PRINTED:	08/08/2022
FORM AP	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 155154 07/18/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/22 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Emergency Preparedness survey, Spring Mill Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 77. Quality Review completed on 07/21/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: E 0037 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), SS=F 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), Bldg. --483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).

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

TITLE

(X6) DATE

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.

I1BF21 Event ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 07/18/2022 155154 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2140 W 86TH ST SPRING MILL MEADOWS INDIANAPOLIS, IN 46260 (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 *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. I1BF21 Event ID: Facility ID: 000074 Page 2 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155154	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/18/2022
	PROVIDER OR SUPPLI	2140 W 86TH ST			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE COMPLETIO
	preparedness tr (vi) If the emerg and procedures hospice must co updated policies procedures.	ency preparedness policies are significantly updated, the induct training on the			
	program. The P following: (i) Initial training policies and pro existing staff, ind under arrangem consistent with f (ii) After initial tr preparedness tr (iii) Demonstrate emergency proc	RTF must do all of the in emergency preparedness cedures to all new and dividuals providing services ent, and volunteers, heir expected roles. aining, provide emergency aining every 2 years. e staff knowledge of redures.			
	preparedness tr (v) If the emerge and procedures	ency preparedness policies are significantly updated, the duct training on the updated			
	organization mu (i) Initial training policies and pro existing staff, in services under a participants, and their expected re (ii) Provide eme at least every 2	rgency preparedness training years.			
	emergency proc	e staff knowledge of edures, including informing rhat to do, where to go, and			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPL		STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR(DEFICIENCY)	D BE OPRIATE COMPLE	TIO	
TAG	whom to contact (iv) Maintain do (v) If the emerge and procedures PACE must cor- policies and pro- *[For LTC Facili Training Progra of the following: (i) Initial training policies and pro- existing staff, in under arrangem consistent with (ii) Provide emer at least annually (iii) Maintain do preparedness tr (iv) Demonstratt emergency pro- *[For CORFs at CORF must do (i) Provide initia preparedness p new and existin services under a consistent with (ii) Provide emer at least and pro- existing staff, in under arrangem consistent with (ii) Demonstratt emergency pro- *[For CORFs at CORF must do (i) Provide initia preparedness p new and existin services under a consistent with (ii) Provide emer at least every 2	ties at §483.73(d):] (1) m. The LTC facility must do all in emergency preparedness cedures to all new and dividuals providing services lent, and volunteers, their expected role. rgency preparedness training /. cumentation of all emergency aining. e staff knowledge of cedures. §485.68(d):](1) Training. The all of the following: I training in emergency olicies and procedures to all g staff, individuals providing arrangement, and volunteers, their expected roles. rgency preparedness training	TAG	DEFICIENCY)	DATE		
	(iv) Demonstrat emergency prod must be oriente responsibilities emergency plar workday. The tr instruction in the	e staff knowledge of cedures. All new personnel d and assigned specific regarding the CORF's within 2 weeks of their first aining program must include e location and use of alarm ynals and firefighting					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING 155154 B. WING			(X3) DATE SURVEY COMPLETED 07/18/2022		
	PROVIDER OR SUPPLIE MILL MEADOWS	R		2140 W	ADDRESS, CITY, STATE, ZIP CO 7 86TH ST APOLIS, IN 46260	D	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETIO
TAG	equipment. (v) If the emerge and procedures a CORF must conce policies and proce *[For CAHs at §4 program. The CA following: (i) Initial training if policies and proce reporting and ext protection, and w of patients, perso prevention, and co and disaster auth existing staff, ind under arrangement consistent with th (ii) Provide emergency proce (v) If the emerge and procedures a CAH must condu policies and proce *[For CMHCs at a The CMHC must emergency prepa procedures to all individuals provid arrangement, and their expected ro documentation o must demonstrate	85.625(d):] (1) Training H must do all of the n emergency preparedness edures, including prompt inguishing of fires, here necessary, evacuation nnel, and guests, fire cooperation with firefighting orities, to all new and viduals providing services nt, and volunteers, eir expected roles. gency preparedness training ears. umentation of the training. staff knowledge of edures. ency preparedness policies are significantly updated, the ct training on the updated edures. A85.920(d):] (1) Training. provide initial training in aredness policies and new and existing staff, ing services under d volunteers, consistent with es, and maintain i the training. The CMHC e staff