						PRIN	TED:	01/06/2023
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FORM APPROVED		
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 09	938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPL	ETED	
		155352	B. WI	NG		11/15/	2022	
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS				2600 M	ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE RT, IN 46517	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	·	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMP	LETION
TAC	DECLILATORY OF	I SC IDENTIFYING INFORMATION	I	TAC	DEFICIENCY)		D.	TE

TO LIVIL OF T	RO VIDER OR SOLLEER	2600 N	2600 MOREHOUSE AVE			
ELKHAR'	T MEADOWS	ELKHART, IN 46517				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
E 0000						
Bldg						
	An Emergency Preparedness Survey was	E 0000	The facility requests that this plan			
	conducted by the Indiana Department of Health in		of correction be considered its			
	accordance with 42 CFR 483.73.		credible allegation of compliance.			
			Preparation and/or execution of			
	Survey Date: 11/15/22		this plan of correction does not			
			constitute admission or agreement			
	Facility Number: 000243		by the provider of the truth of the			
	Provider Number: 155352		facts alleged or conclusions set			
	AIM Number: 100289830		forth in the statement of			
			deficiencies. The plan of correction			
	At this Emergency Preparedness survey, Elkhart		is prepared and/or executed solely			
	Meadows was found not in compliance with		because it is required by the			
	Emergency Preparedness Requirements for		provisions of federal and state law.			
	Medicare and Medicaid Participating Providers		We respectfully request a desk			
	and Suppliers, 42 CFR 483.475		review for compliance instead of a			
			post visit review on or before			
	The facility has 58 certified beds. All beds are		12/11/22.			
	certified for Medicare and Medicaid. At the time					
	of the survey, the census was 52.					
ļ	Quality Review completed on 11/22/22					
E 0039	403.748(d)(2), 416.54(d)(2), 418.113(d)(2),					
SS=F	441.184(d)(2), 482.15(d)(2), 483.475(d)(2),					
Bldg	483.73(d)(2), 484.102(d)(2), 485.625(d)(2),					
]a.g.	485.68(d)(2), 485.727(d)(2), 485.920(d)(2),					
	486.360(d)(2), 491.12(d)(2), 494.62(d)(2)					
	EP Testing Requirements					
	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2),					
ļ	§460.84(d)(2), §482.15(d)(2), §483.73(d)(2),					
	§483.475(d)(2), §484.102(d)(2), §485.68(d)(2),					
	§485.625(d)(2), §485.727(d)(2), §485.920(d)					
	(2), §491.12(d)(2), §494.62(d)(2).					
	*[For ASCs at §416.54, CORFs at §485.68,					
	OPO, "Organizations" under §485.727,					
	CMHCs at §485.920, RHCs/FQHCs at					

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

TITLE (X6) DATE

Evan Wiedeman **Executive Director** 12/19/2022

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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	AN OF CORRECTION	IDENTIFICATION NUMBER 155352	JILDING	NSTRUCTION	COMPL 11/15/	ETED
NAME (F PROVIDER OR SUPPLIE	₹		DDRESS, CITY, STATE, ZIP COD		
ELKH	ART MEADOWS			RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(2) Testing. The [if exercises to test thannually. The [fact following: (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exempt from endity-based functional exercises actual event. (ii) Conduct an additional every 2 years, oper functional exercises actual event. (ii) Conduct an additional exercise (ii) of this section in include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (B) a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an exercises, and endits and community than the community of the commun	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed				

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352		UILDING	NSTRUCTION	(X3) DATE COMPI 11/15	LETED
	PROVIDER OR SUPPLIER T MEADOWS		STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emerged of the emergency exempt from engascale community-facility-based functional exercise of this section is of include, but is not (A) A second full-community-based functional exercise (B) A mock disase (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem stamessages, or present to challenge an engage (3) Testing for hose	spices that provide care in e. The hospice must so to test the emergency sally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not let an individual facility exercise every 2 years; or experiences a natural or lency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Inditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is lor a facility based le; or leter drill; emergency scenario, and a letements, directed lepared questions designed					
	exercises to test t per year. The hos	he emergency plan twice spice must do the following: an annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155352	B. W	ING		11/15/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R			OREHOUSE AVE		
ELKHAR	T MEADOWS				RT, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that is community						
	l ` '	nunity-based exercise is not					
		ıct an annual individual					
		ctional exercise; or					
		experiences a natural or					
	_	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	l ` ′	dditional annual exercise					
	1	but is not limited to the					
	following:						
		scale exercise that is					
	1	or a facility based					
	functional exercis						
	(B) A mock disas						
	1 ' '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	-					
	1 -	rio, and a set of problem					
		ted messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.						
	1 ' '	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	*IFor PRFTs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAHs						
	\ '.	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	iainty bacca choroide is not	1				1

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 5/2022
	PROVIDER OR SUPPLIEF	2	2600 M	ADDRESS, CITY, STATE, ZIP CO OREHOUSE AVE RT, IN 46517	·D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
	facility-based fund (B) If the [PRTF, I an actual natural of that requires active plan, the [facility] its next required from individual, facility following the onset (ii) Conduct at exercise or and the limited to the following the onset (iii) Conduct at exercise or and the limited to the following the onset (B) A monoidal (B) A monoidal (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem state messages, or prefet to challenge an erect (iii) Analyze the challenge and maintain docutableton exercises and revise the [fact needed. *[For PACE at §44 (2) Testing. The Form in the conduct exercises plan at least annuorganization must (i) Participate in a that is community (A) When a communication accessible, conduct facility-based fundaments.	rescale exercise that is or individual, a stional exercise; or lock disaster drill; or or exercise or workshop that for and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. The [facility's] response to sumentation of all drills, and emergency events cility's] emergency plan, as \$60.84(d):] PACE organization must a to test the emergency ally. The PACE and annual full-scale exercise				

