	R MEDICARE & MEDIC				OMB NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155823	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X	 (3) DATE SURVEY COMPLETED 12/07/2021
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
	POINTE HEALTHC			VAR ADMIRAL DRIVE NAPOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
E 0000					
Bldg					
	An Emergency Pre	paredness Survey was	E 0000		
	conducted by the In	ndiana Department of Health			
	in accordance with	42 CFR 483.73.			
	Survey Date: 12/0	7/21			
	Facility Number:	013126			
	Provider Number:				
	AIM Number: 201				
	At this Emergency	Preparedness survey,			
		ncare Center was found in			
	-	mergency Preparedness			
	Requirements for M	Medicare and Medicaid			
	Participating Provi	ders and Suppliers, 42 CFR			
	483.73.				
	The facility has 10	0 certified beds. At the time			
	of the survey, the c	ensus was 99.			
	Quality Review co	mpleted on 12/09/21			
K 0000					
Bldg. 01					
-	A Life Safety Code	e Certification and State	K 0000	Preparation or execution of this	
		was conducted by the Indiana		plan of correction does not	
	Department of Hea	lth in accordance with 42		constitute admission or agreeme	
	CFR 483.90(a).			of the provider of the truth of the	
	Survey Data: 12/0	7/21		facts alleged or conclusions set forth on this statement of	
	Survey Date: 12/0	// 21		deficiencies. The plan of	
	Facility Number:	013126		correction is prepared and	
	Provider Number:	155823		executed solely because it's	
	AIM Number: 201	256070		required by the position of feder	al
				and state law. The plan of	
	At this Life Safety	Code survey, Southpointe		correction is submitted in order	to
	1	NIDER/SUPPLIER REPRESENTATIVE'S SI		TITI F	(X6) DATE

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

TITLE

(X6) DATE

PRINTED: 12/21/2021

FORM APPROVED

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	construction <u>01</u>	COM	E SURVEY PLETED
		155823	B. WING		12/07/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	2	
SOUTH	POINTE HEALTHC	ARE CENTER		WAR ADMIRAL DRIVE NAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	<i>c</i>	DATE
	 with Requirements Medicare/Medicaid Life Safety From F the National Fire F 101, Life Safety C Existing Health Ca 16.2. This one story faci Type V (111) cons The facility has a f detection in the co corridors with hard resident rooms. Th 100 and had a cens visit. 	d, 42 CFR Subpart 483.90(a), Fire and the 2012 Edition of trotection Association (NFPA) ode (LSC), Chapter 19, are Occupancies and 410 IAC lity was determined to be of truction and fully sprinklered. Fire alarm system with smoke cridors, in all areas open to the l wired smoke detectors in all the facility has a capacity of sus of 99 at the time of this sidents have customary access All areas providing facility		respond to the allegations noncompliance cited durin Safety Recertification and Licensure survey on Dece 7th, 2021. Please accept plan of correction as the provider's credible allegati compliance. This facility respectfully requests a de review/paper compliance i a Post Survey Revisit and included documentation to the facility has corrected th issues and implemented s to prevent reoccurrence.	g a Life State mber this on of sk n lieu of has o confirm ne	
< 0291 SS=F	Quality Review co NFPA 101 Emergency Light	mpleted on 12/09/21				
Bldg. 01	Emergency Light Emergency light duration is provid accordance with 18.2.9.1, 19.2.9.1	ing ng of at least 1-1/2-hour ed automatically in 7.9.	K 0291	What corrective action will	l be	12/30/202
	failed to ensure 1 of emergency lighting accordance with L battery operated er reliable types of re with suitable facili properly charged of	of 2 battery powered g systems was maintained in SC 7.9. LSC 7.9.2.6 states nergency lights shall use only chargeable batteries provided ties for maintaining them in ondition. Batteries used in a shall be approved for their		accomplished for those re found to have been affected the deficient practice? No residents were affected alleged deficient practice. How other residents havin potential to be affected by same deficient practice wi	ed by d by the g the the	

