STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING -- B. WING	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

(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: 03/21/23 Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250 At this Emergency Preparedness survey, Homewood Health Campus was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. At the time of the survey, the census was 55. Quality Reveiw completed on 03/23/23	E 0000	Homewood Health campus POC due 04-06-2023 Date of Compliance 04-01-2023. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth 0n the statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during survey visit with exit on March 21. 2023.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Snyder	ED	04/18/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING -- B. WING	03/21/2023

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0004	E004- The Executive Director has updated the Emergency	03/24/2023

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	155680	A. BUILDING -- B. WING	03/21/2023

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	Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 10:45 a.m. and 12:45 p.m., the EOP lacked a current annual update. The most recent updates were 01/1/22 and 12/3/20. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference.		Operations plan and is addressing the annual update to EP plan. The Executive Director was educated by Facilities Management Support on E004- Annual Update to the EOP. The Executive Director will audit the Emergency Operation plan 1x per month x 12 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	155680	A. BUILDING -- B. WING	03/21/2023

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 10:45 a.m. and 12:45 p.m., the EOP lacked documentation indicating the EOP Policies and Procedures were updated within the last year. The most recent updates were 01/1/22 and 12/3/20. During the survey no documentation was provided indicating the EOP Policies and Procedures were updated within the last year. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference.	E 0013	E013- The Executive Director has updated the Emergency Operations Plan to address annual update and lack of documentation. The Executive Director was educated by Facilities Management Support on E013. Policies and Procedures for EPP. The Executive Director will audit EOP 1 times per month times 12 months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.	03/24/2023
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c),			

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	491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 10:45 a.m. and 12:45 p.m., the EOP lacked documentation indicating the EOP Communication Plan was updated within the last year. The most recent updates were 01/1/22 and 12/3/20. During the survey no documentation was provided indicating the EOP Communication Plan was updated within the last year. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference.	E 0029	E029- The Director of Plant Operations updated the Emergency Preparedness communication plan that included the names and contact information for staff, entities providing services under arrangement, patients, physicians, and volunteers. The Executive Director was educated by Facilities Management Support on E029. LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed an updated at least annually. The Executive Director will audit Emergency Preparedness Communication 1 time every 3 months for 12 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue	03/24/2023

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			until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop			

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	155680	A. BUILDING -- B. WING	03/21/2023

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	and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility	E 0036	E036-The Executive Director has	03/24/2023

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	failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 10:45 a.m. and 12:45 p.m., the EOP lacked documentation indicating the EOP Training and Testing Plan was updated within the last year. The most recent updates were 01/1/22 and 12/3/20. During the survey no documentation was provided indicating the EOP Training and Testing Plan was updated within the last year. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference.		updated the Training and Testing plan for EOP located at the Nurse station. The Executive Director was educated by Facilities Management Support on E036 Develop EP plan, review, and update annually to include Training and Testing (483.73(d). The facility must develop and maintain and emergency preparedness plan that must be reviewed and updated at least annually. The Executive Director will audit the emergency preparedness training and testing 1 times per month times 12 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	
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: 03/21/23 Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250	K 0000	Homewood Health campus POC due 04-06-2023 Date of Compliance 04-01-2023. Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth 0n the statement of Deficiencies. The plan of correction is prepared and executed solely because it is	

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	At this Life Safety Code survey, Homewood Health Campus was found not in compliance with Requirements for Participation in Medicare, 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) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The one-story facility was determined to be of Type V (111) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, all areas open to the corridor and has hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 68 and had a census of 55 at the time of this survey. All areas where residents have customary access were sprinklered all areas providing facility services were sprinklered. Quality Review completed on 03/23/23		required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during survey visit with exit on March 21. 2023.	
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 maintain latching hardware on 3 of 3 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient	K 0100	K100- General Requirements-other CFR(S) NFPA 101 Compliance date 03-24-23 Immediate Intervention The DPO (The Director of Plant Operations) Adjusted the speed	03/24/2023