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	OF CORRECTION	IDENTIFICATION NUMBER 155352	 UILDING	NSTRUCTION	COMPI 11/15	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE		
ELKHAR	T MEADOWS			RT, IN 46517		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ergency that requires	ind			DATE
		mergency plan, the PACE				
		gaging in its next required				
	full-scale commur	nity based or individual,				
	facility-based fund	ctional exercise following the				
	onset of the emer	gency event.				
	1 '	ın additional exercise every				
		the year the full-scale or				
		e under paragraph (d)(2)(i)				
		conducted that may include,				
	but is not limited t	_				
	1 ' '	scale exercise that is				
	based functional	or individual, a facility				
	(B) A mock disas					
	` '	ercise or workshop that is				
		and includes a group				
	discussion, using	- -				
	_	emergency scenario, and a				
	set of problem sta					
	messages, or pre	pared questions designed				
	to challenge an er	mergency plan.				
	(iii) Analyze the F	PACE's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	the PACE's emero	gency plan, as needed.				
	*[For LTC Facilitie	es at §483.73(d):]				
	(2) The [LTC facili	ity] must conduct exercises				
	to test the emerge	ency plan at least twice per				
	, ,	announced staff drills using				
		ocedures. The [LTC facility,				
	ICF/IID] must do t	_				
		an annual full-scale exercise				
	that is community					
	' '	nunity-based exercise is not				
		ict an annual individual,				
	facility-based fund	cilonal exercise. cility] facility experiences an				
		nan-made emergency that				
		nan made emergency that				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING			COMPLETED	
		155352	B. W.	ING	_	11/15	/2022	
MANGOR	DROWNER OF CLUBY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	C		2600 M	OREHOUSE AVE			
ELKHAR	T MEADOWS			ELKHAI	RT, IN 46517			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY (DATE	
		n of the emergency plan, the mpt from engaging its next						
	I	ile community-based or						
		based functional exercise						
	_	et of the emergency event.						
	_	dditional annual exercise						
		but is not limited to the						
	following:	bat is not innited to the						
	_	scale exercise that is						
	' '	or an individual, facility						
	based functional							
	(B) A mock disas							
	` '	ercise or workshop that is						
	led by a facilitator							
	discussion, using	• .						
		emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er	· · · · · · · · · · · · · · · · · · ·						
	_	LTC facility] facility's						
		naintain documentation of						
		exercises, and emergency						
	events, and revise	e the [LTC facility] facility's						
	emergency plan, a	as needed.						
	*[For ICF/IIDs at §	§483.475(d)]:						
	(2) Testing. The IC	CF/IID must conduct						
	exercises to test t	he emergency plan at least						
	twice per year. Th	e ICF/IID must do the						
	following:							
	(i) Participate in a	n annual full-scale exercise						
	that is community	-based; or						
	(A) When a comm	nunity-based exercise is not						
		ıct an annual individual,						
	facility-based fund	ctional exercise; or.						
	(B) If the ICF/IID 6	experiences an actual						
		ade emergency that requires						
		mergency plan, the ICF/IID						
		gaging in its next required						
		nity-based or individual						

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	MENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155352	ľ	UILDING	nstruction 	COMPI 11/15	LETED	
	OF PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	facility-based fundonset of the emer (ii) Conduct an ad that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the IC maintain documel exercises, and enthe ICF/IID's eme *[For HHAs at §44 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a district individual, facility-every 2 years; or. (B) If the HH natural or man-materization of the exempt from engate full-scale community-based fundonset of the emerical	ctional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop in ergency events, and revise regency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is i; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual adde emergency plan, the HHA is aging in its next required inty-based or individual, ctional exercise following the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155352	B. W	ING		11/15	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			OREHOUSE AVE		
ELKHAR	T MEADOWS				RT, IN 46517		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
	-	ctional exercise; or					
	, ,	isaster drill; or					
	, ,	o exercise or workshop that					
	· ·	or and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
		pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	une in in to emerge	bridy plant, as needed.					
	*[For OPOs at §48	86.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test the	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	· ·	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
		cy scenario, and a set of					
		its, directed messages, or					
		ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
		of the emergency plan, the					
	•	om engaging in its next					
		xercise following the onset					
	of the emergency						
		PO's response to and					
		ntation of all tabletop					
	exercises, and em	nergency events, and revise					

