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	09/11/2023

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: 09/11/23 Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920 At this Emergency Preparedness survey, Warsaw 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 a capacity of 80 and had a census of 54 at the time of this survey. The requirements of 42 CFR, Subpart 483.73 is Not Met as evidenced by: Quality Review completed on 09/13/23	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 28, 2023. We respectfully request paper compliance for this survey resolution.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Jackson, HFA	Administrator	09/27/2023

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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	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of			

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	assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location	E 0018	It is the practice of this facility to have procedures for tracking of staff and patients. All residents and staff who are on duty have the potential to be affected by the deficient practice. The corrective action taken for those staff found to be affected by the deficient practice include:	09/28/2023

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	in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director (MD) on 09/11/23 at 11:30 a.m., a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency was provided, but the policy did not provide a system to track the location for on-duty staff. Based on interview at the time of record review then again at the exit conference, the MD confirmed a policy and procedure for tracking residents did not include staff.		The facility Evacuation Policy was re-written to include tracking of STAFF as well as RESIDENTS evacuated to alternate locations. (See Revised 2023 Evacuation Plan) The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with the IDT team regarding the revision made to the Evacuation Policy. The revised Evacuation Policy was placed in all Emergency Preparedness Plan binders throughout the facility. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews the Emergency Preparedness Plan binders to ensure the revised policy is still in place. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 27, 2023.	

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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: 09/11/2023 Facility Number: 000359 Provider Number: 155566 AIM Number: 100274920 At this Life Safety Code survey, Warsaw 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, areas open to the corridors and battery powered smoke detection in the resident sleeping rooms. The facility has a capacity of 80 and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/13/23	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 September 28, 2023. We respectfully request paper compliance for this survey resolution.	
K 0211 SS=D	NFPA 101 Means of Egress - General			

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Bldg. 01	Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means 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 2 exit doors from the scale room only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect one staff and one resident using the scale room. Findings include: Based on observation with the Maintenance Director (MD) on 09/11/23 at 1:35 p.m., one of the exit doors to the scale room was equipped with two latching devices, a latching door turn knob and a separate hasp latch. Based on interview at the time of observation, the MD agreed the scale room exit door was equipped with two latching devices. This finding was reviewed with the Maintenance Director and Administrator during the exit conference.	K 0211	It is the practice of this facility to have all aisles, passageways, corridors, exit discharges, exit locations and accesses continuously maintained and free of obstructions to full use in case of an emergency. Any resident currently occupying the Scale Room during the event of an emergency have the potential to be affected by the deficient practice. The corrective action taken for those residents found to be affected by the deficient practice include: The locking hasp latch on the Scale Room door was removed. The Scale Room door now has one latching device, a latching door turn knob. (See Hasp on Door Frame Removed Photo) The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with the Environmental Services team regarding the regulation referencing Means of Egress. A Whole-house audit was completed by the Maintenance Department to	09/28/2023

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	3.1-19(b)		ensure there were no other door frames had more than 1 latching mechanism; none were found. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly inspects door frames for 1 latching mechanism. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 27, 2023.	
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			

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	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 storage room with a large amount of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) on 09/11/23 at 1:30 p.m., the interim medical record storage room contained over 30 boxes of medical record and 3 large trash containers and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the MD agreed the storage room contained a large amount of combustible storage, was larger than 50 square	K 0321	It is the practice of this facility to have Hazardous Areas enclosed by doors that shall be self-closing or automatic-closing. Any resident residing on the hall where the interim Medical Records storage room is located (Liberty Hall) have the potential to be affected by the deficient practice. The corrective action taken for those residents found to be affected by the deficient practice include: The door enclosing the interim Medical Records storage room has been equipped with a self-closing, self-locking device. The door was tested and self-closes and self-locks, completely latching the door. (See Door with self-closing device	09/28/2023

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	feet, and the corridor door to the room did not self-close and latch when tested. The finding was reviewed with the Administrator and the MD during the exit conference. 3.1-19(b)		photo) The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with the Maintenance team regarding the regulation referencing Hazardous Areas-Enclosure. A Whole-house audit was completed by the Maintenance Department to ensure there were no other hazardous areas that did not meet the regulatory requirements; none were found. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly inspects Hazardous Area enclosures throughout the facility. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 27, 2023.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens			

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	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 Liberty Hallway by resident room 36, flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 10 residents in the Liberty Hallway. Findings include: Based on observation with the Maintenance	K 0920	It is the practice of this facility to not have extension cords used a substitute for fixed wiring of a structure. Any resident residing on the Liberty Hall has the potential to be affected by the deficient practice. The corrective action taken for those residents found to be affected by the deficient practice include: The light fixture (lamp) that had a two-wire receptacle built into it was replaced with a new light fixture without an integrated	09/28/2023

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	Director (MD) on 09/11/23 at 1:55 p.m. it was discovered that a lamp on the wall in the Liberty Hallway corridor by resident room 36 had a two wire receptacle built into it which is considered to be an extension cord. Based on interview at the time of observation, the MD acknowledged the aforementioned condition. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		receptable. (See New light fixture without integrated receptacle photo) The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with the Maintenance Department regarding the regulation referencing Electrical Equipment-Power Cords and Extension Cords. A Whole house audit of any light fixtures in the facility was completed by the Maintenance Department to ensure there were no other light fixtures containing two-wire receptacles; none were found. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly inspects all wall lamps throughout the facility for two-wire receptacles. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 27, 2023.	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director (MD) on 09/11/23 at 2:10 p.m. in the oxygen storage room there was no means to separate full cylinders from empty cylinders with empty cylinders intermingled with full cylinders. Based on interview at the time of observation, the MD agreed that the empty cylinders were mixed with full cylinders. This finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)	K 0923	It is the practice of this facility to not have empty Oxygen cylinders mixed with full cylinders. Any resident residing on the Freedom Hall near the Oxygen Storage Room has the potential to be affected by the deficient practice. The corrective action taken for those residents found to be affected by the deficient practice include: There was signage placed in the Oxygen Storage room designating Empty/Full tank location. (See OXYGEN ROOM SIGNAGE photo) The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with the Maintenance Department as well as the Nurse Management team regarding the regulation referencing Gas Cylinders and Container Storage. An audit was completed by the Maintenance Department to ensure the signage designating the EMPTY/FULL cylinder storage area is present, and the cylinders were located in the correct location regarding their EMPTY/FULL status; none were found to be in the incorrect location. The corrective action taken to	09/28/2023

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	09/11/2023

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

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			monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly inspects the correct segregation of the Oxygen cylinders. The Maintenance Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 27, 2023.	