STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
111,212,111	or conduction.	155154	B. WING			04/27/2021	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
E 0000							
Bldg			E 00	E 0000 The creation and submiss this plan of correction doe constitute an admission be provider of any conclusion in the statement of deficie of any violation of regulation. This provider respectfully that the 2567 plan of corrections and requests dereview (paper compliance after 5/19/2021.		ot s forth es, or uests on be le	
K 0000							
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/27/21 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050		K 0	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or		ot s : forth :s, or uests un be le	
	-	Code survey, Spring Mill and not in compliance with			after 5/19/2021.		

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		A. BUILDING 01 COMPLETED B. WING 04/27/2021				
	ROVIDER OR SUPPLIER MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	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 two story facility with a basement was					
	determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 69 at the time of this survey. All 74 resident sleeping rooms were surveyed.					
	All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered. Quality Review completed on 05/04/21					
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.					
	1. Based on observation and interview, the facility failed to remove 1 of 3 essential electric system remote manual stop stations which was no longer in use. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by	K 0100	K100 General Requirements other What corrective action(s) wil be accomplished for those residents found to have beer	ı		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/27/2021			
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER		2140 W 86TH ST				
SPRING	MILL MEADOWS		INDIANAPOLIS, IN 46260				
(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	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	·	ither maintained or removed.		affected by the deficient			
	_	ice could affect all residents,		practice?			
	staff, and visitors.			1 - The inoperable manu	ıal		
	Findings in 1.4			stop station was removed.			
	Findings include:			· 2 – The fire door by the			
	Dagad am alegamietis	ons with the Director of		first-floor west nurses' station			
		g a tour of the facility from 1:30		repaired to latch fully during s closure.	eli		
	_	n 04/27/20, three remote manual		· 2 – The smoke barrier d	oor		
		ated at the west nurse's		set by room 126 was repaired			
	•			latch fully during self closure.	110		
station near the elevators on the first floor. Based on interview at the time of the observations, the				How will you identify other			
Director of Maintenance stated the remote manual				residents having the potenti			
stop station located above the computer screen at			to be affected by the same	ai			
	_	vas no longer operational and		deficient practice and what			
		le manual stop station should		corrective action will be take	nn?		
		d confusion as to which stop		· 1 - All residents on first flo			
	stations were function			west have the potential to be			
	stations were raneti	ona.		affected by the alleged deficie	ent		
	This finding was re	viewed with the Executive		practice.			
	Director during the			·2 – Residents on the first fl	oor		
				east, near room 126, have the			
	3.1-19(b)			potential to be affected by the			
	()			alleged deficient practice.			
	2. Based on observa	ation and interview, the facility		·The Maintenance Supervis	or		
		atching hardware on 2 of 8 sets		will be inserviced by the Exec	I		
	of smoke barrier do	ors per 4.6.12.3. LSC 4.6.12.3		Director/designee on the			
		e safety features obvious to		regulatory standard indicated	by		
	the public if not req	uired by the Code, shall be		this requirement by 5/19/2021	•		
	either maintained or	removed. This deficient					
	practice could affec	t over 30 residents, staff, and		What measures will be put in	nto		
	visitors on the first	floor.		place or what systemic			
				changes you will make to			
	Findings include:			ensure that the deficient			
				practice does not recur?			
		ons with the Director of		·The Maintenance Supervis	or		
	_	g a tour of the facility from 1:30		will be inserviced by the Exec	utive		
		n 04/27/20, the smoke barrier		Director/designee on the			
		floor by the west nurse's		regulatory standard indicated	by		
	station by the elevat	tors was equipped with		this requirement by 5/19/2021	1.		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(x3) date survey completed 04/27/2021		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	latched into the doo north door hit the fa failed to fully self c frame when tested t door in the door set fire resistance rating barrier door set by I with latching hardw to latch the door int to close multiple tin was equipped with a rating label. Based observations, the D the aforementioned latching hardware for frame when tested to	n both doors. The south door reframe, but the face of the ce of the south door and lose and latch into the door of close multiple times. Each was equipped with a one hour glabel. In addition, the smoke Room 126 was also equipped are, but the south door failed to the door frame when tested thes. Each door in the door set at one hour fire resistance on interview at the time of the crector of Maintenance agreed smoke barrier door set's tailed to latch into the door of close multiple times.		·As construction is complete on the building the Maintenand supervisor will ensure fire door with self latching units are maintained to latch fully. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? · A life safety Review QA the will be utilized weekly x 4 week monthly x 6 months, and quark thereafter for one year with responsed to the Quality Assural and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant Date of Correction May 19, 2021	he ut ool ks, terly sults nce ut ot		
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to emergency, unles through 18/19.2.1 18.2.1, 19.2.1, 7.1	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211	K211 Means of Egress Gono	ral 05/10/2021		
	failed to ensure 2 of	on and interview, the facility 12 means of egress was sined free of all obstructions	K 0211	K211 Means of Egress Gene What corrective action(s) will be accomplished for those			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/27/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR or impediments to f fire or other emerge could affect over 30 needing to exit the f Findings include: Based on observation Maintenance during p.m. to 4:20 p.m. or noted: a. a love seat bench wall in the corridor Room on the first fl Room 114 and in the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION full instant use in the case of ney. This deficient practice of residents, staff and visitors if facility. ons with the Director of g a tour of the facility from 1:30 in 04/27/20, the following was was stored up against the outside the Medication Prep oor, in the corridor outside e corridor outside Room 118. ed 27 inches into the eight foot	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE TO THE APPROPRIATE TO THE APPROPRIADE TO THE APPROPRIATE TO THE A	n were / the est, , and . /ers wer		
	b. a plastic three dra placed up against th shower room and ex- eight foot wide corr measuring tape. Based on interview observations, the Di- the aforementioned continuously mainta or impediments to f fire or other emerge	rector of Maintenance agreed means of egress was not ained free of all obstructions full instant use in the case of ncy.		All residents on the first and second floor west have the potential to be affected by the alleged deficient practice. The Maintenance Superwill be inserviced by the Execution Director on the regulatory star indicated by this requirement 19, 2021. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Superwill be inserviced by the Execution Director/designee on keeping 8-foot clearance in the corridor and the regulatory standard indicated by this requirement also removed the furniture in areas out of compliance by M	visor utive ndard May nto visor utive and ors and both		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155154	B. WI			04/27	
	PROVIDER OR SUPPLIED	3	•	2140 W	ADDRESS, CITY, STATE, ZIP COD / 86TH ST APOLIS, IN 46260		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	19, 2021. The Maintenance Supervisor/designee will mak environmental rounds daily to ensure facility corridors remai clear of obstructions. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place? A life safety Review QA will be utilized daily x 4 weeks monthly x 6 months, and qual thereafter for one year with re reported to the Quality Assura and Performance Improveme Committee overseen by the Executive Director. If a threshold of 95% is r achieved, an action plan will to developed to ensure complian Date of Correction May 19, 2021	the tool s, terly sults ance nt	DATE
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking ar CLINICAL NEEDS LOCKING Where special lockinical security not used, only one locking with the special locking and the special locking locking security not used, only one locking security not used.	ed means of egress shall not a latch or a lock that of a tool or key from the s using one of the following rangements: S OR SECURITY THREAT cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