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
STAT	EMENT OF DEFICIENCIES PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/15/2022		
	E OF PROVIDER OR SUPPLIE	R	2600	ET ADDRESS, CITY, STATE, ZIP COD D MOREHOUSE AVE HART, IN 46517			
(X4) I PREFI	X (EACH DEFICIENTS) REGULATORY O	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	reeded. *[RNCHIs at §40 (d)(2) Testing. The exercises to test RNHCI must do to (i) Conduct a papata least annually. group discussion narrated, clinically scenario, and a societed message designed to challe (ii) Analyze the Romaintain docume exercises, and error the RNHCI's emergased on record regalied to conduct explan at least twice unannounced staff procedures. The Language (i) Participate in arror is community-based a. When a community-based function is the emergency promise of the emergency promise of the emergency promise of the conset of the activation in the onset of the activation in the onset of the activation in the same and the same activation in	the emergency plan. The he following: er-based, tabletop exercise is a led by a facilitator, using a y-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCl's response to and intation of all tabletop intergency events, and revise ingency plan, as needed. View and interview, the facility is erecises to test the emergency every ear, including drills using the emergency for facility must do the in annual full-scale exercise that it is an annual individual, it is exempt the exercise for 1 year following individual, facility-based in exercise for 1 year following	E 0039	E039 What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice; An after action report was completed from a severe wir weather scenario that had occurred. How other residents having the potential to be affected the same deficient practice be identified and what corrective action(s) will be taken; All residents have the potential to the potential to the same deficient practice be identified and what corrective action(s) will be taken;	en nter g by will		

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include, but is not limited to the following:

community-based or an individual, facility-based

a. A second full-scale exercise that is

Event ID:

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be affected by the deficient

practice. An after action report

was completed for the emergency

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		155352	B. WING		11/15/2022
	PROVIDER OR SUPPLIER		2600	ET ADDRESS, CITY, STATE, ZIP COD O MOREHOUSE AVE HART, IN 46517	-
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPED DEFICIENCY) Scenario. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur; ED educated on running two emergency preparedness draw the calendar year. How the corrective action(will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and by what dat the systemic changes for edeficiency will be complete	COMPLETION DATE Completion Date conic con
K 0000	additional exercise facility had a docum dated 9/21/22, but a available at the time interview, the Adminot participate an adlast 12 months.	p.m., no documentation of an was available for review. The mented COVID outbreak report a second exercise was not e of the survey. Based on inistrator stated the facility did diditional exercise within the assed with the Administrator irector at exit conference.		ED and maintenance director review exercises and documentation and report reto QAPI team with an action in place if compliance is not Deficiencies corrected by 12	sults plan met.
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 0000	The facility requests that this of correction be considered credible allegation of complication and/or execution this plan of correction does reconstitute admission or agree	ance. n of not

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	
		155352	B. W	'ING		11/15/	/2022
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
		· ·			OREHOUSE AVE		
ELKHAR	T MEADOWS			ELKHAI	RT, IN 46517		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Facility Number: 0	00242			by the provider of the truth of the		
	Provider Number:				facts alleged or conclusions so forth in the statement of	eι	
	AIM Number: 100289830				deficiencies. The plan of corre	oction	
	7 Mivi Tvuilloci. 1002	207030			is prepared and/or executed s		
	At this Life Safety Code survey, Elkhart Meadows				because it is required by the	OlCly	
	1	impliance with Requirements			provisions of federal and state	law	
		Medicare/Medicaid, 42 CFR			We respectfully request a des		
		Life Safety from Fire and the			review for compliance instead		
		National Fire Protection			post visit review on or before	J. G	
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				12/11/22.		
	This one story facili	ity was determined to be of					
	Type III (200) cons	truction and was fully					
	sprinklered. The fa	cility has a fire alarm system					
		oke detectors in the corridors,					
		corridors, and resident					
		battery-powered smoke					
		ity has a capacity of 58 and					
	had a census of 52 a	at the time of this survey.					
	All areas where the	residents have customary					
		ered and all areas providing					
		re sprinklered, except, one					
	detached shed used						
		mpleted on 11/22/22					
K 0321	NFPA 101						
SS=D	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas						
5.4g. 01		are protected by a fire					
		our fire resistance rating					
		rated doors) or an					
	l '	nguishing system in					
		3.7.1 or 19.3.5.9. When the					
	_	tic fire extinguishing system					
		e areas shall be separated					
		by smoke resisting					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/15/2022	
	PROVIDER OR SUPPLIEF	·	2600 N	ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE ART, IN 46517	
ELKHAR (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF partitions and doo Doors shall be sel automatic-closing nonrated or field-add not exceed 48 the door. Describe the floor	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ITS in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	b. Laundries (larg c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collectio (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32 Based on observation failed to ensure 2 or corridor doors in the obstructed from clocould affect staff in Findings include: Based on observation with the Administration 11/15/22 between Laundry Room and	-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64 In Rooms lons) orage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility of 5 Hazardous storage room e service hall were not sing. This deficient practice	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Laundry room and linen storage room doors were closed and tifrom doors removed. How other residents having the potential to be affected by the same deficient practice were identified and what	ge des

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making this a hazardous area. The doors to the

laundry room and linen room were self-closing but

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taken;

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All residents have the potential to

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/15/2022
	PROVIDER OR SUPPLIEF	2	2600 N	ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE ART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	the doors were tied by the handle to prevent closing. Based on interview at the time of observation, the Maintenance Director confirmed doors were tied open and contained large amounts of combustible storage and were larger than 50 square feet.			be affected by the deficient practice. Laundry room and storage room doors were clo and ties from doors removed	sed
	This finding was re	viewed with the Administrator irector during the exit		What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur; MD/HSK supervisor educate ensuring laundry and linen redoors remain closed.	d on com
				How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and by what date the systemic changes for each deficiency will be complete. Maintenance director will mo to ensure compliance is met will report results to QAPI tea with an action plan in place if compliance is not met.	put e ach d; nitor and am
K 0331 SS=F Bldg. 01	exposed interior s as fixed or movab columns, and hav	•		Deficiencies corrected by 12/	/11/22