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTH	PLE CONSTRUCTION		OMB NO. 0938-03 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		č - 1	COMPLETED	
	of conduction	155823	B. WING	01	_	07/2021	
		199829			_	5172021	
NAME OF	PROVIDER OR SUPPLIE	ĒR		REET ADDRESS, CITY, STATE, ZIP (CODE		
				04 WAR ADMIRAL DRIVE			
SOUTH	POINTE HEALTHC	ARE CENTER	IN	DIANAPOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF	FIX PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	RECTION HOULD BE	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	G CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
	intended use and s	hall comply with NFPA 70		identified and what co	rrective		
		Code. This deficient practice		actions will be taken?			
		idents, staff and visitors.		All residents had the p	otential to		
		,		be affected by the alle			
	Findings include:			deficient practice. The	•		
	8			powered emergency li	-		
	Based on observat	ions with the Executive		system located at the	• •		
	Director, Maintena			generator was repaire	• •		
	,	Fraining during a tour of the		12.9.21 by facility gen			
		p.m. to 3:50 p.m. on		vendor (Evapar). The			
	12/07/21, the battery operated lighting systemtested again immediately asinstalled in the weatherproof shell for theas the next day and found tofacility's emergency generator located outsidefunctioning properly.the building on the west side of the propertyWhat measures will be put ir				-		
					- nut into		
		e when its respective test		place and what system	-		
		l multiple times. Based on		changes will be made			
	-	ne of the observations, the		that the deficient prace			
		ctor stated he tests the light		not recur?			
		thly basis but agreed the		Maintenance Director	will conduct		
		attery powered emergency		an ongoing 30 second			
		iled to illuminate when its		functional test of all fa	•		
		ton was pushed multiple times.		emergency battery ba	-		
	1			lighting systems and in	•		
	This finding was r	eviewed with the Executive		documentation of this			
	Director and the M	faintenance Director during		facility TELS logbook.	-		
	the exit conference	e		in-serviced maintenan			
				on 12.17.2021 on requ			
	3.1-19(b)			life safety code K291 a			
				the procedure for cond			
				monthly test to ensure	•		
				emergency battery ba			
				lighting is functioning			
				How the corrective ac			
				monitored to ensure th			
				practice will not recur	-		
				QA program will be pu			
				place)?			
				Executive Director/des	-		
	1			conduct an audit of rai	ndom		

_

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE C	ONSTRUCTION		MB NO. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	î î	A. BUILDING <u>01</u>			PLETED
		155823	B. WIN	G	01	12/0	7/2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIE	R			VAR ADMIRAL DRIVE	*	
SOUTHE	POINTE HEALTHC	ARE CENTER			VARCADIMINAL DIRIVE		
	1				1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	р	ID REFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	ION D BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE
					emergency lighting system	ns to	
					ensure proper functioning		
					tested. Executive		
					Director/designee will also		
					conduct an audit of the TE		
					logbook documentation to		
					compliance with completio		
					required monthly emergen battery backup lighting tes	-	
					Maintenance Director. Th	•	
					audits will be completed m		
					for three (3) months then o	-	
					thereafter. Results of the a	audit will	
					be reported, reviewed, and		
					trended for compliance thr	-	
					the facility Quality Assurar		
					Committee for a minimum	OT SIX	
					(6) months for further recommendations.		
K 0324	NFPA 101						
SS=D	Cooking Facilitie						
Bldg. 01	Cooking Facilitie						
5	•	ent is protected in					
	accordance with	NFPA 96, Standard for					
	Ventilation Contr	ol and Fire Protection of					
		king Operations, unless:					
		ing equipment (i.e., small					
		as microwaves, hot plates,					
	,	d for food warming or accordance with					
	18.3.2.5.2, 19.3.2						
		s open to the corridor in					
	-	ents with 30 or fewer					1
		vith the conditions under					1
	18.3.2.5.3, 19.3.2	2.5.3, or					
	-	s in smoke compartments					1
		patients comply with					1
		18.3.2.5.4, 19.3.2.5.4.					
	Cooking facilities	protected according to			1		