	N OF CORRECTION	IDENTIFICATION NUMBER 155154	UILDING	01	COMPL 04/27/	ETED		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260					
(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		
	by: remote controlocks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks afety needs of the Clinical or Secare being met. In electrical locks the release upon loss building is protected automatic sprinkle space is protected detection system at an attended lock space); and both systems are arranupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, supplemental systems are arrangulated for the systems in the systems are arrangulated for the systems in	king arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked d by a complete smoke (or is constantly monitored action within the locked the sprinkler and detection aged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by pervised automatic fire or an approved, supervised er system. 2.2.4 COLLED EGRESS						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA'		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COM		COMPLETED	
		155154	B. W	B. WING 04/27/202			
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CDDING	MILL MEADOWS		2140 W 86TH ST INDIANAPOLIS, IN 46260				
SPRING	MILL MEADOWS			INDIAN	IAPOLIS, IN 46260		
(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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	18.2.2.2.4, 19.2.2.2.4						
	ELEVATOR LOBBY EXIT ACCESS						
	LOCKING ARRAN	NGEMENTS					
	Elevator lobby exi	t access door locking in					
	accordance with 7	7.2.1.6.3 shall be permitted					
	on door assemblie	es in buildings protected					
	throughout by an	approved, supervised					
		ection system and an					
	approved, supervi	ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of						
			K 0	222	K222 Egress Doors	05/19/2021	
					What corrective action(s) will	II	
	5 exits on the first f	loor were readily accessible for			be accomplished for those		
	residents without a	clinical diagnosis requiring			residents found to have been	n	
	specialized security	measures. Doors within a			affected by the deficient		
	required means of e	egress shall not be equipped			practice?		
	with a latch or lock	that requires the use of a tool			· A – The correct code for	the	
	or key from the egr	ess side unless otherwise			stairwell next to room 112 was	s	
	permitted by LSC 1	9.2.2.2.4. Door-locking			corrected and reposted.		
	arrangements shall	be permitted in accordance			B – The correct code for	the	
		This deficient practice could			exit door to the outside near the	he	
	affect over 10 resid	ents, staff and visitors if			stairwell by room 121 was		
	needing to exit the	facility\.			corrected and reposted.		
					How will you identify other		
	Findings include:				residents having the potential	al	
					to be affected by the same		
		ons with the Director of			deficient practice and what		
	_	g a tour of the facility from 1:30			corrective action will be take		
	p.m. to 4:20 p.m. or	n 04/27/20, the following was			 All residents on the first t 		
	noted:				have the potential to be affect	ed	
		was not posted for the stairwell			by the alleged deficient praction	I	
		by Room 112. The door was			· The Maintenance Super	I	
		d and could be released by			will be inserviced by the Exec		
	entering a four digit code, but an incorrect code was posted which was entered and the door did				Director on the regulatory star	I	
					indicated by this requirement	by	
	not release to open.				May 19, 2021.		
		he outside of the facility in the			What measures will be put in	nto	
	-	121 on the first floor was			place or what systemic		
	marked as a facility exit, was magnetically locked				changes you will make to		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155154	B. W	ING		04/27/	/2021	
SPRING	PROVIDER OR SUPPLIER MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
TAG	and could be opene but the correct code door to open. The proof release the door Based on interview observations, Direct different code than by Room 112 which The Director of Mathe stairwell door be entering different codes released the codes released the codes released the doors would the fire alarm system correct code to release posted.	d by entering a four digit code was not posted to release the costed code when entered did to open. at the time of the tor of Maintenance entered a the posted code for the door in released the door to open. intenance attempted to release y Room 121 to open by odes but none of the entered door to open. The Director of the magnetic holding devices release the doors to open if m was activated but agreed the ase the doors to open was not viewed with the Executive			ensure that the deficient practice does not recur? The Maintenance Superwill be inserviced by the Executive Director on the regulatory star indicated by this requirement of May 19, 2021. The Maintenance Supervisor/designee will review coded exits monthly to ensure codes provide egress correctly how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? A life safety QA tool will be utilized monthly x 4 weeks, monthly x 6 months, and quarthereafter for one year with recommittee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	utive indard by w all ithe ut be terly sults ince int oot ie ince	DAIL	
K 0232 SS=E Bldg. 01		-			Date of Correction May 19, 2021			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155154	B. W	ING	04/2		2021
NAME OF T	DROLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	C.	2140 W 86TH ST				
	MILL MEADOWS			INDIAN	IAPOLIS, IN 46260		
(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		TAG	BETEIENCT		DATE
		maintained to provide the alof nonambulatory patients					
		ept as modified by					
	19.2.3.4, exception	· •					
	19.2.3.4, exception 19.2.3.5	113 1-3.					
		on and interview, the facility	KO	232	K232 Aisle, corridor, or ram	ın	05/19/2021
		lear width requirement for 2 of	I IX U	<i>434</i>	width		03/13/2021
	12 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is				What corrective action(s) wil		
					be accomplished for those	•	
		ctions into the required width			residents found to have been		
	shall be permitted for fixed furniture, provided that all of the following conditions are met:				· A - The love seat benche		
					were removed from the corrido		
	(a) the fixed furniture is securely attached to the				by the med room on the first fl		
	floor or to the wall.				west, the corridor outside roor		
	(b) the fixed furnitu	are does not reduce the clear		114, and the corridor outside			
	unobstructed corrid	or width to less than six feet,		118.			
	except as permitted	by 19.2.3.4(2).		How will you identify other			
	(c) the fixed furnitu	re is located only on one side		residents having the potential		al	
	of the corridor.				to be affected by the same		
	(d) the fixed furnitu	re is grouped such that each			deficient practice and what		
	grouping does not e	exceed an area of 50 square			corrective action will be take	n?	
	feet.				· All residents on the first f	loor	
	1 1	re groupings addressed in			and second floor west have th	е	
		eparated from each other by a			potential to be affected by the		
	distance of at least 1				alleged deficient practice.		
	` '	re is located so as to not			The Maintenance Superv		
		uilding service and fire			will be inserviced by the Execu		
	protection equipmen				Director on the regulatory star		
		hout the smoke compartment			indicated by this requirement	viay	
		electrically supervised etection system in accordance			19, 2021.	10	
		fixed furniture spaces are			What measures will be put in	iiO	
		d to allow direct supervision			place or what systemic changes you will make to		
	_	from a nurse's station or similar			ensure that the deficient		
	space.	nom a nuise s station of similal			practice does not recur?		
	_	partment is protected			practice does not recui !		
		oproved, supervised automatic			· The Maintenance Superv	/isor	
		accordance with 19.3.5.8.			will be inserviced by the Execu		
	1 -	ice could affect over 30			Director/designee on keeping		
	residents, staff and				8-foot clearance in the corrido		