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1 1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETE B. WING 11/15/202			
		155352	B. W	ING		11/15/	2022
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
ELKHAR	T MEADOWS			ELKHART, IN 46517			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Sprinkler system as		TAG	DETERMENT		DATE
	prescribed in 10.2						
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 for resident rooms,		K 0	331	What corrective action(s) will	ll .	04/15/2023
					be accomplished for those	_	
		ance way on 1 floor met the			residents found to have been affected by the deficient	11	
		of Class A or Class B in			practice;		
		.3.3.1. LSC 101 10.2.3.4 states			Facility requesting a temporar	y life	
	products required to be tested in accordance with				safety waiver request to ensur	•	
	ASTM E 84, Standard Test Method for Surface				that paneling on ceilings has		
		stics of Building Materials or			documentation for flame sprea	ad	
		adard for Test for Surface			rating.		
	_	stics of Building Materials shall					
		ollowing classes in accordance			How other residents having		
	_	ead and smoke development. Wall and Ceiling Finish. Flame			the potential to be affected by the same deficient practice with the same deficient practice with the same deficient practice.	-	
	1 1	development 0-450. Includes			be identified and what	VIII	
	_	ied at 25 or less on the flame			corrective action(s) will be		
	1 -	d 450 or less on the smoke test			taken;		
	scale. Any element	thereof, when so tested, shall			All residents have the potentia	al to	
	not continue to prop	•			be affected by the deficient		
		Wall and Ceiling Finish. Flame			practice. MD and ED toured		
	_	e development 0-450. Includes			entire facility to identify all are		
	1	ied at more than 25 but not			that have paneling in the facili	-	
	more than /5 on the 450 or less on the si	e flame spread test scale and			that does not have flame spre	au	
		ice could affect all residents			rating.		
	and staff				What measures will be put		
					into place and what systemic	С	
	Findings include:				changes will be made to		
					ensure that the deficient		
		on with the Administrator and			practice does not recur;		
		for on 11/15/22 between 2:06			MD/ED will review any panelir	_	
	_	wood paneling was used as an			that is installed in the facility to		
		e main entrance way, all staff office ceilings. Based on			ensure the proper flame sprea	aa	
		veen 10:14 a.m. and 2:00 p.m			rating.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155352		, ,	ILDING	nstruction 01	(X3) DATE S COMPL 11/15/	ETED		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	the paneling was aver interview at the time. Administrator stated documentation for the located and the main documentation for which the finding was re-	he paneling could not be n office was looking for			How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place; and by what date the systemic changes for each deficiency will be completed Maintenance director will monito ensure compliance is met a will report results to QAPI tear with an action plan in place if compliance is not met.	ut ch ; itor nd		
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8.	supply source RKS information on non-required or partial r system. and NFPA 25						
	facility failed to ma in accordance with automatic sprinkler	review and interview, the intain 1 of 2 sprinkler systems LSC 9.7.5. LSC 9.7.5 requires all systems shall be inspected ecordance with NFPA 25,	K 03	353	What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice;		12/11/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155352	B. WI	ING		11/15/	2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IOREHOUSE AVE		
ELKHAD	T MEADOWS				RT, IN 46517		
ELMIAN	T MEADOWS			ELKITA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		spection, Testing, and			MD/designee to check gauges	s on	
		nter-Based Fire Protection			wet pipe sprinkler systems		
		5, 2011 edition, Table 5.1.1.2			monthly. Two inch penetration	n	
	indicates the required frequency of inspection and				sealed in laundry room.		
	testing. NFPA 25, 5.2.4.1 states gauges on wet						
	pipe sprinkler systems shall be inspected monthly				How other residents having		
	and gauges on dry systems (5.2.4.2) shall be				the potential to be affected b	у	
	inspected weekly to ensure normal water or air				the same deficient practice v	vill	
	-	aintained. NFPA 25 13.3.2.1			be identified and what		
	states valves should be inspected weekly or				corrective action(s) will be		
	valves secured locks or supervised (13.3.2.1.1)				taken;		
	shall be permitted to be inspected monthly. This				All residents have the potentia	al to	
	deficient practice could affect all occupants.				be affected by the deficient		
					practice. MD/designee to che	ck	
	Findings include:				gauges on wet pipe sprinkler		
					systems monthly. Two inch		
	Based on records re	eview with the Maintenance			penetration sealed in laundry		
		22 between 10:14 a.m. and 2:00			room.		
	_	monthly inspection of the wet					
		m's gauges for the past 12					
	_	interview at the time of record			What measures will be put		
	· ·	nance Director stated the			into place and what systemic	c	
	_	y valve and gauge inspections			changes will be made to		
		but had no documentation for			ensure that the deficient		
	the wet system gau	ges at the time of the survey.			practice does not recur;		
					MD educated on importance of		
	-	ussed with the Maintenance			wet sprinkler gauge checks, a	nd	
	Director and Admir	nistrator at exit conference.			ensuring any penetrations are		
					identified and sealed immedia	tely.	
	3.1-19(b)						
					How the corrective action(s)		
		ation and interview, the facility			will be monitored to ensure t	the	
		he ceiling construction in 1 of 4			deficient practice will not		
		its. The ceiling traps hot air and			recur, i.e., what quality		
	-	orinkler and cause the sprinkler			assurance program will be p		
	to operate at a specified temperature. NFPA 13,				into place; and by what date		
		1.1 states the distance between			the systemic changes for ea		
	•	tor and the ceiling above shall			deficiency will be completed		
		n the type of sprinkler and the			Maintenance director will com		
	type of construction	This deficient practice			daily rounds to ensure complia	ance I	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	ľ í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/15/2022	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE		
ELKHAR	T MEADOWS			ELKHA	ART, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE	
	could affect all staf Findings include:	f in one smoke compartment.			is met and will report results to QAPI team with an action plan place if compliance is not met	n in	
	Based on observation with the Maintenance Director and the Administrator on 11/15/22 at 12:41 p.m., in the laundry room near the service hallway, there was a two inch unsealed gaps around a pipe that ran through the ceiling. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed gaps in the ceiling and would fill it in as soon as possible. Findings were discussed with the Administrator and Maintenance Director at exit conference.				Deficiencies corrected by 12/	11/22	
K 0355 SS=E Bldg. 01	installed, inspected accordance with North Portable Fire Extinguishers, states portable fire wheeled extinguish	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers.	K 0	355	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; MD removed fire extinguisher ED office and was properly disposed of and fire extinguish.	n from	12/11/2022