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	practice could affect staff and at least 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the following sets of smoke barrier doors was provided with latching hardware but failed to latch when tested. A) The double door set leading from the 300 Hall into the service hall. B) The double door set near Resident Room 103. C) The double doors near the conference room. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the floor, walls, ceiling, and dryers in the room behind the dryers in the laundry area were substantially covered with dryer lint. Additionally, cardboard		on the door. So that the door's in question closes and latches properly. The DPO (Director of Plant Operations) clean lint out of dryer area and will continue to monitor 2x per week. Director of Plant Operations or designee will monitor smoke barrier doors in facility for proper closure and latching 5xs/week during rounds. Director of Plant Operations will bring monitoring to QAPI monthly x's 3 months. The Director of Plant Operations was educated by the Executive Director on smoke barrier doors. The DPO (Director of Plant Operations) will monitor dryer area 2x per week. The Director of Plant operations was educated by the Executive Director on the importance of a lint free dryer area.	

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	boxes and other combustible material were being stored in this location behind the dryers. Based on interview at the time of observation, the Director of Plant Operations agreed there was a substantial amount of dryer lint within the room behind the dryers and the area was populated with cardboard boxes. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623			

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	155680	A. BUILDING 01 B. WING	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

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	Based on observation and interview, the facility failed to ensure 1 of over 4 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the door leading from the dining area into the kitchen which is part of the Fire Wall assembly separating the AL and Skilled nursing sections of the facility failed to self-close and latch. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0131	K131- Multiple Occupancies CFR(S) NFPA 101. Compliance date 03-24-23 Immediate Intervention The DPO (Director of Plant Operations) replaced bad hinges on doors. Leveling the door so that it closes and latches properly. Director of Plant Operations or designee will monitor doors in facility for proper closure 5xs/week during rounds. Director of Plant Operations will bring monitoring to QAPI monthly x's 3 months. The Director of Plant Operations was educated by the Executive Director on corridor-doors.	03/24/2023
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 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.			

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	18.2.1, 19.2.1, 7.1.10.1 1. Based on observation and interview, the facility failed to ensure 2 of over 6 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 25 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the exits from (1) the service hall to the parking lot and (2) the 300 Hall exit to the parking lot were obstructed with a large dumpster, a shipping container, stacks of bricks, sand, a port-a-potty and other construction materials. The facility is adding an addition to their Assisted Living and the Director of Plant Operations and Facilities Support Representative stated that they simply didn't think about exit obstructions in that location when staging the site. Each of the two paths of egress was marked as a facility exit with exit signage. Based on interview at the time of the observations, the Director of Plant Operations and Facilities Support Representative agreed the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference.	K 0211	K211- Egress Door's CFR(s) NFPA 101 Compliance date 03-24-23 Immediate Intervention The DPO (Director Of Plant Operations) Removed all obstructions out of hall and will continue to monitor daily. The DPO (Director of Plant Operations) instructed the construction company to move the dumpsters and shipping containers from 300 hall exit to the parking lot. The Director of Plant Operations was educated by the Executive Director on K211- Means of Egress The Director of Plant Operations will audit all hallway corridors for obstructions impending the path of egress 1 x per week x's 6 weeks. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	03/24/2023

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	2. Based on observation and interview, the facility failed to ensure 2 of 8 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 15 residents in the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., in the corridor near Resident Rooms 107-110 there were 10 wheelchairs, near RR 310 there were 2 electric motorized scooters, a Hoyer lift and a metal weight chair all being stored in the respective corridor. The Director of Plant Operations stated that the 10 wheelchairs were being stored in the corridor because the residents had supplied their own chairs (reclining chairs) and that the addition of the resident supplied chairs didn't leave room for the wheelchairs in the resident rooms. The Director of Plant Operations			

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	stated that there wasn't space in the rooms for the motorized scooters. It was unclear to this surveyor whether all the aforementioned wheelchairs (10) or the 2 motorized scooters would be needed to transport residents in the event of an emergency. It did not appear the wheelchairs were regularly (daily) being used by the residents. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

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	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 1 of over 5 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 10 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the double door exit from the service hall leading to the generator, was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. The Director of Plant Operations stated that he believed the door had been recently replaced and that the signage had not been reinstalled. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0222	K222 Egress Door's CFR(s) NFPA 101 Compliance date 03-24-23 Immediate Intervention The DPO (Director Of Plant Operations) Added 15 second Egress signage to service hall door. The Director of Plant Operations added signage indicating that the exit door located in service hall leading out to generator could be opened in 15 seconds by pushing on door. The Director of Plant Operations was educated by the Executive Director on K22, Means of Egress, LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 in stroke width on contrasting background that read as follows shall be located on the door leaf adjacent to the release device in the direction of egress. "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS" The Director of Plant Operations will audit the deficient door on the service hall for appropriate signage 1x per week x 6 weeks x 2 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines	03/24/2023