knowledge of edures. Thereafter, the		TAG			DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 07/18/2022 155154 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2140 W 86TH ST SPRING MILL MEADOWS INDIANAPOLIS, IN 46260 (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 preparedness training at least every 2 years. Based on record review and interview, the facility E 0037 E037 EP Training Program 08/01/2022 failed to ensure the emergency preparedness What corrective action(s) will training and testing program includes a training be accomplished for those program. The LTC facility must do all of the residents found to have been following: (i) Initial training in emergency affected by the deficient preparedness policies and procedures to all new practice? and existing staff, individuals providing services Attached content of all staff under arrangement, and volunteers, consistent meeting held 7-28-22. with their expected roles; (ii) Provide emergency How will you identify other preparedness training at least annually; (iii) residents having the potential Maintain documentation of the training; (iv) to be affected by the same Demonstrate staff knowledge of emergency deficient practice and what procedures in accordance with 42 CFR 483.73(d) corrective action will be taken? (1). This deficient practice could affect all ·All residents have the potential occupants. to be affected by the alleged deficient practice. Findings include: ·Annual requirements of education are reviewed in QAPI Based on review of "Emergency Preparedness monthly. Policies & Procedures" documentation dated 03/14/22 with the Administrator and the Director What measures will be put into of Maintenance during record review from 9:40 place or what systemic a.m. to 12:20 p.m. on 07/18/22, documentation for changes you will make to staff training on emergency preparedness within ensure that the deficient the most recent twelve month period was not practice does not recur? available for review. Based on interview at the Executive Director/Designee time of record review, the Administrator stated monitors completion of online staff training on emergency preparedness program training and all staff education documentation is tracked in a Relias database on monthly through the QAPI computer but was not able to provide the process. documentation for staff training on the emergency preparedness program within the most recent How the corrective action(s) twelve month period because she had an off-site will be monitored to ensure the appointment and had to leave the building before deficient practice will not the facility was able to provide the Relias training recur, i.e., what quality documentation. assurance program will be put into place? This finding was reviewed with the Director of A life safety Review QA tool will be utilized monthly x 3 Maintenance during the exit conference. I1BF21 Event ID: Facility ID: 000074 Page 6 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	R MEDICARE & MEDI				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIE	ER	2140 V	ADDRESS, CITY, STATE, ZIP COD V 86TH ST VAPOLIS, IN 46260	I	
	1	ACT A TEN JENT OF DEFICIENCIE		1		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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	
				months, and quarterly thereat for one year with results repo to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is achieved, an action plan will the developed to ensure compliant Date of Correction August 2022	not pe nce	
K 0000						
Bldg. 01	Licensure Survey Department of He 483.90(a). Survey Date: 07/1 Facility Number: Provider Number: AIM Number: 10 At this Life Safety Meadows was fou Requirements for Medicare/Medicai Life Safety from F National Fire Prot Life Safety Code (Health Care Occur This two story fac determined to be of fully sprinklered. system with smok	000074 155154 0290050 7 Code survey, Spring Mill nd not in compliance with	K 0000	Please accept State form 256 Plan of Correction, for the and Life Safety Code survey cond on July 18, 2022. The facility respectfully requests that the serve as our letter of credible allegation of compliance. The facility also respectfully requests a desk review in lieu post survey revisit on or after August 1, 2022.	nual lucted 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155154 B. WING 07/18/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2140 W 86TH ST SPRING MILL MEADOWS INDIANAPOLIS. IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 77 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 07/21/22 K 0211 **NFPA 101** SS=E Means of Egress - General Bldg. 01 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility K 0211 K211 Means of Egress General 08/01/2022 failed to maintain the means of egress free from What corrective action(s) will obstructions in 1 of 9 means of egress on the first be accomplished for those floor. LSC 19.2.3.4(4) states, projections into the residents found to have been required width shall be permitted for wheeled affected by the deficient equipment, provided that all of the following practice? conditions are met: The cooler was removed (a) The wheeled equipment does not reduce the immediately from the corridor. clear unobstructed corridor width to less than 60 How will you identify other in. (1525 mm.) residents having the potential (b) The health care occupancy fire safety plan and to be affected by the same training program address the relocation of the deficient practice and what wheeled equipment during a fire or similar corrective action will be taken? emergency. 10 residents and staff and (c) The wheeled equipment is limited to the visitors could be affected by the following: alleged deficient practice.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (x 01	(X3) DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIE	ĒR	2140 V	ADDRESS, CITY, STATE, ZIP COD V 86TH ST		