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STATEMEN	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>		COMPLETED		
		155154	B. W	B. WING			04/27/2021	
				CTREET	ADDRESS SITY STATE ZID SOD			
NAME OF P	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD			
ODDINO	MUL MEADOWN				/ 86TH ST			
SPRING	MILL MEADOWS			INDIAN	IAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPR			DATE	
					and the regulatory standard			
	Findings include:				indicated by this requirement	and		
	Based on observations with the Director of				also removed the furniture in the			
					areas out of compliance by Ma			
		g a tour of the facility from 1:30			19, 2021.	ау		
		1 04/27/20, a love seat bench			The Maintenance			
		st the wall in the corridor						
		ion Prep Room on the first			Supervisor/designee will make			
		•			environmental rounds daily to			
		r outside Room 114 and in the			ensure facility corridors remain	n		
	corridor outside Room 118. Each bench projected 27 inches into the eight foot wide corridor, as measured with a measuring tape, and each bench was not affixed to the floor or to the wall. Based				clear of obstructions.			
					How the corrective action(s)			
					will be monitored to ensure t	.he		
					deficient practice will not			
		time of the observations, the			recur, i.e., what quality			
		nance agreed furniture was			assurance program will be p	ut		
	_	f egress at the aforementioned			into place?			
		eted more than two feet into			A life safety Review QA to			
	the eight foot wide	corridor.			will be utilized daily x 4 weeks	,		
					monthly x 6 months, and quar	terly		
	_	viewed with the Executive			thereafter for one year with re	sults		
	Director during the	exit conference.			reported to the Quality Assura	nce		
					and Performance Improvemer	nt		
	3.1-19(b)				Committee overseen by the			
					Executive Director.			
					· If a threshold of 95% is n	ot		
					achieved, an action plan will b	e		
					developed to ensure compliar	ice.		
					Date of Correction May 19,			
					2021			
			İ					
K 0351	NFPA 101		İ					
SS=E	Sprinkler System	- Installation						
Bldg. 01	Spinkler System -							
Ŭ	2012 EXISTING							
		nd hospitals where required						
	by construction ty							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/27/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(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)	(X5) COMPLETION DATE		
	sprinkler system in 13, Standard for the Systems. In Type I and II concepted for spreare as where states sprinklers. In hospitals, sprinklers. In hospitals, sprinklers. In hospitals, sprinklers. In hospitals, sprinklers for the area of 6 square feet and the closet footpring standard for Instates Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 19.3.5, 19.4.2, 19.3.5, 19.4.2, 19.3.5, 19.4.2, 19.3.5, 19.4.2, 19.3.5, 19.4.2, 19.3.5, 19.4.2, 19	approved automatic in accordance with NFPA in accordance with NFPA in accordance with NFPA in accordance with NFPA in accordance with NFPA in accordance with NFPA in accordance with the protection in specific or local regulations prohibit in patient sleeping rooms the closet does not exceed sprinkler coverage covers as required by NFPA 13, and allation of Sprinkler in 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) on and interview, the facility for over 200 sprinkler heads in talled in accordance with a scandard for the Installation is accordance with a sprinkler shall be part of sembly. Section 6.2.7.2 is sed with recessed, alled sprinklers shall be part of sembly. Section 6.2.7.3 states ith concealed sprinklers shall sprinkler assembly. This bould affect over 40 residents, the first and second floor.	K 0351	K351 Sprinkler Installation What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice? The escutcheons in roor 118, 232, 236, and 237 were installed. The residents in 118, 23 236, and 237 could be affecte the alleged deficient practice. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take All resident rooms were checked for escutcheons. The Maintenance Supervis will be inserviced on the regu standard indicated by this	n 2, ed by sal en?		

