STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155825	A. BUILDING -- B. WING	08/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 08/01/23 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Emergency Preparedness survey, St. Augustine Home for the Aged was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 42 certified beds. At the time of the survey, the census was 23. Quality Review completed on 08/03/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 08/01/23 Facility Number: 000389 Provider Number: 155825 AIM Number: 100288920 At this Life Safety Code survey, St. Augustine	K 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven M. Still, MPA	Administrator	08/15/2023

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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	Home for the Aged was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility, located on the 2nd and 3rd floor of a three-story building, was determined to be of Type II (222) construction and was fully sprinklered except for 1 of 4 walk-in coolers in the kitchen and the upper enclosed patio area. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident rooms. The facility has a capacity of 42 and had a census of 23 at the time of this visit. Quality Review completed on 08/03/23		be considered the facility's allegation of compliance. Compliance is effective August 15, 2023. We respectfully request a desk review of our Plan of Correction.	
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 _____ c) Water system supply source _____ Provide in REMARKS information on			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems. 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. Findings include: Based on records review of the quarterly sprinkler reports and interview with the Maintenance Director on 08/01/23 between 9:40 a.m. and 12:50 p.m., the quarterly sprinkler report dated 04/20/23 stated "Anti-freeze tested above requirements." The report stated the solution tested to 19 degrees. Based on interview at the time of record review, the Maintenance Director said the anti-freeze has not yet been replaced and that the facility was seeking to have to issue corrected by the vendor. This finding was acknowledged by the Maintenance Director at the time of discovery and	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be directly affected by this practice. **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 could be affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** It should be noted, at no time was the sprinkler system operation compromised. It would have operated as designed, if called upon. The facility had contacted the sprinkler maintenance contractor to schedule the replacement of the anti-freeze solution. As of the date of the survey, the contractor had not scheduled the maintenance, claiming supply chain issues with the anti-freeze. (The solution is more complex than used in automobiles and less widely available.) The facility has	08/15/2023

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	again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		since scheduled the contractor to perform the maintenance on August 14 & 15, 2023. (See Exhibit K353 – A, proposal for system service & Exhibit 353 – B, work order noting completion.) **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.** The contractor conducts quarterly inspections of the sprinkler system and fire detection system per State, Federal and NFPA guidelines. The contractor will notify the facility when the anti-freeze tests above specifications and both entities will schedule the proper maintenance timely. The life of the anti-freeze solution is approximately five (5) years. **By what date the systemic changes for each deficiency will be complete.** August 15, 2023	
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			

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	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 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 over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include:	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The survey noted the potential of	08/01/2023

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	Based on observations and interview during a facility tour with the Maintenance Director on 08/01/23 between 12:50 p.m. and 2:30 p.m., the corridor door to the storage room, located across from room # 207, had a 3/8-inch hole near the handle hardware which penetrated completely through the door. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		two residents being affected by the practice. The Maintenance Director repaired the identified opening in the door on the day of the survey by filling the opening with fire caulk. (See Exhibit K363 – A, photo of repair.) **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.** As noted in the survey, thirty (30) corridor doors were inspected with no others displaying openings contrary to regulations. No other residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance staff will inspect doors during the routine performance of their duties. Any doors identified with openings contrary to regulation will be identified and repaired immediately. Instances as noted will be shared with the QAPI Committee to identify any patterns or occurrence. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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			assurance program will be put into place. The maintenance staff will inspect doors during the routine performance of their duties. Any doors identified with openings contrary to regulation will be identified and repaired immediately. Instances as noted will be shared with the QAPI Committee to identify any patterns or occurrence. **By what date the systemic changes for each deficiency will be complete.** August 1, 2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K 0712	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified to have been directly affected by this	08/15/2023

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	Based on records review and interview with the Maintenance Director and Administrator on 08/01/23 between 9:40 a.m. and 12:50 p.m., 8 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		practice. **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 could be affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director has scheduled fire drills for the next twelve (12) months based on a protocol that ensures the drills are random in timing of day, shift and date. (See Exhibit K712-A Fire Drill Schedule.) **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.** The fire drill schedule will be submitted to the Administrator for review and approval annually to ensure a random scheduling of fire drills commensurate with regulations. **By what date the systemic changes for each deficiency will be complete.** August 15, 2023	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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 Based on observation and interview, the facility failed to ensure 1 of 1 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 3 residents. Findings include:	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be directly affected by this practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/11/2023

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	Based on observations and interview during a facility tour with the Maintenance Director on 08/01/23 between 12:50 p.m. and 2:30 p.m., in room 229 a power strip was being used to power a window air conditioning unit (high power draw equipment). This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**action(s) will be taken.** All residents have the potential to be affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The power strip was removed and the small 110v window air conditioner was plugged directly into a wall outlet on the day of the survey. (See Exhibit K920 – A, Photo of Power Strip removed.) The window air conditioner had been installed to provide temporary cooling until the PTAC unit in the wall could be obtained and replaced. The PTAC unit was replaced on August 14, 2023 and the window unit removed from the room. (See Exhibit K920 – B, New PTAC.) **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 will educate staff on the proper use of power strips in an all-staff in-service on August 11, 2023. (See Exhibit K920 – C, in-service syllabus.) Future findings of power strip usage will be brought to the QAPI Committee for review and trend analysis.	

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			By what date the systemic changes for each deficiency will be complete. August 11, 2023	