SPRING	MILL MEADOWS		INDIAN	NAPOLIS, IN 46260		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	 i. Equipment in us ii. Medical emerge iii. Patient lift and This deficient prace residents, staff and facility. Findings include: Based on observat Maintenance durin 12:45 p.m. to 3:10 carts for isolation stored up against to another near the fir resident Room 100 corridor width to 1 foot wide corridor time of the observed Maintenance agree each side of the cocc cart into the nurse This finding was r 	ency equipment not in use transport equipment etice could affect over 10 d visitors if needing to exit the tions with the Director of ng a tour of the facility from 0 p.m. on 07/18/22, two wheeled supplies and a cooler were the corridor wall opposite one rst floor nurse's station by 0 and reduced the unobstructed less than 60 inches for the eight 5. Based on an interview at the ations, the Director of ed wheeled carts were stored on porridor and moved the cooler	TAG	 All staff will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by August 1, 2022. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff will be inserviced by the Executive Director/designee on keeping an 5-foot clearance in the corridors and the regulatory standard indicated by this requirement by August 1, 2022. The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility corridors remain clear of obstructions. 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 to will be utilized daily x 4 weeks, monthly x 6 months, and quarter thereafter for one year with resu reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is no achieved, an action plan will be 	nd e pol rly lts pe	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	· /	ILDING	ONSTRUCTION 01	COM	e survey pleted 8/2022
	PROVIDER OR SUPPLIE MILL MEADOWS	R		2140 V	ADDRESS, CITY, STATE, ZIP COD V 86TH ST VAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY) developed to ensure com	LD BE COPRIATE	(X5) COMPLETION DATE
< 0300 SS=E Bldg. 01	Section 18.3 and requirements tha provided K-tags, information, along Safety Code or N should be include Based on observat failed to replace 3 smoke alarms insta in accordance with Edition, Section 14 recommended by t instructions, single alarms shall be rep to operability tests longer than 10 yea This deficient prace residents, staff and Findings include: Based on observat Maintenance durin 12:45 p.m. to 3:10 documentation affi battery operated sr ceiling in resident floor indicated the 02/07/12. The main stated to replace th the date of manufa	r RKS section any LSC 19.3 Protection t are not addressed by the but are deficient. This g with the applicable Life IFPA standard citation, ed on Form CMS-2567. ion and interview, the facility of over 50 battery operated alled in resident sleeping rooms n NFPA 72. NFPA 72, 2010 4.4.8.1 states unless otherwise he manufacturer's published e- and multiple-station smoke laced when they fail to respond but shall not remain in service rs from the date of manufacture. tice could affect over 20	K 03	300	K300 Protection - other What corrective action(s) be accomplished for tho residents found to have affected by the deficient practice? • The smoke detector room 210 was replaced. • 50 smoke detectors ordered and replaced by 2022. How will you identify oth residents having the pot to be affected by the sam deficient practice and will corrective action will be • 20 residents could affected by the alleged de practice. • The Maintenance Supervisor will be inservio the Executive Director on regulatory standard indica this requirement by Augus 2022.	y will se been r in s were August 1, er ential ne hat taken? be efficient ced by the ated by	08/01/2022

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155154	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 2 01	x3) date survey completed 07/18/2022	
	PROVIDER OR SUPPLIE MILL MEADOWS	R	STREET ADDRESS, CITY, STATE, ZIP COD 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O battery operated sn	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION noke alarm installed on the sleeping Room 210 indicated	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What measures will be put interplace or what systemic	DATE	
	 ceiling in resident sleeping Room 210 indicated the device was manufactured 03/21/11 and to "replace the alarm by year 2021". Manufacturer's documentation affixed to the USI Model 1122L battery operated smoke alarm installed on the ceiling in resident sleeping Room 236 indicated the device was manufactured 12/28/11 and to "replace by 12/28/21". No installation date was recorded on the smoke detectors. Based on interview at the time of the observations, the Director of Maintenance Supervisor agreed the three smoke alarms were each more than ten years old. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b) 		 changes you will make to ensure that the deficient practice does not recur? The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by August 1, 2022 A TELs system prompt was added to the Maintenance Director's preventative management system. A date will be recorded for each battery operated smoke detector effective immediately. 	y		