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			substantial compliance has been achieved. This deficient practice had the potential to affect 10 staff.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice could affect 7 kitchen staff.	K 0324	Immediate Intervention: The Director of Plant Operations contacted North Mechanical to re-arrange the steamer and the deep fat fryer, providing fire suppression cover to deep fat fryer. The Director of Plant Operations and Director of Food Services was educated by the Executive Director on NFPA 101, Cooking	03/24/2023

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	Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., a deep fat fryer in use was not completely positioned under the hood so that the appliance had coverage by the suppression system. Based on interview at the time of observation, the Director of Plant Operations stated the fryer was not placed back under the hood properly and it appeared the appliances had been shifted on the floor. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)		Facilities. The kitchen hood exhaust system provides complete coverage for equipment that produces grease-laden vapors. The Director of Plant operations will audit the deep fat fryer for proper alignment to the kitchen hood exhaust system, providing coverage from the fire suppression system. Results of this audit will be presented by the Executive Director to the QAPI Committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 7 kitchen staff.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 _____			

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	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 observation and interview, the facility failed to ensure sprinkler heads in the kitchen area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 7 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the sprinkler heads in the kitchen area were covered in dust or showed signs of loading. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0353	K353 Sprinkler System-Maintenance and testing CFR(s) NFPA101 Compliance date 03-24-23 Immediate Intervention The DPO (Director Of Plant Operations) Has contacted Safe Care to have deficient sprinkler heads replaced in the kitchen. The Director of Plant Operations has contacted the contractor to replace the deficient sprinkler heads in the kitchen. The Director of Plant Operations was educated by Executive Director on K353 Sprinkler System.-Maintenance and Testing Automatic sprinkler system and standpipe systems are inspected, tested and maintained in accordance with NFPA 25. The Director of Plant Operations will audit sprinkler system 1 x per week x 4 weeks x 1 month. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect 7 staff.	03/24/2023
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m., the corridor door to the sprinkler riser room failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Director of Plant Operations agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0363	K363 Corridor Door's CFR(s) NFPA 101 Compliance date 03-24-23 Immediate Intervention The DPO (Director of Plant Operations) changed out the battery and strike plate to door. Fixing the latching issue. The Director of Plant Operations was educated by the Executive Director on K363, 18.3.6.3. there is no impediment to the closing doors. The Director of Plant Operations will audit corridor door to sprinkler riser room 1 x per week x 4 weeks x 1 month. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	03/24/2023
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded			

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HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN 46052

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	announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 10:45 a.m. and 12:45 p.m., 9 of 13 fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted on unexpected days. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0712	K712 Fire Drills CFR(s) NFPA 101 Compliance date 03-24-23 Immediate Intervention The DPO (Director of Plant Operations) was educated by Facilities management support/ED and will audit 1x per month. The Director of Plant Operations was educated by the Executive Director on K712, Fire Drills 101. Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Executive Director will audit/review each fire drill with the Director of Plant Operations 1 x month x 3 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all residents and staff.	03/24/2023
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING 01 B. WING	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 3 residents and 3 staff in the business office. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Support Representative on 03/21/23 between 12:45 p.m. and 3:00 p.m. in the Business Office a power strip was plugged	K 0920	K920 Electrical Equipment- Power cords and Extens Compliance date 03-24-23 Immediate Intervention The DPO (Director of Plant Operations) removed all power cords and will round rooms/offices 3x per week to ensure there's no power strips or extension cords. Corrective Action: The Director of Plant Operations immediately removed power strip from business office. The Director of Plant Operations or designee will round all offices weekly x 3 months to ensure compliance or until 100% compliance is maintained.. Results of this audit will be presented by the Executive	03/24/2023

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	into and supplied power by another power strip. This finding was acknowledged by the Director of Plant Operations and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)		Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	