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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 was

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on north hallway monthly

inspection tag was found and

placed on fire extinguisher.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′			(X3) DATE SURVE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155352	B. W	ING		11/15/2022	
NAME OF T	DROMDED OF CHIPPLIES		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	(2600 M	IOREHOUSE AVE		
ELKHAR	T MEADOWS			ELKHA	RT, IN 46517	<u>, </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	LETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	D _i	ATE
		re area but could affect staff in			How other residents having		
	the maintenance sho	op.			the potential to be affected by	-	
	F: 1: : 1 1				the same deficient practice v	vill	
	Findings include:				be identified and what		
	Based on observation	ons during a tour of the facility			corrective action(s) will be taken;		
		ce Director and Administrator			All residents have the potential	_{ll to}	
		3 p.m., an ABC portable fire			be affected by the deficient		
		Administrators Office was			practice. MD removed fire		
	_	netal cabinet unsecured. Based			extinguisher from ED office ar	_d	
		time of observation, the			was properly disposed of, and		
		tor agreed the extinguisher was			extinguisher on north hallway		
sitting on the cabinet and stated it is a spare				monthly inspection tag was fo	und		
	extinguisher used for training.				and placed on fire extinguishe		
	Findings were discu	ussed with the Administrator					
	and Maintenance D	irector at exit conference.					
					What measures will be put		
	3.1-19(b)				into place and what systemic	;	
					changes will be made to		
		ation and interview, the facility			ensure that the deficient		
	_	of 17 portable fire extinguishers			practice does not recur;		
		10, Standard for Portable Fire			MD educated on importance		
	-	ion 7.2.1.2 states fire			ensuring all fire extinguishers		
	-	be inspected either manually or			properly secured and importa		
	_	etronic device / system at a rintervals. Section 7.2.2 states			of ensuring monthly inspection	is	
	-	or electronic monitoring of fire			are occurring for all fire extinguishers in the building.		
		include a check of at least the			extriguistiers in the building.		
	following items:	merude a cheek of at least the			How the corrective action(s	.	
	(1) Location in desi	onated place			will be monitored to ensure		
	, ,	to access or visibility			deficient practice will not		
	` '	reading or indicator in the			recur, i.e., what quality		
	operable range or pe	_			assurance program will be p	_{ut}	
		ined by weighing or hefting for			into place; and by what date		
	self expelling-type				the systemic changes for ea	_{ch}	
		extinguishers, and pump tanks			deficiency will be completed		
		es, wheels, carriage, hose, and			Maintenance director will com		
	nozzle for wheeled				daily rounds to ensure compli		
		nrechargeable extinguishers			is met and will report results to		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155352		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/15/2022		
	PROVIDER OR SUPPLIEF			2600 M	ADDRESS, CITY, STATE, ZIP COD OREHOUSE AVE RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	inspections shall ke	es personnel making manual ep records of all fire		QAPI team with an action plan in place if compliance is not met.			
	require corrective a where at least mont conducted, the date performed and the inperforming the insp. Section 7.2.4.4 requare conducted, reconshall be kept on a transportation on file, Section 7.2.4.5 requirements that at inspections have be	cted, including those found to ction. Section 7.2.4.3 requires hly manual inspections are the manual inspection was nitials of the person ection shall be recorded. The manual inspections are gor label attached to the fire inspection checklist or by an electronic method. The manual inspection was not attached to the fire inspection checklist or by an electronic method. The manual inspection was not attached to the fire inspection checklist or by an electronic method. The manual inspection was not attached to the fire inspection checklist or by an electronic method. The manual inspections was not attached to the fire inspection checklist or by an electronic method. The staff and residents in North was not attached to the fire inspection was not attached to the fire inspection.			Deficiencies corrected by 12/1	1/22	
	with the Maintenan Administrator on 1 monthly inspection North Hallway was extinguisher and co interview at the tim Maintenance Direct located in the North inspection tag.	1/15/22 at 3:10 p.m., the tag on the ABC located in the					
K 0511 SS=D	NFPA 101 Utilities - Gas and	Electric					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPLETED 11/15/2022	
		155352	B. W	ING		11/15/	2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Utilities - Gas and	Electric					
		gas or related gas piping					
		PA 54, National Fuel Gas					
		iring and equipment					
	•	PA 70, National Electric					
	_	tallations can continue in					
	service provided n						
	18.5.1.1, 19.5.1.1,						
		on and interview, the facility	K 0	511	What corrective action(s) wil	ı	12/11/2022
		f 1 ground fault circuit			be accomplished for those		
		was properly maintained for			residents found to have been	n	
	2011 Edition at 210	lectric shock. NFPA 70, NEC			affected by the deficient		
		Protection for Personnel,			practice; MD had contractor come in to		
	-	circuit-interruption for					
	_	provided as required in 210.8.			replace/rewire the GFCI electric receptacle in the assisted dini		
		ice could affect 8 residents			receptacle in the assisted diffi	ng	
	Tinis deficient practi	ice could affect 6 residents			100111.		
	Findings include:				How other residents having		
	6				the potential to be affected b	v	
	Based on observation	on with the Administrator and			the same deficient practice v	-	
	the Maintenance Di	rector on 11/15/22 between			be identified and what		
	2:06 p.m. and 3:15 j	p.m., when the GFCI electric			corrective action(s) will be		
	receptacle in the As	sisted Dining Room was			taken;		
		tester, the GFCI receptacle			All residents have the potentia	al to	
	•	d not break the electrical			be affected by the deficient		
		terview at the time of			practice. MD had contractor		
	·	intenance Director agreed the			come in to replace/rewire the		
	-	tacle did not properly work			GFCI electric receptacle in the	9	
		uld contact the contracted			assisted dining room.		
	electricians to fix.				l		
	E' 1' '	1 24 4 4 1 1 1 1 1 1			What measures will be put		
	-	wed with the Administrator			into place and what systemic	C	
	and Maintenance Di	irector during the exit			changes will be made to		
	conterence.				ensure that the deficient		
	3.1-19(b)				practice does not recur; MD educated on importance of	of all	
	J.1-17(U)				GFCI electric receptacles in	л ан	
					proper working order and havi	ina a	
					contactor out to complete work	-	
l l	1		1		1 Southouse out to complete Worl	13 11	i