				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 QA tool will b utilized monthly x 6 months, and quarterly thereafter for one year with results reported to the Qua Assurance and Performance Improvement Committee overse by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Date of Correction August 1, 2022	t be d r lity een ot	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 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 07/18/2022 155154 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2140 W 86TH ST SPRING MILL MEADOWS INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 01 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and K 0353 08/01/2022 K353 Sprinkler system interview; the facility failed to maintain automatic Maintenance and Testing sprinkler systems in accordance with NFPA 25. What corrective action(s) will LSC 9.7.5 requires all sprinkler systems shall be be accomplished for those inspected, tested, and maintained in accordance residents found to have been with NFPA 25, Standard for the Inspection, The inspection contractor Testing, and Maintenance of Water-Based Fire corrected all listed items on Protection Systems. NFPA 25, 2011 Edition, 7-27-22. Section 4.1.4.1 states the property owner or The canopy is not designated representative shall correct or repair combustible as noted from the deficiencies or impairments that are found during inspection letter attached. the inspection, test and maintenance required by How will you identify other this standard. Corrections and repairs shall be residents having the potential performed by qualified maintenance personnel or to be affected by the same a qualified contractor. NFPA 25, 4.3.1 requires deficient practice and what records shall be made for all inspections, tests, corrective action will be taken? and maintenance of the system components and All residents could be shall be made available to the authority having affected by the alleged deficient jurisdiction upon request. This deficient practice practice. Event ID: I1BF21 Facility ID: 000074 Page 12 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION		E SURVEY
ND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER 155154	A. BUILDING B. WING	<u>01</u>	COMPLETED 07/18/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COI	D	
SPRING	MILL MEADOWS) W 86TH ST ANAPOLIS, IN 46260		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX		ULD BE PROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	could affect all res	idents, staff, and visitors in the		The Maintenance		
	facility.			Supervisor will be inserv	iced by	
				the Executive Director or	n the	
	Findings include:			regulatory standard indic	cated by	
				this requirement August	1, 2022.	
	Based on review o	f the sprinkler system				
		tor's "Form for Inspection,		What measures will be	put into	
	-	enance of Wet Pipe Fire		place or what systemic	-	
	-	" documentation dated 04/22/22		changes you will make		
	-	ator and the Director of		ensure that the deficien		
	Maintenance durin	g record review from 9:40 a.m.		practice does not recur	?	
		7/18/22, deficiencies were noted				
	-	rinkler system during the most		• The Maintenance		
		ection for the facility. The		Supervisor will be inserv	iced by	
	-	nary" section of the 04/22/22		the Executive Director/de	-	
	-	stem inspection report stated		regarding follow up/com	•	
		dry need 2-piece ugly skirt; (1)		non compliance issues v		
		(SR) 155 pendant in		contractors within 7 days		
	-	ement needs replaced due to		inspection standard indic		
		SR 155 pendant in Kitchen are		this requirement by Aug	-	
	-	ed; (2) SR 155 pendants are too		2022.	ust 1,	
		chaust hood; Therapy has (6)		· The Maintenance		
		sed escutcheons - concealed		Supervisor/designee will	roviow	
		(1) SR 155 pendant in Therapy		vendor outstanding issue		
	-	placed with semi-recessed		-	-	
		et in Therapy room has no		management meeting wi		
		oms 126 and 128 have missing		How the corrective active will be monitored to en		
	· ·	sed escutcheons in closet; 2nd				
				deficient practice will n	οι	
		4) SR 155 pendants need		recur, i.e., what quality	l ha nut	
	_	rrosion and paint; Front canopy hkler heads installed; they have		assurance program will	i ne hur	
	-	right now; (1) SR 155 pendant		into place?	W OA tool	
		or by DON Office". Based on		• A life safety Revie		
		ne of record review, the		will be utilized daily x 4 v		
		ed the inspection contractor		monthly x 6 months, and		
		the corrections on or after		thereafter for one year w		
				reported to the Quality A		
		id not know if all repairs had		and Performance Improv		
	-	reed repair documentation on or		Committee overseen by	une	
		not available for review at the		Executive Director.	-0/:- /	
	time of the survey.	Based on observations with		 If a threshold of 95 	5% is not	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155154	B. WING	<u></u>		18/2022
NAME OF	PROVIDER OR SUPPLIE	ER		f address, city, state, zip co W 86TH ST	D	
SPRING	MILL MEADOWS			NAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	Ϋ́,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE PROPRIATE	COMPLETION DATE
		untenance during a tour of the		achieved, an action plar	n will be	
	facility from 12:45	5 p.m. to 3:10 p.m. on 07/18/22, the		developed to ensure cor		
		e building at the main entrance		Date of Correction Au	ugust 1,	
		e building and had no		2022		
	-	d on the underside of the				
	was of combustibl	not be determined if the canopy e construction.				