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Event ID:

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/27/2021		
	PROVIDER OR SUPPLIER MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	recessed sprinklers located in Room 232, Room 236 and Room 237 were each missing its cover plate. Based on interview at the time of the observations, the Director of Maintenance stated the recessed sprinklers have never had a cover plate but agreed the sprinkler locations did not have an escutcheon or a cover plate. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		what measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervise will be inserviced on the regulation standard indicated by this requirement by May 19, 2021. Maintenance Supervisor/ve support will make rounds to ensure escutcheons remain in appropriately. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? A life safety QA tool will utilized weekly x 4 weeks, monthly x 6 months, and qual thereafter for one year with rereported to the Quality Assurand Performance Improveme Committee overseen by the Executive Director. If a threshold of 95% is a achieved, an action plan will a developed to ensure compliant Date of Correction May 19 2021	or latory . endor ntact the but be rterly esults ance nt out not one noce		
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED	
		155154	B. WI	NG		04/27/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(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	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	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 REMAF coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record acility failed to ensimitatined in according 9.7.5 requires all sprinspected, tested, are with NFPA 25, Star Testing, and Mainter Protection Systems. Section 4.1.1 states designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system. Section 4.1 or designated represent properly maintaining system.	ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a land readily available. It is system last checked system last checked system test supply source. RKS information on mon-required or partial er system. It is and NFPA 25 review and interview, the sure the sprinkler system was dance with NFPA 25. LSC rinkler systems shall be and maintained in accordance and maintained in accordance and for the Inspection, the property owner or tative shall be responsible for g a water based fire protection at 1.4.1 states the property owner sentative shall correct or repair airments that are found during and maintenance required by deficient practice could affect and visitors.	K 03		K353 Sprinkler System – Testing and Maintenance What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? 1 - The alarm trim on the alarm valve was repaired and operation. 2a – The ceiling mounted sprinkler in the closet nearest corridor in room 110 was repla 2b – The deflector for the ceiling mounted sprinkler in th closet nearest the corridor in r 211 was replaced. How will you identify other residents having the potentia to be affected by the same deficient practice and what	in the aced. e e oom	05/19/2021
	_	or's "Form for Inspection,			corrective action will be take	n?	
1	I Testing and Mainte	nance of Wet Pipe Fire			· 1 - All residents have the		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01		COMPLETED	
		155154	B. WIN	NG		04/27/2021	
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ODDINO	MUL MEADOWO				/ 86TH ST		
SPRING	MILL MEADOWS			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'L	DATE
	Sprinkler Systems"	documentation dated 07/02/20			potential to be affected by the		
	and 10/06/20 with t	the Executive Director and the			alleged deficient practice.		
	Director of Mainter	nance during record review			·2 – Residents in room 110	and	
		:30 p.m. on 04/27/21, the alarm			second floor in room 211, have		
		er system alarm valve is not in			potential to be affected by the		
	_	s to be removed. The			alleged deficient practice.		
	_	ary" section of aforementioned			·The Maintenance Superviso	or	
	-	The alarm trim on the alarm			will be inserviced by the Execu		
	^	ation: it is closed off and needs			Director/designee on the		
	_	ere is a vane-style flow switch			regulatory standard indicated	hv	
	that is active and working. This switch replaced				this requirement by 5/19/2021	•	
	the alarm valve, however if it is installed it must be				·All sprinklers were inspecte		
	in operation and it is not, therefore it needs to be				and corrected as needed.	~	
	removed". Based on interview at the time of				and somested as needed.		
	record review, the Executive Director provided				What measures will be put in	ıto.	
		on on the status of repair from			place or what systemic		
		n contractor dated 04/27/21 at			changes you will make to		
		'This has not been completed. I			ensure that the deficient		
	can get this schedul	_			practice does not recur?		
	can get time senedar	ica for you .			·The Maintenance Superviso	or	
	This finding was re	eviewed with the Executive			will be inserviced by the Execu		
	Director during the				Director/designee on the	JUVC	
	Birector during the	can conference.			regulatory standard indicated	hv	
	3.1-19(b)				this requirement by 5/19/2021	-	
	3.1 17(0)				·Maintenance Supervisor/ve		
	2 Based on observa	ation and interview, the facility			support will make rounds to	ildoi	
		er more than 2 of over 200			ensure sprinklers remain in go	nod	
		he facility which had been			repair.	,ou	
	_	with foreign materials were			Topaii.		
	_	ance with NFPA 25. NFPA 25,			How the corrective action(s)		
	_	spection, Testing, and			will be monitored to ensure t	ho	
		ater-Based Fire Protection			deficient practice will not	116	
		ion, Section 5.2.1.1.1 states			recur, i.e., what quality		
	_	show signs of leakage; shall			assurance program will be p		
	_	, foreign materials, paint, and			into place?	ut	
		nd shall be installed in the			A life safety Review QA to	ool	
		(e.g., up-right, pendent, or			will be utilized weekly x 4 wee		
		nore, at 5.2.1.1.2 any sprinkler			•		
	· ·	any of the following shall be			monthly x 6 months, and quar	-	
	_	any of the following shall be			thereafter for one year with re-		
	replaced:				reported to the Quality Assura	nce	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155154	A. BUILDING B. WING	01	COMPI 04/27	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	(1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless panufacturer. In lieu of replacing dust, it is permitted compressed air or bequipment does not This deficient practices residents, staff, and second floor. Findings include: Based on observation Maintenance during p.m. to 4:20 p.m. or noted: a. the ceiling mount nearest the corridor painted. b. the deflector for the closet nearest the was painted. Based on interview observations, the Dithe aforementioned painted.	the glass bulb heat responsive painted by the sprinkler sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the touch the sprinkler. Ice could affect over 40 visitors on the first and ons with the Director of y a tour of the facility from 1:30 in 04/27/20, the following was ed sprinkler in the closet door in Room 110 was spray the ceiling mounted sprinkler in the corridor door in Room 211 at the time of the frector of Maintenance agreed sprinkler head locations were		and Performance Improve Committee overseen by Executive Director. If a threshold of 95° achieved, an action plant developed to ensure compate of Correction Ma 2021	the % is not will be npliance.		
K 0355 SS=F	NFPA 101	nguishers					