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ZAVK21 Facility ID: 000243

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/15/2022
	ROVIDER OR SUPPLIER		2600 M	ADDRESS, CITY, STATE, ZIP COD 1OREHOUSE AVE ART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION DATE
K 0741 SS=C Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartri liquids, combustib used or stored and location, and such signs that read NO posted with the instance smoking. (2) In health care smoking is prohibit prominently place secondary signs v smoking shall not	ns shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is do in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are do at all major entrances, with language that prohibits be required.		one is found not functionic. How the corrective active will be monitored to ensign deficient practice will not recur, i.e., what quality assurance program will into place; and by what the systemic changes for deficiency will be complimated director will weekly rounds to ensure compliance is met and with results to QAPI team with action plan in place if contist is not met. Deficiencies corrected by	be put date or each eted; complete Il report an appliance

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i ´		ì í			ì '	3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155352		B. WING			11/15/2022	
		100002	J		ADDRESS OF A STATE TIP COD	11/10/	2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
ELKHAR	T MEADOWS				RT, IN 46517			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		ent of 18.7.4(3) shall not	+	TAG	BLITCLENCTY		DATE	
	. , ,	patient is under direct						
	supervision.							
	1 ' '	oncombustible material and						
	_	be provided in all areas						
	where smoking is	s permitted. ers with self-closing cover						
	1 ' '	h ashtrays can be emptied						
		vailable to all areas where						
	smoking is permi	tted.						
	18.7.4, 19.7.4		1	5 41			10/11/2022	
		ion and interview; the facility of 1 smoking areas were	K	741	What corrective action(s) will be accomplished for those	I	12/11/2022	
		posing cigarette butts in a metal			residents found to have beer	1		
		container with self-closing			affected by the deficient	•		
	cover devices. This deficient practice could affect				practice;			
	all staff.				MD removed cigarette butts from			
					the smoking area and placed			
	Findings include:				sign outside the kitchen as a r smoking area.	10		
	Based on observat	ion during a tour of the facility						
		rator and Maintenance Director			How other residents having			
		en 2:06 p.m. and 3:15 p.m., in the			the potential to be affected b	-		
	_	nd the kitchen, there were over disposed on the ground in and			the same deficient practice v	vill		
		g area. Based on interview at			corrective action(s) will be			
		ations, the Maintenance			taken;			
	Director and Admi	inistrator agreed there were			All residents have the potentia	ıl to		
	cigarette butts on t				be affected by the deficient			
	aforementioned lo	cations.			practice. MD removed cigaret			
	This finding was r	eviewed with the Administrator			butts from the smoking area a placed a sign outside the kitch			
	_	Director during the exit			as a no smoking area.	1011		
	conference.							
	3.1-19(b)				What measures will be put			
					into place and what systemic	:		
					changes will be made to			
					ensure that the deficient			
					practice does not recur;			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD MOREHOUSE AVE	
ELKHAR'	T MEADOWS			ART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch	s - Maintenance and s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing, is performed at intervals ented performance data, sted as hospital-grade at the tested at intervals not on this. Line isolation monitors are tested at intervals of to 1 month by actuating on per 6.3.2.6.3.6, which ual and audible alarm. For		MD educated on importance ensuring smoking area was of from cigarette butts and ensure proper disposal containers at available in the smoking area. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and by what date the systemic changes for experience deficiency will be complete. Maintenance director will condaily rounds to ensure complismet and will report results QAPI team with an action plaplace if compliance is not me. Deficiencies corrected by 12.	clear uring re a. s) the put e ach d; mplete liance to an in et.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155352	B. WING 11/15/2022				/2022	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹	2600 MOREHOUSE AVE					
FI KHAR	T MEADOWS			ELKHART, IN 46517				
	1				T			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
		automated self-testing, this						
		formed at intervals less						
		2 months. LIM circuits are						
	1	.2 after any repair or						
		electric distribution system.						
		tained of required tests and						
	associated repairs							
	results.	oom or area tested, and						
	6.3.4 (NFPA 99)							
	·	on, record review and	K 0914		What corrective action(s) will		12/21/2022	
	interview, the facility failed to ensure non-hospital grade electrical receptacles in 37 of 37 resident		K 0714		be accomplished for those		12/21/2022	
					residents found to have been	n		
		re tested at least annually.			affected by the deficient			
		Care Facilities Code 2012 Edition,			practice;			
	· ·	ates receptacles not listed as			Ordered hospital grade electri	cal		
		atient bed locations and in			receptacles to install in reside			