	This finding was r	eviewed with the Director of				
	-	ng the exit conference.				
	3.1-19(b)					
K 0374	NFPA 101					
SS=E		uilding Spaces - Smoke				
Bldg. 01	Barrie	vilding Changes Cracks				
	Barrier Doors	uilding Spaces - Smoke				
	2012 EXISTING					
		parriers are 1-3/4-inch thick				
		od-core doors or of				
	construction that	resists fire for 20 minutes.				
	Nonrated protect	ive plates of unlimited height				
		pors are permitted to have				
		assemblies per 8.5. Doors				
	-	or automatic-closing, do not				
		and are not required to swing f egress travel. Door opening				
		num clear width of 32 inches				
	for swinging or h					
	19.3.7.6, 19.3.7.8					
		ion and interview, the facility	K 0374	K374 Smoke Barrier –		08/01/2022
	failed to ensure 1	of 5 sets of smoke barrier doors		subdivision of spaces		
		r would restrict the movement		What corrective action		
		ast 20 minutes. LSC, Section		be accomplished for th		
		hat doors in smoke barriers shall		residents found to have		
		Section 8.5.4. LSC, Section		affected by the deficier	nt	
	-	oors in smoke barriers to close g only the minimum clearance		practice? • The smoke barrie	r door	
		er operation which is defined		near room 223 on secor		
	increasing for prop	er operation which is defined				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	A. BUILDING <u>01</u> COM B. WING 07/		COMI	date survey completed)7/18/2022	
	PROVIDER OR SUPPLIE	R	2140	T ADDRESS, CITY, STATE, ZIP W 86TH ST ANAPOLIS, IN 46260	COD		
SPRING				ANAFOLIS, IN 40200			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	This deficient prace residents, staff and Findings include: Based on observat Maintenance durin 12:45 p.m. to 3:10 smoke barrier door 223 on the second leaving a gap of gr meeting edges of t door set swings in meeting edges of t door set to not full multiple times and edges of the doors time of the observa Maintenance agree door set would not smoke. This finding was r	ict the movement of smoke. tice could affect over 20 visitors on the second floor.		 was repaired to close How will you identify residents having the to be affected by the deficient practice an corrective action will The alleged deficient could affect 20 reside visitors. The Maintenance S will be inserviced on the standard indicated by requirement by August What measures will the place or what system changes you will materiate does not reactive does not not not not not not not not not not	y other e potential e same d what I be taken? ent practice ents, staff and Supervisor the regulatory this st 1, 2022. be put into nic ke to cient cur? Supervisor the regulatory this st 1, 2022. ervisor the regulatory this st 1, 2022. ervisor the security this st 1, 2022. ervisor ve a TELs es testing fire completion to y QAPI		
				deficient practice will recur, i.e., what qual assurance program into place? A life safety QA utilized monthly x 6 m quarterly thereafter for	II not ity will be put A tool will be nonths, and		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, í	ULTIPLE CO JILDING	ONSTRUCTION	. ,	TE SURVEY	
AND PLAN	OF CORRECTION	155154	B. WI		01		OMPLETED 7/18/2022	
	PROVIDER OR SUPPLIE	R	•	2140 W	ADDRESS, CITY, STATE, ZIP COE V 86TH ST JAPOLIS, IN 46260)		
(X4) ID		STATEMENT OF DEFICIENCIE					(X5)	
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE	
< 0511	NFPA 101				with results reported to the Assurance and Performan Improvement Committee by the Executive Director If a threshold of 95 achieved, an action plan developed to ensure com Date of Correction Auto 2022	nce overseen 5% is not will be 1pliance		
SS=E Bldg. 01	Utilities - Gas and Utilities - Gas and Equipment using complies with NF Code, electrical w complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.7 1. Based on observ failed to ensure ele was maintained in 19.5.1.1 requires u LSC 9.1.2 requires to comply with NF NFPA 70, 2011 Ec or conduit body sh point unless otherv through (I). Articl conduit bodies use shall comply with deficient practice of	l Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life.	К 0.	511	K511 Utilities – Gas and What corrective action(s be accomplished for the residents found to have affected by the deficient practice? 1 - Facility wiring w repaired near room 121 of floor to meet this requirer 2 – Electrical outle repaired near room 210 a to meet the stated require the second floor. How will you identify off residents having the po to be affected by the same	s) will ose been t vas on the first ment. ts were as needed ement on her tential	08/01/2022	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		155154				07/18/	
		100101	2			01/10/	2022
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
	MILL MEADOWS				/ 86TH ST		
SPRING				INDIAN	IAPOLIS, IN 46260		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	p.m. on 07/18/22, exposed			have the potential to be affected		
	-	vas noted in an open ended			by the alleged deficient practic		
		s above the suspended ceiling			·2 residents staff and visitors		
		wall by Room 121 and were not			near room 210 on the second		
	contained within a			have the potential to be affected	ed y		
	Based on interview			the alleged deficient practice.			