	R MEDICARE & MEDIC						IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			01	COMPI	
		155823	B. WIN	G		12/07	/2021
		D	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		4904 W	AR ADMIRAL DRIVE		
SOUTHF	POINTE HEALTHC	ARE CENTER		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		BROUTDERIG DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	Р	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIAT		IAIE	DATE	
	NFPA 96 per 9.2.	3 are not required to be					
		ardous areas, but shall not					
	be open to the co						
		h 18.3.2.5.4, 19.3.2.5.1					
	-	5, 9.2.3, TIA 12-2					
	-	on and interview, the facility	K 03	24	What corrective action will be		12/30/2021
		of 1 kitchen range hood fire	11 0521		accomplished for those residents		12/30/2021
		ns was maintained in			found to have been affected		
		FPA 96. LSC 9.2.3 refers to			the deficient practice?	~ y	
		d for Ventilation Control and			No residents were affected b	w the	
		Commercial Cooking			alleged deficient practice.	y uie	
		96, 2011 Edition, Section				the	
	-	natic fire-extinguishing			How other residents having		
		stalled in accordance with the			potential to be affected by th		
	-	g, the manufacturer's			same deficient practice will k		
		e following standards where			identified and what corrective	9	
	applicable:	6			actions will be taken?		
	(1) NFPA 12				This alleged deficient practic		
	(2) NFPA 13				could have affected over two	statt	
	(3) NFPA 17				and visitors in the kitchen. A		
	(4) NFPA 17A				certified contractor inspected	I the	
		n 4.3.1.5 states all discharge			facility's kitchen hood fire		
		ovided with caps or other			suppression system on		
	_	prevent the entrance of grease			12.17.2021 and replaced thr		
		or other foreign materials.			discharge nozzle blow off ca		
		tes the protection device shall			This system was fully function	IBI	
		nt discharge. This deficient			and passed the inspection.		
		ct over two staff and visitors			What measures will be put in	πΟ	
	in the kitchen.				place and what systemic		
					changes will be made to ens		
	Findings include:				that the deficient practice do	es	
					not recur?		
	Based on observati	ons with the Executive			The facility has a task entere		
	Director, Maintena	nce Director and			the TELS software program	to	
		raining during a tour of the			have the kitchen hood fire		
		o.m. to 3:50 p.m. on			suppression system inspected	ed	
		three discharge nozzle caps			every six months. Facility		
		chen hood fire suppression			Maintenance Director will vis		
		n place. One of the three			the kitchen hood fire suppres		
		-			system immediately following		

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

Event ID:

ZQDW21 Facility ID: 013126

If continuation sheet

Page 5 of 13

ENTERS FO				0310TD 110TL 031		AT 10 1 10 1
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPI	
		155823	B. WING		12/07/2021	
NAME OF	PROVIDER OR SUPPLI	70	STREET	ADDRESS, CITY, STATE, ZIP CODE		
TATIVIL OF	I KO VIDEK OK BOI I EI		4904 W	VAR ADMIRAL DRIVE		
SOUTH	POINTE HEALTHC	CARE CENTER	INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROVIDEDIC DI AN OF CODRECTI	ON .	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO) BE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	caps were affixed	to the nozzle but were not		completion of this inspection	on to	
	covering the disch	arge nozzle. Based on		ensure that discharge nozz	zle blow	
	interview at the tin	me of the observations, the		off caps are present and a	ffixed to	
	Maintenance Dire	ctor agreed nozzle caps were		the nozzle. In addition, the	e	
	not in place for th	e kitchen range hood fire		Kitchen manager will comp	olete	
	suppression system	ns three discharge nozzles.		periodic visual inspections		
				ensure the nozzle caps are	Э	
	-	eviewed with the Executive		present and affixed. Both		
		Aaintenance Director during		Maintenance Director and		
	the exit conference	е.		Manager were educated of		
				purpose of having the disc	•	
	3.1-19(b)			nozzle caps in place for fire		
				prevention and the need for		
				additional visual inspection		
				How the corrective action		
				monitored to ensure the de	eficient	
				practice will not recur (i.e.		
				QA program will be put into	0	
				place)?		
				ED/designee will conduct v		
				inspections of the kitchen I		
				fire suppression system to		
				discharge nozzle caps are		
				present and affixed. These		
				inspections will be conduct		
				weekly for eight (8) weeks		
				monthly for three (3) month		
				then each quarterly therea	tter.	
				Results of the audit will be	un al a al	
				reported, reviewed, and tre		
				for compliance throughout facility Quality Assurance	une	
				Committee for a minimum	of civ	
				(6) months for further		
				recommendations.		
0353	NFPA 101					
SS=E		n - Maintenance and Testing				
Bldg. 01		n - Maintenance and Testing				
2		ler and standpipe systems				
	· ·					1