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Facility ID: 000074

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	ing <u>01</u>		COMPLETED	
		155154	B. W	ING		04/27/2021		
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
CDDING			2140 W 86TH ST INDIANAPOLIS, IN 46260					
SPRING	MILL MEADOWS			INDIAN	IAPOLIS, IN 46260			
(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 APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bldg. 01	Portable Fire Extir	nguishers						
	Portable fire exting	guishers are selected,						
	installed, inspecte	d, and maintained in						
	accordance with N	IFPA 10, Standard for						
	Portable Fire Extir	nguishers.						
	18.3.5.12, 19.3.5. ²	12, NFPA 10						
	Based on observa	ation and interview, the facility	K 0	355	K355 Portable Fire		05/19/2021	
		f 17 portable fire extinguishers			Extinguishers			
	-	ear maintenance documented			What corrective action(s) wil	II		
		accordance with NFPA 10.			be accomplished for those			
	NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire				residents found to have been	n		
	extinguishers shall be internally examined at				affected by the deficient			
		ling those specified in Table			practice?			
		7.3.1.2.1 states every six years,			· 1 - The four ABC type			
	-	extinguishers that require a			portable fire extinguishers loca	ated		
		test shall be emptied and			in the corridor by room 103, ro	oom		
		licable internal examination			207, room 213, and room 235			
	*	ed in the manufacturer's			received maintenance as			
		this standard. Sections 7.3.3.1			prescribed every 6 years.			
	-	e fire extinguishers that pass			· 2 – The ABC type portab	ole		
		ar requirement shall have the			fire extinguishers located by			
		nation recorded on a durable			corridor room 207, room 213,			
	_	that is a minimum size of 2			the basement mechanical roo	m		
	-	s. The label shall be affixed to			received maintenance as			
		nclude the month and year the			prescribed monthly.			
		erformed. The label shall			How will you identify other			
		of the person performing the			residents having the potentia	aı		
		e name of the agency			to be affected by the same			
	-	ntenance. A verification of			deficient practice and what	_		
		be located around the neck of			corrective action will be take			
		ting the month and year of			· 1 - All residents on the sec	ond		
		e of the agency performing			floor have the potential to be			
		recharge. This deficient			affected by the alleged deficie	ent		
	visitors on the first	t 40 residents, staff, and			practice.			
	visitors on the first a	and second Hoor.			·2 – No residents would be			
	Findings incl. 1.				affected by the alleged deficie	erit		
	Findings include:				practice in the basement			
	Dagad on alease d'	ong with the Dinest			mechanical room.			
		ons with the Director of			·All fire extinguishers were			
	iviaintenance during	g a tour of the facility from 1:30			inspected, and corrections ma	ade		

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						T	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155154	B. W	ING		04/27	/2021
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			/ 86TH ST		
SPRING	MILL MEADOWS			INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
1710		n 04/27/20, the wall mounted		1710	as needed.		DATE
	1				·The Maintenance Supervis	or	
	ABC type portable fire extinguisher located in the						
	corridor by Room 103, by Room 207, by Room 213 and by Room 235 each had a 6-year maintenance				will be inserviced by the Exec	ulive	
		-			Director/designee on the	b	
	sticker and maintenance collar affixed to the				regulatory standard indicated	-	
	container stating the most recent 6-year maintenance was performed in July 2014. Based				this requirement by 5/19/202	1.	
	on interview at the time of the observations, the				What magazines will be said:	nto	
					What measures will be put i	IICO	
	Director of Maintenance agreed each of the four portable fire extinguishers did not have				place or what systemic		
	documented 6-year maintenance within the most				changes you will make to		
	recent six year period.				ensure that the deficient		
	recent six year peri	od.			practice does not recur?		
	TTI ' C' 1'	t didd e			·The Maintenance Supervis		
	_	eviewed with the Executive			will be inserviced by the Exec	cutive	
	Director during the	e exit conference.			Director/designee on the		
					regulatory standard indicated	-	
	3-1.19(b)				this requirement by 5/19/202		
					·Maintenance Supervisor/ve	endor	
		review, observation, and			support will make rounds to		
		ity failed to ensure 3 of 17			ensure portable fire extinguis	hers	
		uishers had documented			receive maintenance per		
		e in accordance with NFPA 10.			regulatory requirements.		
		portable fire extinguishers shall					
		ed, inspected, and maintained			How the corrective action(s	-	
		NFPA 10. NFPA 10, Standard			will be monitored to ensure	the	
		xtinguishers, 2010 Edition,			deficient practice will not		
		tates fire extinguishers shall be			recur, i.e., what quality		
	l ,	ance at intervals of not more			assurance program will be p	out	
	· ·	e time of hydrostatic test, or			into place?		
		ndicated by an inspection or			· A life safety Review QA		
		ion. Section 7.3.3 states each			will be utilized weekly x 4 wee		
	fire extinguisher sh	nall have a tag or label securely			monthly x 6 months, and qua	rterly	
	attached that indica	ntes the month and year the			thereafter for one year with re	esults	
	maintenance was p	erformed, identifies the person			reported to the Quality Assura	ance	
	performing the wor	rk, and identifies the name of			and Performance Improveme		
	the agency perform	ning the work. This deficient			Committee overseen by the		
	practice could affect	ct over 20 residents, staff, and			Executive Director.		
	visitors.				· If a threshold of 95% is i	not	
					achieved, an action plan will l	be	
	Findings include:				developed to ensure complia		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 04/27/2021			
	PROVIDER OR SUPPLIER		2140 W	ADDRESS, CITY, STATE, ZIP COD 86TH ST APOLIS, IN 46260		
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	inspection contracted documentation with the Director of Main from 9:30 a.m. to 1: maintenance was perextinguishers in the Based on observation Maintenance during p.m. to 4:20 p.m. on ABC type portable corridor by Room 2 basement Mechanic maintenance tag by not indicate the more maintenance was perexting at the time of the observation	viewed with the Executive		Date of Correction May 19, 2021		
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material ag fire for at least 20 fully sprinklered smoke enough on the control of th				

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STATEMENT OF DEFICIE AND PLAN OF CORRECT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/27/2021		
NAME OF PROVIDER OR		₹	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
PREFIX (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)	(X5) COMPLETION DATE		
hardware CMS regulapply to a flammable Clearance covering if doors cor if provided the door of applied. closing of release w permitted unlimited meeting 1 frames sh other mat unless the sprinklere allowed p there are resistance assemblie 19.3.6.3, 483, and Show in F fire protect devices, e	Roller I lation. I lation. I lation. I lation. I lation. I lation. I lation. I lation with a closed with a closed with a closed with each of the lation restrict of glases.	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors 6 are permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3, compartment is 1 fire window assemblies are in sprinklered compartments actions in area or fire is or frames in window Parts 403, 418, 460, 482, 483 details of doors such as ings, automatics closing	V 0262	K262 Consider Doors	05/10/2021		
failed to e corridor d latching ir passage of	nsure 2 of pors had a to the do samoke. 20 residor.	on and interview, the facility f 74 resident sleeping room no impediment to closing and or frame or would resist the This deficient practice could ents, staff and visitors on the	K 0363	What corrective action(s) wis be accomplished for those residents found to have bee affected by the deficient practice? • a - The Corridor door to 230 obstruction was removed b - The one-inch gap for room 233 door frame was rep	n room l.		