		ep sedation or general			rooms. Electrician coming to			
		istered, shall be tested at			facility to test hospital grade			
	intervals not exceed	ding 12 months. Additionally,			receptacles to ensure complia	ince		
	Section 6.3.3.2, Red	ceptacle Testing in Patient Care			with Section 6.3.3.2, on 12/21			
	Rooms requires the	physical integrity of each						
	1 -	confirmed by visual inspection.			How other residents having			
	•	ne grounding circuit in each			the potential to be affected b	-		
		e shall be verified. Correct			the same deficient practice v	vill		
		and neutral connections in			be identified and what			
		ptacle shall be confirmed; and			corrective action(s) will be			
		ne grounding blade of each			taken;			
	·	e (except locking-type			All residents have the potentia	al to		
		e not less than 115 grams (4			be affected by the deficient			
		ient practice could affect all			practice. Ordered hospital gra			
	residents.				electrical receptacles to install	ıın		
	Findings in -11-				resident rooms. Electrician	tal		
	Findings include:				coming to facility to test hospit	ıaı		
	Rosed on observation	one during a tour of the facility			grade receptacles to ensure	2		
		ons during a tour of the facility ator and Maintenance Director			compliance with Section 6.3.3 on 12/21/22.	.∠		
		en 2:06 p.m. and 3:15 p.m., the			OII 12/21/22.			
		t sleeping rooms contained						
		ospital-grade electrical			What measures will be put			
	I TOM TO SIGHT HOH-III	opium grado oroditour	1		i triidi iiicasares wiii be bul		1	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE (A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/15/2022		
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	5.112		
	10:14 a.m. and 2:00 receptacle testing for receptacles was pass receptacle testing docompletion date of the time of the obsethe Maintenance Dithe electrical recept rooms were hospital documentation for the Findings were discussed.	04/01/21. Based on interview at rvation and records review, rector could not confirm all of acles in the resident sleeping l-grade nor have updated		into place and what system changes will be made to ensure that the deficient practice does not recur; MD educated on importance ensuring all electrical recepts in resident rooms are hospits grade. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and by what date the systemic changes for edeficiency will be complete Maintenance director will mot to ensure compliance is met will report results to QAPI tea with an action plan in place it compliance is not met. Deficiencies corrected by 12.	of acles al s) the put e ach d; nitor and am f		
K 0918 SS=C Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the pocess shall be provided to nis capability for the life branches. Maintenance generator and transfer formed in accordance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDI	A. BUILDING 01 COMPLE				
155352			B. WING 11/15/2022				
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDENCE N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	TIX (EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA		DEFICIENCY)	VIE.	DATE
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	nths for 4 continuous hours.					
	Scheduled test un	der load conditions include					
	a complete simula	ated cold start and					
	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored						
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
	•	tablished according to					
	-	uirements. Written records					
		nd testing are maintained ble. EES electrical panels					
	· ·	arked, readily identifiable,					
		n normal power circuits.					
	-	ssibility of damage of the					
		source is a design					
	consideration for r	•					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	•					
	Based on record review and interview, the facility		K 0918	Wha	t corrective action(s) wil	II	12/11/2022
	failed to ensure the	continuing reliability and			ccomplished for those		
	integrity of 1 of 1 e	mergency generators. This			dents found to have beer	n	
	deficient practice co	ould affect all occupants.		affec	cted by the deficient		
				prac	tice;		
	Findings include:			MD	contacted generator comp	oany	
				who	has ordered parts to com	plete	
		view with the Administrator		gene	erator maintenance.		
		irector on 11/15/22 between					
		p.m., the Generator		l l	v other residents having		
	-	t from 05/05/22 stated the		-	potential to be affected b	-	
		or recommended replacement		l l	same deficient practice v	vill	
		l block heater hoses for		1	dentified and what		
	-	enance. Generator report states			ective action(s) will be		
	-	erable at time of maintenance.		take		al to	
	_	ith the Administrator and tor, they stated they were			esidents have the potentia	ai lO	
	iviaintenance Direct	ioi, mey stated mey were		l be a	ffected by the deficient		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155352		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 11/15/2022		
	PROVIDER OR SUPPLIER T MEADOWS		2600	ET ADDRESS, CITY, STATE, ZIP COD) MOREHOUSE AVE HART, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FICIENCY)	LD BE	(X5) COMPLETION DATE
	aware of the report, documentation for a preventative/routing the survey.			practice. MD contacted good company who has ordere complete generator main	d parts to	