OF CORRECTION ROVIDER OR SUPPLIE DINTE HEALTHC			01 ADDRESS, CITY, STATE, ZIP CODE	COMPL 12/07/	
DINTE HEALTHC			ADDRESS, CITY, STATE, ZIP CODE		
DINTE HEALTHC		1004 1			
			VAR ADMIRAL DRIVE		
SUMMARY S	ARE CENTER	INDIA	NAPOLIS, IN 46237		
	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	-	DATE
are inspected, tes	sted, and maintained in				
-					
	•				
-	-				
	-				
	-				
a) Date sprinkle	r system last checked				
b) Who provided	d system test				
2)e presider					
c) Water system	supply source				
coverage for any automatic sprinkle	non-required or partial er system.				
Based on observati failed to ensure 1 of Hall Breakroom we materials in accord 25, Standard for th Maintenance of We Systems, 2011 Edi sprinklers shall not be free of corrosion physical damage; a correct orientation sidewall). Furthern sprinkler that show shall be replaced: (1) Leakage (2) Corrosion (3) Physical Dama (4) Loss of fluid in element (5) Loading	erage for any non-required or partial omatic sprinkler system. 5, 9.7.7, 9.7.8, and NFPA 25 ed on observation and interview, the facility ed to ensure 1 of 2 sprinkler heads in the 600 I Breakroom were not loaded with foreign erials in accordance with NFPA 25. NFPA Standard for the Inspection, Testing, and ntenance of Water-Based Fire Protection tems, 2011 Edition, Section 5.2.1.1.1 states nklers shall not show signs of leakage; shall tree of corrosion, foreign materials, paint, and sical damage; and shall be installed in the ect orientation (e.g., up-right, pendent, or wall). Furthermore, at 5.2.1.1.2 any nkler that shows signs of any of the following 1 be replaced: Leakage Corrosion Physical Damage Loss of fluid in the glass bulb heat responsive nent		found to have been affected by the deficient practice? No residents were affected by alleged deficiency. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? 600 hall residents have the potential to be affected by the alleged deficiency. The identifie sprinkler is scheduled to be replaced by SafeCare on 12.30.21.	/ the e	12/30/202
	accordance with Inspection, Testin Water-based Fire Records of syster inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8 Based on observati failed to ensure 1 of Hall Breakroom w materials in accord 25, Standard for th Maintenance of W Systems, 2011 Edi sprinklers shall not be free of corrosion physical damage; a correct orientation sidewall). Furthen sprinkler that show shall be replaced: (1) Leakage (2) Corrosion (3) Physical Dama (4) Loss of fluid in element (5) Loading	 (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element 	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 observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the 600 Hall Breakroom were not loaded with foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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	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 observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the 600 Hall Breakroom were not loaded with foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and teadily 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 observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the 600 Hall Breakroom were not loaded with foreign materials in accordance with NFPA 25. NPPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corosion, 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

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

Event ID:

ZQDW21 Facility ID: 013126

If continuation sheet Page 7 of 13

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION C	X3) DATE SURVEY COMPLETED		
		155823	B. WING		12/07/2021		
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE				
SOUTH	POINTE HEALTHC	ARE CENTER		WAR ADMIRAL DRIVE NAPOLIS, IN 46237			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETI		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	-	mitted to clean sprinklers with		Maintenance director will contin			
	-	by a vacuum provided that the		to complete a weekly in-house	fire		
		ot touch the sprinkler.		sprinkler visual inspection in			
	-	tice could affect over 10		accordance to instructions			
		l visitors in the vicinity of the		provided by TELS. This will be			
	600 Hall Breakroo	em.		recorded on TELS logbook for			
				documentation of completion.			
	Findings include:			in-serviced maintenance directo			
				on 12.17.2021 on requirement of			
	Based on observat	ions with the Executive		life safety code K353 as well as	6		
	Director, Maintena	ance Director and		the procedure for visually			
	Administrator in T	raining during a tour of the		inspecting all sprinkler heads fo	r		
	facility from 1:00	p.m. to 3:50 p.m. on		signs of leakage/corrosion.			
	12/07/21, one of th	ne two ceiling mounted		How the corrective action will be	e		
	sprinklers in the 6	00 Hall Breakroom had a black		monitored to ensure the deficien	nt		
	liquid substance of	n the deflector and appeared to		practice will not recur (i.e. – what	at		
	be leaking. Based	on interview at the time of the		QA program will be put into			
		Maintenance Director agreed		place)?			
	the aforementione	d automatic sprinkler location		Executive Director/designee wil	1		
	appeared to be leaf	king.		conduct an audit of random			
				sprinkler heads throughout facil	ity		
	-	eviewed with the Executive		to ensure that sprinklers do not			
		laintenance Director during		show signs of leakage and are			
	the exit conference	2.		free of foreign materials.			
				Executive Director/designee wil	1		
	3.1-19(b)			also conduct an audit of the TE	LS		
				logbook documentation to ensu	re		
				compliance with completion of t	he		
				required weekly in-house fire			
				sprinkler visual inspection by th	e		
				Maintenance Director. These			
				audits will be completed weekly	for		
				eight (8) weeks, then monthly for	or		
				three (3) months and then each			
				quarterly thereafter. Results of t	the		
				audit will be reported, reviewed	,		
				and trended for compliance			
				throughout the facility Quality			
				Assurance Committee for a			
				minimum of six (6) months for			