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Event ID:

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Facility ID: 000074

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/27/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	Based on observation Maintenance during p.m. to 4:20 p.m. or noted: a. the corridor door the fully open position b. a one inch gap with the door and the door the corridor door to Based on interview observations, the Different the aforementioned impediment to closiframe or would not	as noted in between the top of or stop on the door frame for Room 233. at the time of the rector of Maintenance agreed corridor doors had an ng and latching into the door resist the passage of smoke.	TAG	How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be tak ·a – The resident in room 2 could have been affected by alleged deficient practice. ·b –The resident in room 23 could have been affected by alleged deficient practice. ·The Maintenance Supervis staff will be inserviced by the Executive Director/designee the regulatory standard indicate by this requirement by 5/19/2 What measures will be put it place or what systemic changes you will make to ensure that the deficient practice does not recur? ·The Maintenance Supervis staff will be inserviced by the Executive Director/designee the regulatory standard indicate by this requirement by 5/19/2 ·Maintenance Supervisor/designee support make rounds to ensure reside room doors close per regulate requirements. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? · A life safety Review QA	en? 30 the 33 the sor/all on ated 021. nto sor/all on ated 021. will ent ory) the	

FTZX21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE : COMPL 04/27/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
					will be utilized weekly x 4 week monthly x 6 months, and quart thereafter for one year with restreported to the Quality Assurant and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant Date of Correction May 19, 2021	erly sults nce t	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Constructic 2012 EXISTING Smoke barriers sh 1/2-hour fire resist barriers shall be p atrium wall. Smok in duct penetration systems where an is installed for smo to the smoke barri 19.3.7.3, 8.6.7.1(1 Describe any med system in REMAR	nall be constructed to a tance rating per 8.5. Smoke permitted to terminate at an use dampers are not required in a in fully ducted HVAC in approved sprinkler system toke compartments adjacent iter.					
	failed to ensure ope smoke barriers was resistance rating of 19.3.7.3 refers to Se penetrations for cab similar items that per assembly constructed through the ceiling	on and interview, the facility enings through 1 of 3 ceiling protected to maintain the fire the smoke barrier. LSC ection 8.5. Section 8.5.6.2 states bles, conduits, pipes, and ass through a floor/ceiling ed as a smoke barrier, or membrane of a ceiling smoke tected by a system or material	K 037	2	K372 Subdivision of Building Spaces – Smoke Barriers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The three holes in the basement ceiling in the laundry washer room were repaired.		05/19/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/27/2021 155154 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2140 W 86TH ST INDIANAPOLIS, IN 46260 SPRING MILL MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE capable of resisting the transfer of smoke. Where How will you identify other a smoke barrier is also constructed as a fire barrier, residents having the potential the penetrations shall be protected in accordance to be affected by the same with the requirements of Section 8.3.5 to limit the deficient practice and what spread of fire for a time period equal to the fire corrective action will be taken? resistance of the assembly and Section 8.5.6. This ·No residents could have been deficient practice could affect over 30 residents, affected by the alleged deficient staff, and visitors on the first floor above the practice. basement laundry rooms. ·The Maintenance Supervisor/all staff will be inserviced by the Findings include: Executive Director/designee on the regulatory standard indicated Based on observations with the Director of by this requirement by 5/19/2021. Maintenance during a tour of the facility from 1:30 p.m. to 4:20 p.m. on 04/27/20, three holes were What measures will be put into noted in the basement ceiling smoke barrier in the place or what systemic washing machine room of the laundry in the changes you will make to basement. Based on interview at the time of the ensure that the deficient observations, Director of Maintenance agreed the practice does not recur? aforementioned openings in the ceiling smoke The Maintenance Supervisor barrier were not protected to maintain the fire will be inserviced by the Executive resistance rating of the basement ceiling smoke Director/designee on the regulatory standard indicated by barrier. this requirement by 5/19/2021. This finding was reviewed with the Executive ·Maintenance Supervisor will Director during the exit conference. make rounds to ensure there are no breaks in smoke barriers per 3.1-19(b)regulatory requirements. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A life safety Review QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155154	A. BUILDING B. WING	01	COMPLETED 04/27/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				and Performance Improvemer Committee overseen by the Executive Director. If a threshold of 95% is n achieved, an action plan will b developed to ensure complian Date of Correction May 19, 2021	ot e	
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that in Nonrated protectivare permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of provides a minimulator swinging or ho 19.3.7.6, 19.3.7.8	esists fire for 20 minutes. The plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening are clear width of 32 inches rizontal doors. 19.3.7.9				
	Based on observation failed to ensure 1 of would restrict the m 20 minutes. LSC 1 barriers shall comple 8.5.4.1 requires door the opening leaving necessary for prope	on and interview, the facility 6.8 sets of smoke barrier doors dovement of smoke for at least 9.3.7.8 requires doors in smoke y with LSC Section 8.5.4. LSC ars in smoke barrier shall close only the minimum clearance or operation. This deficient t over 30 residents, staff and	K 0374	K374 Subdivision of Building Spaces – Smoke Barrier Doo What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The fire door by the first-twest nurses' station was repair to latch fully during self closure How will you identify other residents having the potentiat to be affected by the same	floor red	

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Event ID:

