STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING -- B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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: 10/28/24 Facility Number: 013005 Provider Number: 155816 AIM Number: 201256400 At this Emergency Preparedness survey, Arlington Place Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 84 certified beds. At the time of the survey, the census was 56. Quality Review completed on 10/30/24	E 0000	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 on 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 the **Life Safety Emergency Preparedness survey** visit with exit on October 28th 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 11 2024.	
K 0000 Bldg. 01	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/28/24 Facility Number: 013005 Provider Number: 155816 AIM Number: 201256400 At this Life Safety Code Survey, Arlington Place	K 0000	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 on 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Dent	HFS	11/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	Health Campus was found not in compliance with Requirements for Participation 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 one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 84 and had a census of 56 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/30/24		noncompliance cited during the **Life Safety Emergency Preparedness survey** visit with exit on October 28th 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 11 2024.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors. Findings include:	K 0222	**K 222 - Egress Doors NFPA 101** **Immediate Intervention** A - The Director of Plant Operations has placed the proper signage of No Exit and placed the exit code for the two doors in the assisted living area to satisfy the deficiency that could affect 10 residents, staff and visitors. B – The Director of Plant Operation placed the exit code for the front main building door to allow after hour access this deficiency could affect 10	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	Based on observations with the Facilities Management Support and the Assistant Director of Plant Operations during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 10/28/24, three of eleven exit door locations in the facility were each marked as a facility exit with an exit sign. The three exit doors were magnetically locked and could be unlocked by entering a code at a keypad by the door but the code to release the door to open was not posted at the keypad. One of the three exit door locations is the main entrance to the facility which consisted of a set of two doors which were unlocked during the survey. Based on an interview at the time of the observations, the Assistant Director of Operations stated the exit door set is unlocked during the day but is locked daily after 8:00 p.m. The other two exit door locations were in the main entrance lobby smoke compartment by the conference room near the assisted living dining room. The two exit doors were locked, and the code was not posted to release the exit doors to open. Based on interview at the time of the observations, the Assistant Director of Plant Operations stated the facility does not have a dedicated wing or area for residents which require specialized security measures such as Alzheimer's or dementia and agreed the aforementioned exit door locations did not have the keypad code posted to release the doors to open when locked. These findings were reviewed with the Facilities Management Support during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1,		residents, staff and visitors. C – The Director of Plant Operations adjusted the delayed egress trigger to allow the door to activate upon pressure of door within 15 seconds to satisfy the deficiency that could affect 10 residents, staff and visitors. **Compliance Date** **11/11/2024** The Director of Plant Operations and maintenance staff has been educated by Regional Support on maintaining the posting of the code on doors. Doors within 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 otherwise permitted in accordance with 19.2.2.2.5.2 **Exhibit A – Inservice** The Director of Plant Operations will perform a monthly check using TELS management system. Results of these reviews 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Facilities Management Support and the Assistant Director of Plant Operations during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 10/28/24, the exit door to the outside of the facility in the main entrance lobby by the conference room nearest the assisted living dining room was marked as a facility exit with an exit sign. The exit door was also marked with delayed egress signage but the door did not release to open when pushed for 15 seconds multiple times. Based on interview at the time of the observations, the Facilities Management Support agreed the exit door did not release to open when pushed for 15 seconds multiple times. These findings were reviewed with the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all	K 0291	**K291- Emergency lighting** **Immediate Intervention** The Director of Plant Operations replaced the failed battery backup light fixture located in the electrical room facing the ATS for the building. This deficiency could affect all residents, staff and visitors.	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	residents, staff and visitors. Findings include: Based on observations with the Facilities Management Support and the Assistant Director of Plant Operations during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 10/28/24, the battery operated lighting system installed inside the electrical room housing the facility's emergency generator automatic transfer switches failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Facilities Management Support agreed the battery operated lighting system failed to illuminate when tested multiple times. These findings were reviewed with the Field Management Support during the exit conference. 