STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING -- B. WING	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/26/23 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Emergency Preparedness survey, Spring Mill Meadows was found 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 81. Quality Review completed on 07/31/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/26/23 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Life Safety Code survey, Spring Mill Meadows was found not in compliance with	K 0000	Please accept State Form 2567 Plan of Correction for the Annual Life Safety Survey that was conducted on July 26, 2023. I also ask that the 2567 serve as our letter of credible allegation of compliance. The facility respectfully requests a desk review in lieu of a post survey revisit on or after August 18, 2023. Thank you for your consideration of this request.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia Marker-Kump	Executive Director	08/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 partial 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 81 at the time of this survey. 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 07/31/23			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			
	Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in	K 0345	**K345** It is the policy of this facility to ensure the fire alarm system has an accurate time.	08/18/2023

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	accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation of the fire alarm control panel on 07/26/23 at 12:00 p.m. during a tour of the facility with the Maintenance Director, the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the correct date, but the time displayed was 12:18 p.m. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed time updated on the fire alarm control panel as soon as he could. This finding was reviewed with the facility Administrator and the Maintenance Director during the exit conference on 07/26/23 at 2:25 p.m. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The fire alarm system time was corrected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents at the facility have the potential to be affected by this alleged deficient practice. · The time was corrected on the fire panel by Integrated Electronics on 8-11-23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Director/designee will monitor the day/time on the fire panel daily Mon- Fri on morning rounds. · The management team will be educated on the facility fire alarm panel to ensure the day/time is accurate by the ED by 8-18-23. **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**	

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			into place? · Weekly LSC QA tool will be utilized weekly x 4 weeks, monthly thereafter for 6 months with results reported to the Quality Assurance 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**: 8-18-23	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler	K 0351	**K351** It is the policy of this facility to ensure that spray patterns for	08/18/2023

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	heads were not obstructed in 1 of 1 kitchen office in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect as many as 4 staff. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 07/26/23 at 12:10 p.m., the Kitchen office had a ceiling fan installed in it. The blades of the ceiling fan came within eight inches of the sprinkler head located in the office and would obstruct the spray pattern of the sprinkler head if it were to open in the event of a fire. Based on an interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition, and gave the listed measurement, and stated that he would take down the fan as soon as he could. This finding was reviewed with the facility Administrator and the Maintenance Director during the exit conference on 07/26/23 at 2:25 p.m. 3.1-19(b)		sprinkler heads are not obstructed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The ceiling fan was removed from the kitchen office ceiling on 8-4-23. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents at the facility have the potential to be effected by the alleged deficient practice. · The maintenance director will be educated by 8-18-23 regarding sprinkler obstructions by the ED. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The maintenance director will be educated by 8-18-23 regarding sprinkler obstructions by the ED. · The facility TELs system was updated with this requirement to be checked monthly. **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?** · Annual LSC QA tool will be	

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			utilized weekly x 4, and monthly thereafter for 6 months with results reported to the Quality Assurance 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**: 8-18-23	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 27 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect as many as 6 staff in the basement. Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 07/26/23 at 1:27 p.m., the portable fire extinguisher located in the basement nearest to the Maintenance office was mounted on the wall with the top of the extinguisher five feet four inches above the floor. Based on interview at the	K 0355	**K355** It is the policy of this facility to ensure portable fire extinguishers are install in accordance with NFPA 10. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The fire extinguisher located in the basement was lowered on 8-4-23. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents in the facility have the potential to be affected by this	08/18/2023

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	time of observation, the Maintenance Director agreed that the portable fire extinguisher was mounted too high and gave the aforementioned measurement. He also added that he would have the extinguisher lowered as soon as he was able to do so. This finding was reviewed with the facility Administrator and the Maintenance Director during the exit conference on 07/26/23 at 2:25 p.m. 3.1-19(b)		alleged deficient practice. · The maintenance director will be educated by 8-18-23 regarding portable fire extinguisher placement by the ED. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The maintenance director will be educated by 8-18-23 regarding portable fire extinguisher placement by the ED. · The facility TELs system was updated with this requirement to be checked monthly. **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?** · Annual LSC QA tool will be utilized weekly x 4 weeks, monthly thereafter for 6 months with results reported to the Quality Assurance 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**: 8-18-23	