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Facility ID: 000074

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/27/2021	
	PROVIDER OR SUPPLIER		2140 V	ADDRESS, CITY, STATE, ZIP COD N 86TH ST NAPOLIS, IN 46260		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
TAG	Based on observation Maintenance during p.m. to 4:20 p.m. or smoke barrier door west nurse's station of the south door are when tested to close the door set was equivalent time of the observation Maintenance agreed aforementioned smouth fully self close whe times.	ons with the Director of g a tour of the facility from 1:30 n 04/27/20, the north door in the set on the first floor by the by the elevators hit the face and failed to fully self close be multiple times. Each door in supped with a one hour fire bel. Based on interview at the stions, the Director of If the north door in the boke barrier door set failed to on tested to close multiple wiewed with the Executive	TAG	deficient practice and what corrective action will be take. All residents on first floor we have the potential to be affect by the alleged deficient practice. The Maintenance Supervise will be inserviced by the Executive Director/designee on the regulatory standard indicated this requirement by 5/19/202. What measures will be put it place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervise will be inserviced by the Executive Director/designee on the regulatory standard indicated this requirement by 5/19/202. As construction is complete on the building the Maintenar supervisor will ensure fire does with self latching units are maintained to latch fully. How the corrective action(signification will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? A life safety Review QA will be utilized weekly x 4 week monthly x 6 months, and quality assurance program will be proported to the Quality Assurand Performance Improvemed Committee overseen by the	en? vest ted ice. sor cutive by 1. ed ice ors) the tool eks, rerly esults ance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		A. BUII	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/27/2021	
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD / 86TH ST		
SPRING	MILL MEADOWS				IAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure complian Date of Correction May 19, 2021	е	
K 0541	NFPA 101			ļ			'
SS=D	_	Incinerators, and Laundry					
Bldg. 01	Chu	,					
		Incinerators, and Laundry					
	Chutes			ļ			
	2012 EXISTING	non and track chuta					
	1 ' ' '	nen and trash chute, atic rubbish and linen				ĺ	
	1 .	ens directly onto any				ĺ	
		sealed by fire resistive		ļ		ĺ	
	construction to pre	event further use or shall be				ĺ	
	-	re door assembly having a		ļ		ĺ	
	•	ing of 1-hour. All new chutes		ļ		ĺ	
	shall comply with					ĺ	
	1 ' '	hute or linen chute, atic rubbish and linen		ļ			
		provided with automatic		l		ļ	
	-	tection in accordance with		l		ļ	
	9.7.			l		ļ	
	(3) Any trash chuf	te shall discharge into a		l		ļ	
		oom used for no other		l		ļ	
		ected in accordance with		l		ļ	
		ndry chutes permitted to		l		ļ	
	_	me room are protected by ers in accordance with		l		ļ	
	19.3.5.9 or 19.3.5			ļ			
		ed incinerators shall be		ļ			
	1 ' '	istive construction to prevent		l		ļ	
	further use.			l		ļ	
	19.5.4, 9.5, 8.4, N			!			
		on and interview, the facility	K 054	41	K541 Rubbish Chutes,		05/19/2021
		of 1 laundry chutes was		l	Incinerators, and Laundry	ļ	
	maintained in accor	rdance with NFPA 82. NFPA		ı	Chutes	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/27/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
SPRING (X4) ID PREFIX TAG	SUMMARY: (EACH DEFICIEN REGULATORY OR 82, Standard on Inc Handling Systems a Section 5.2.3.2.2 sta shall be protected b self closing door in 5.2.3.1. Section 5.2 as follows: (1) 1 1/2 fire resista enclosures. (2) 1-hour fire resista enclosures. This deficient pract in the basement in t machine room. Findings include: Based on observation Maintenance during p.m. to 4:20 p.m. on linen chute in the w basement was not e closing or self closi at the time of the ob Maintenance agreed was not enclosed w closing door.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION inerators and Waste and Linen and Equipment, 2009 Edition, ates the bottom of a linen chute by a listed automatic closing or accordance with Section and Sattles openings shall be ance rating for 2-hour rated transpace are rating for 1-hour rated dice could affect over two staff the vicinity of the washing ons with the Director of a tour of the facility from 1:30 and 04/27/20, the bottom of the ashing machine room in the anclosed with an automatic and door. Based on interview diservations, the Director of a the bottom of the linen chute with an automatic closing or self	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) What corrective action(s) wis be accomplished for those residents found to have bee affected by the deficient practice? The linen chute in the washing machine room in the basement was repaired to incomplished for those a self-closing door. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken and the process of the process o	II n clude al en? ential cor cutive by 1. nto		
	3.1-19(b)	exit conference		will be inserviced by the Executive Director/designee on the regulatory standard indicated this requirement by 5/19/202. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place?	by I. the		

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Event ID:

FTZX21 Facility

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155154	A. BUIL B. WINC	DING	01	COMPL 04/27/	ETED
	ROVIDER OR SUPPLIER MILL MEADOWS		1	2140 W	DDRESS, CITY, STATE, ZIP COD 86TH ST APOLIS, IN 46260		
OI ININO	WILL WEADOWS		<u>, L</u>	INDIAIN			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a pused for component patient-care-relate (PCREE) assembled by quanthe conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care roother UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the patient cords are recompletion of the patient cords.	ent - Power Cords and ent - Power Cords and patient care vicinity are only nts of movable d electrical equipment			· A life safety Review QA to will be utilized weekly x 4 week monthly x 6 months, and quart thereafter for one year with res reported to the Quality Assurar and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Date of Correction May 19, 2021	erly eults nce t	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/27/2021	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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
TAG	10.2.3.6 (NFPA 9 (NFPA 70), 590.3 Based on observatifailed to ensure 1 or power strips were refixed wiring. LSC comply with Section electrical wiring and NFPA 70, National NFPA 70, National NFPA 70, Article 4 specifically permitted shall not be used as a structure. LSC Secretice equipment of safety shall be designed as a structure with NFPA 99, Standard edition, defines patter of a health care factintended to be exampled intended for the example of the bed, device that support examination and treextends vertically the floor. NFPA 99, Second of the patient care vicinity of the patient care vicinity of floor office appliances grounding conducted be permitted provided the patient care vicinity of Reference of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the patient care vicinity of the	9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility f 1 extension cords including not used as a substitute for 19.5.1 requires utilities to in 9.1. LSC 9.1.2 requires d equipment to comply with Electrical Code, 2011 Edition00.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ection 4.5.7 states any building or safeguard provided for life gned, installed, and approved all applicable NFPA standards. I for Health Care Facilities, 2012 ient care areas as any portion ility wherein patients are nined or treated. Patient care as a space, within a location amination and treatment of 6 ft (1.8 m) beyond the normal chair, table, treadmill, or other as the patient during eatment. A patient care vicinity o 7 ft 6 in. (2.3 m) above the ection 10.4.2.3 states household as not commonly equipped with ors in their power cords shall led they are not located within inity. This deficient practice 0 residents, staff, and visitors	K 0	920		oved n oved n? ould ged or/all n ted o21. or/all n	05/19/2021