		Director of Maintenance agreed					
	the exposed electric			What measures will be put in	to		
	within a junction b	box or conduit body.			place or what systemic		
					changes you will make to		
	•	eviewed with the Director of			ensure that the deficient		
	Maintenance durir	ng the exit conference.			practice does not recur?		
	2 1 1 0 ()				•The Maintenance Supervise		
	3.1-19(b)				will be inserviced by the Execu	itive	
					Director/designee on the		
		vation and interview, the facility			regulatory standard indicated I	зу	
		ectrical receptacles in 1 of over			this requirement by August 1,		
	25 resident sleepin			2022.			
	were properly wire			·Maintenance Supervisor			
	with NFPA 70. LS			completes preventative			
	comply with Section			maintenance tasks via TELs			
	electrical wiring an			system which includes checking	-		
		al Electrical Code. NFPA 70, 16.4 General Installation			electrical wiring and outlets, an	nd	
					submits completion to the ED		
		es receptacle outlets shall be circuits in accordance with Part			during monthly QAPI meeting		
	III of Article 210. General installation requirements shall be in accordance with 406.4(A)				How the corrective action(s)	ha	
	through (F).			will be monitored to ensure t	ne		
		pe. Receptacles installed on 15-			deficient practice will not		
		anch circuits shall be of the			recur, i.e., what quality assurance program will be p		
	grounding type.	men encurts shan be of the			into place?	ut	
		ceptacles shall be installed only				tool	
	0.11	voltage class and current for			A life safety Review QA will be utilized monthly x 6	1001	
		ed, except as provided in Table			months, and quarterly thereaft	or	
		Table 210.21(B)(3).			for one year with results report		
	Exception: Nongro			to the Quality Assurance and	eu		
	installed in accord			Performance Improvement			
	(B) To Be Ground			Committee overseen by the			
	connectors that ha			Executive Director.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **I1BF21** Facility ID: **000074**

If continuation sheet Page 17 of 19

STATEME	FERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155154			(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			OMB NO. 0938-03 [X3] DATE SURVEY COMPLETED 07/18/2022	
	PROVIDER OR SUPPLIER		2	140 W	ddress, city, state, zip cod 86TH ST APOLIS, IN 46260			
SPRING (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR conductor contacts is connected to an equ Exception No. 1: Re and vehicle-mounted with 250.34. Exception No. 2: Re permitted by 406.4((C) Methods of Group grounding conductor cord connectors shat to the equipment gr circuit supplying the The branch-circuit to provide an equipment which the equipment contacts of the recept connected. Informational Note acceptable grounding Informational Note existing branch circuit This deficient pract and staff in resident Findings include: Based on observation Maintenance during 12:45 p.m. to 3:10 p electrical receptacted box at the foot of the door in resident Roce have an "open group"	unding. The equipment or contacts of receptacles and ll be grounded by connection ounding conductor of the e receptacle or cord connector. wiring method shall include or nt grounding conductor to at grounding conductor ptacle or cord connector are No. 1: See 250.118 for ng means. No. 2: For extensions of	IN II PRE	IDIAN/		^{D BE} OPRIATE % is not vill be pliance.	(X5) COMPLETIO DATE	
	the testing device sl electrical receptacle	rector of Maintenance agreed nowed the aforementioned						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC.	AID SERVICES					OMB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154	, í	JILDING	01	X3) DATE SURVEY COMPLETED 07/18/2022		
	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	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ED BY FULL PREFIX CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR(DEFICIENCY)) BE	(X5) COMPLETION DATE	
	Maintenance during 3.1-19(b)	the exit conference.						

FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID:	I1BF21	Facility ID:	000074	If continuation sheet	Page 19 of 19
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