	_	riewed with the Administrator e Director during the exit		What measures will be into place and what syst changes will be made to ensure that the deficient practice does not recur; MD educated on importate ensuring generator maint completed in a timely fast. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will into place; and by what	temic t nce of enance is hion. on(s) ure the ot	
				the systemic changes for deficiency will be completed. Maintenance director will to ensure compliance is rewill report results to QAP with an action plan in place compliance is not met. Deficiencies corrected by	or each eted; monitor net and I team ce if	
K 0920 SS=E Bldg. 01	Extens Electrical Equipmonents Extension Cords Power strips in a pused for components patient-care-relate (PCREE) assemb	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment les that have been				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155352	B. WING 11/15/2022			2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			OREHOUSE AVE		
FI KHAR	T MEADOWS		ELKHART, IN 46517				
·			1		, 10011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		10.2.3.6. Power strips in					
	1	cinity may not be used for					
	, -	, personal electronics),					
		m care resident rooms that					
		E. Power strips for PCREE					
		r UL 60601-1. Power strips					
		the patient care rooms					
	1 '	r) meet UL 1363. In ooms, power strips meet					
	-	ls. All power strips are					
		precautions. Extension					
	I -	d as a substitute for fixed					
		re. Extension cords used					
	_	moved immediately upon					
	1 .	purpose for which it was					
	1	ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	•	(D) (NFPA 70), TIA 12-5					
		ation and interview, the facility	K 0	920	What corrective action(s) will	II	12/11/2022
	failed to ensure 1 of	f 1 flexible cords were installed			be accomplished for those		
	properly and used in	n a safe manor. NFPA 99,			residents found to have been	n	
	Section 10.2.4.2 sta	ites adapters and extension			affected by the deficient practice; MD removed power strip from		
	cords meeting the re	equirements of 10.2.4.2.1					
	1	shall be permitted. Section					
		e cabling shall comply with			supply room near sprinkler ris	er	
		2.3.5.1 states cord strain relief			room, and removed extension	l	
	shall be provided at the attachment of the power				cords from MDS office and		
		e so that mechanical stress,			conference room.		
	_	bend, is not transmitted to					
		s. This deficient practice could			How other residents having		
	all staff.				the potential to be affected by	-	
	TP' 1' ' 1 1				the same deficient practice v	vill	
	Findings include:				be identified and what		
	D 1 1 2	tal al . A 1 . t t			corrective action(s) will be		
		on with the Administrator and			taken;	.14.	
		tor on 11/15/22 between 2:06			All residents have the potentia	ai to	
	_	in the storage room connected			be affected by the deficient	_4	
	_	er Room, a power strip used to			practice. MD removed power	-	
		vas not secured, and was			from supply room near sprinkl		
	dangling from the o	outlet on the wall. This			riser room, and removed exte	nsion	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		155352	B. WING 11/15/2022			2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			OREHOUSE AVE		
ELKHAR [.]	T MEADOWS				RT, IN 46517		
T	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE				, 	1	ave.
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	•	stress on the power cord			cords from MDS office and		
		the power cord. Based on			conference room.		
	interview at the time of observations, the Maintenance Director agreed the power strip was						
		ed, and stated the power strip			What measures will be put		
	will need to be mou	inted or set on the floor.			into place and what systemic	С	
	Tl.:- £: J'	ad annual and discount of the			changes will be made to		
	_	viewed with the Maintenance			ensure that the deficient		
		nistrator during the exit			practice does not recur;	£	
	conference.				MD educated on importance of	OŤ .	
	2.1.10(1)				ensuring power strips and		
	3.1-19(b)				extension cords are not in use) .	
	2. Based on observa	ation and interview, the facility			How the corrective action(s	١	
		f 1 flexible cords were not used			will be monitored to ensure	-	
		ixed wiring. NFPA-70/2011,			deficient practice will not		
		pecifically permitted in 400.7			recur, i.e., what quality		
		ables shall not be used for (1)			assurance program will be p	ut	
		ixed wiring. This deficient			into place; and by what date		
	practice could affect				the systemic changes for ea		
	F				deficiency will be completed		
	Findings include:				Maintenance director will com		
	8				daily rounds to ensure compli	-	
	Based on observation	on during a tour of the facility			is met and will report results to		
		ce Director and Administrator			QAPI team with an action plan		
		en 2:06 p.m. and 3:15 p.m., a			place if compliance is not met		
		rigerator were plugged into and					
		nsion cord. Another extension			Deficiencies corrected by 12/	11/22	
	-	he conference room plugged					
		d on interview at the time of					
		aintenance Director and					
	-	owledged an extension cord					
		oved the extension cord when					
	observed.						
		viewed with the Maintenance					
		lministrator during the exit					
	conference.						
	3.1-19(b)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/15/2022	
NAME OF PROVIDER OR SUPPLIER ELKHART MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 2600 MOREHOUSE AVE ELKHART, IN 46517			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE

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