FTZX21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/27/2021	
	PROVIDER OR SUPPLIER		2140 \	ADDRESS, CITY, STATE, ZIP COD W 86TH ST NAPOLIS, IN 46260	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	strip on the floor wi bed nearest the corr Room 219. The UL identified with a stic E157293. Based on observations, the Di a power strip was be non-PCREE within a substitute for fixed	viewed with the Executive		will make daily rounds to ensure power cords/extension cords not being used. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? A life safety Review QA will be utilized weekly x 4 weemonthly x 6 months, and qual thereafter for one year with rereported to the Quality Assurand Performance Improveme Committee overseen by the Executive Director. If a threshold of 95% is rachieved, an action plan will be developed to ensure complian Date of Correction May 19, 2021	the tool eks, terly sults ance nt oot
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or eo Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withir space of non- or li construction, with that can be secure				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
155154			B. WING 04/27/2021				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			/ 86TH ST		
SPRING	MILL MEADOWS				IAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROJUDERNA NA ANA ANA ANA ANA ANA ANA ANA ANA A		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	from combustibles	s by 20 feet (5 feet if					
	sprinklered) or en	closed in a cabinet of					
	noncombustible c	onstruction having a					
	minimum 1/2 hr. f	ire protection rating.					
	Less than or equa	al to 300 cubic feet					
	_	compartment, individual					
	_ ·	e for immediate use in					
	l ·	s with an aggregate volume					
	· ·	ual to 300 cubic feet are not					
		red in an enclosure.					
	_ ·	e handled with precautions					
	as specified in 11						
		ign readable from 5 feet is					
	_	ate of a cylinder storage					
		sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
		ey are received from the cylinders are segregated					
		. When facility employs					
		egral pressure gauge, a					
	I -	e considered empty is					
		oty cylinders are marked to					
		Cylinders stored in the open					
	are protected fron	-					
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)						
	. ,	on and interview, the facility	K 09	923	K923 Gas Equipment – Cylin	der	05/19/2021
		inders of nonflammable gases		-	and Container Storage		
		re properly secured from falling			What corrective action(s) wil	I	
	in 1 of 1 oxygen sto	orage and transfilling rooms.			be accomplished for those		
	NFPA 99, Health C	Care Facilities Code, 2012			residents found to have been	n	
		.3.1 states storage for			affected by the deficient		
	_	es equal to or greater than 85			practice?		
		cubic feet) shall comply with			· The E Type oxygen cylin	ders	
		3.3. NFPA 99, Section			were placed in the correct sto	-	
	` ′ *	es cylinders be provided with			stand to secure them from fall	ing.	
		her fastenings to secure all			How will you identify other		
	cylinders from falli	ng, whether connected,			residents having the potentia	al	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155154	B. WING		04/27/2021		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
ODDINO	NAUL NAEA DOVAGO				86TH ST		
SPRING	MILL MEADOWS			INDIAN	APOLIS, IN 46260		
(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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	unconnected, full or	empty. This deficient			to be affected by the same		
	practice could affec	t over 30 residents, staff and			deficient practice and what		
	visitors in the vicini	ty of the second floor oxygen			corrective action will be take	n?	
		ing room near Room 203.			·The resident in room 203 co		
					have been affected by the alle		
	Findings include:				deficient practice.	Ŭ	
					·The Maintenance Superviso	or/all	
	Based on observation	ons with the Director of			staff will be inserviced by the		
	Maintenance during	g a tour of the facility from 1:30			Executive Director/designee o	n l	
	_	n 04/27/20, one of five 'E' type			the regulatory standard indica		
		ere freestanding on the floor			by this requirement by 5/19/20		
		oor oxygen storage and					
		ear Room 203 and were not			What measures will be put in	nto	
		er cylinder stand or otherwise			place or what systemic		
	secured from falling	g. The oxygen storage and			changes you will make to		
	transfilling room ha	d three liquid oxygen			ensure that the deficient		
	containers and five	'E' type oxygen cylinders			practice does not recur?		
	stored in the room.	Based on interview at the time			·The Maintenance Superviso	or/all	
	of the observations,	the Director of Maintenance			staff will be inserviced by the		
	moved the unsuppor	rted cylinder to a supporting			Executive Director/designee o	n	
	rack in the room bu	t agreed the one oxygen			the regulatory standard indica	ted	
	cylinder had not bee	en supported in a cylinder			by this requirement by 5/19/20		
	stand or otherwise s	secured from falling.			The maintenance		
					Supervisor/designee will make	e	
	This finding was re-	viewed with the Executive			daily rounds to ensure the		
	Director during the	exit conference.			freestanding cylinders are in the	he	
					appropriate storage stand.		
	3.1-19(b)						
					How the corrective action(s)		
					will be monitored to ensure t	the	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					 A life safety Review QA t 	iool	
					will be utilized weekly x 4 wee	ks,	
					monthly x 6 months, and quar	terly	
					thereafter for one year with re	sults	
					reported to the Quality Assura	nce	
			1		and Performance Improvemer	nt	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154			(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/27/2021	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID		STATEMENT OF DEFICIENCIE	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Committee overseen by the		
					Executive Director.		
					· If a threshold of 95% is no	ot	
					achieved, an action plan will be	е	
					developed to ensure complian	ce.	
					Date of Correction May 19,		
					2021		
			l				

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