3.1-19(b)		**Compliance Date** **11-11-2024** The Director of Plant Operations was educated by Regional Support on NFPA 101 Emergency Lighting. Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting system is battery powered. The emergency lighting equipment shall be fully operational for the tests required by LSC Section 7.9.2.6, 7.9.18.2.9.1, 19.2.9.1. Written records of visual inspections and tests shall be kept for inspection by the AHJ. **Exhibit A - Inservice** The Director of Plant Operations will inspect the facility 1 x per month x 3 months for the deficient emergency lighting. **Exhibit B – Audit tool** The results of these inspections 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 07/25/24 with the Facilities Management Support during record review from 10:20 a.m. to 12:55 p.m. on 10/28/24, semi-annual fire alarm system inspection documentation six months prior to 07/25/24 was not available for review. Based on interview at the time of record review, the Facilities Management Support agreed semi-annual fire alarm system inspection documentation six months prior to 07/25/24 was not available for review. These findings were reviewed with the Facilities	K 0345	**K345 – Fire Alarm System – Test and Maintenance** **Immediate Intervention** The Director of Plant Operations was counselled on the importance of maintaining records to satisfy this deficiency could affect all residents, staff and visitors. **Compliance Date** **11/11/2024** The Director of Plant Operations was educated by Regional Support on NFPA 101, 2012 edition, NFPA 70, NFPA 72 9.6.1.3, 9.6.1.5 and the National Fire Alarm Code as required by LSC section 19.3.4.5.1 **Exhibit A – Inservice** The Director of Plant Operations will verify that semi-annual visual inspection is completed in a timely manner. 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.	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	Management Support during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Facilities Management Support during record review from 10:20 a.m. to 12:55 p.m. on 10/28/24, third shift fire drills conducted within the most recent twelve month period on 03/29/24, 05/12/24 and 09/22/24 period were conducted at, respectively, 1:00 a.m., 1:00 a.m. and 1:30 a.m. Based on interview at the time of record review, the Facilities Management Support stated the facility operates three shifts per day, additional third shift fire drill documentation was not available for review and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Facilities Management Support during the exit conference.	K 0712	**K712- Fire Drills** **Immediate Intervention** The Director of Plant Operations was counselled on properly conducted fire drills on varied times and dates to this deficiency could affect all residents, staff and visitors. **Compliance Date** **11/11/2024** The Director of Plant Operations was educated by Regional Support on NFPA 101 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. **Exhibit A - Inservice**	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	3.1-19(b)		The Director of Plant Operations will inspect drills 1 x per month x 3 months for proper varying timing of fire drills. The results of these inspections 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.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 2 of 2 oxygen transfilling locations was provided with a precautionary sign indicating that transfilling is occurring. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states the transfilling of liquid oxygen area shall be posted with a sign indicating that transfilling is occurring. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the facility's two oxygen storage and transfilling rooms. Findings include: Based on observations with the Facilities Management Support and the Assistant Director of Plant Operations during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 10/28/24, the oxygen storage/transfilling room by the north nurse's	K 0927	**K 927 Gas Equipment – Transfilling Cylinders** **Immediate Intervention** Signage that was missing indicating transfilling is currently occurring and area in use or open was ordered and will be installed once it arrives to the campus to prevent the practice that could affect 10 residents in one smoke compartment to meet deficiency K 927.	11/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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
	station and the oxygen storage/transfilling room by the east nurse's station were both not provided with signage indicating that transfilling is occurring. Four liquid oxygen containers and 19 'E' type oxygen cylinders were observed stored in the transfilling room by the north nurse's station. Four liquid oxygen containers and 13 'E' type oxygen cylinders were observed stored in the transfilling room by the east nurse's station. Transfilling signage was also not stored inside the rooms which could be moved to the corridor side of the door when transfilling occurs. Based on interview at the time of the observations, the Assistant Director of Plant Operations stated oxygen transfilling occurs in the rooms and agreed the oxygen storage/transfilling rooms were not provided with signage indicating that transfilling is occurring. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**Compliance Date** **11/11/2024** The Director of Plant Operations was educated by Regional Support on K 927 Gas Equipment – Transfilling Cylinders in accordance with CGA P2.5, Transfilling to liquid oxygen containers or to portable containers over 50 PSI in compliance under 11.5.2.3.1 (NFPA 99), 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99). **Exhibit A – Inservice** The Director of plant Operations will visually inspect signage of Hazardous areas to ensure appropriate indicators are present. This will be completed weekly x3 months then monthly thereafter. **Exhibit C – Audit tool** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 01 B. WING	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(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