, common areas, and work areas that includes checking for power strips and extension cords will be performed for six months. The results of those audits will be presented to the Quality Assurance Process Improvement Committee at the monthly meeting. Any deficiencies will be corrected immediately. *The date the systemic change will be completed: 9/13/2022*	

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