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	î.	3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155823	B. WING		12/07/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
SOUTU					
	POINTE HEALTHC			NAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO
IAU	REGULATORY O	R LSC IDENTIFY ING INFORMATION)	IAG	further recommendations.	DATE
K 0754	NFPA 101				
SS=E	Soiled Linen and	Trash Containers			
Bldg. 01		Trash Containers			
		ash collection receptacles			
		32 gallons in capacity. The			
		of container capacity in a			
		all not exceed 0.5			
	-	et. A total container			
		llons shall not be exceeded			
		are feet area. Mobile soiled			
		ection receptacles with			
	-	r than 32 gallons shall be protected as a hazardous			
	area when not at	•			
		solely for recycling are			
		xcluded from the above			
		ere each container is less			
		96 gallons unless attended,			
		or combustibles are labeled			
	and listed as mee	eting FM Approval Standard			
	6921 or equivale				
	18.7.5.7, 19.7.5.7	7			
	Based on observat	on and interview, the facility	K 0754	What corrective action will be	12/30/202
		attended soiled linen		accomplished for those residents	s
		11 means of egress were		found to have been affected by	
		otected as a hazardous area in		the deficient practice?	
		9.7.5.7. This deficient		No residents were affected by th	e
	-	ct over 20 residents, staff and		alleged deficient practice.	
	visitors.			How other residents having the	
				potential to be affected by the	
	Findings include:			same deficient practice will be	
	Record on charment	ions with the Executive		identified and what corrective	
		e initial walk through of the		actions will be taken?	
	-	a.m. to $8:50$ a.m. on $12/07/21$,		The alleged deficient practice	
		linen and trash bins were		could affect over 20 residents,	
		lor outside Room 707, 709,		staff, and visitors. Facility	
		Documentation of the		immediately removed all	
	1 01 1, 200 unu 207.			containers in question as	

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

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
AND LAN	OF CORRECTION		A. BUILDING B. WING	01	
		155823	B. WING		12/07/2021
NAME OF P	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
			4904 W	VAR ADMIRAL DRIVE	
SOUTHP	OINTE HEALTHC	ARE CENTER	INDIAN	IAPOLIS, IN 46237	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	capacity of the bin	s was not affixed to each bin.		identified during the survey.	
	Based on interview	v at the time of the		Facility confirmed that the	
		Maintenance Director stated he		containers in question are 32	
		nt be 33 gallon capacity but did		gallon capacity.	
	not know if the cap	pacity of each bin exceeded 32		What measures will be put inte	0
		observations with the		place and what systemic	
		r, Maintenance Director and		changes will be made to ensu	re
	Administrator in T	raining during a tour of the		that the deficient practice doe.	s
		p.m. to 3:50 p.m. on		not recur?	
		nen and trash bins were stored		Facility will replace the soiled	linen
		side Room 603, 604, 707,		and trash containers identified	
	709, 905 and 907.	The trash and soiled linen		during the survey with differer	nt
	bins outside Room	905 and 907 were stored		receptacles that do not exceed	
	within six feet of c	one another. Each bin was		gallons in capacity. In addition	
		h soiled linen or trash and was		the facility will cease to have o	one
	unattended. The c	apacity by volume of each bin		trash and one soiled linen	
	was not labeled or	identified on the bin. Based		container in each hallway, opt	ing
	on interview at the	time of the observations, the		instead to have one or the oth	•
	Executive Director	r and the Maintenance		ensure compliance with the	
	Director stated the	bins are stored in the corridor		prescribed capacity per squar	e
	and agreed the bin	s were not stored in a room		footage. ED in-serviced	
	protected as a haza	ardous area when unattended.		maintenance director on	
				12.17.2021 on requirement of	life
	This finding was re	eviewed with the Executive		safety code K754 and allowab	
	Director and the M	laintenance Director during		soiled linen and trash recepta	
	the exit conference	2.		capacities.	
				How the corrective action will	be
	3.1-19(b)			monitored to ensure the defici	
				practice will not recur (i.e. – w	
				QA program will be put into	nat
				place)?	
				Maintenance Director/designe	
				will conduct rounds to ensure	
				unattended soiled linen and tr	a511
				receptacles are stored in a	
				hazardous area room and not	
				hallways. These rounds will b	
				completed weekly for eight (8)	
				weeks, then monthly for three	
				months and then each quarter	rly

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

ZQDW21 Facility ID: 013126

If continuation sheet Page 10 of 13

PRINTED: 12/21/2021 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIO NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y 2) M	UI TIDI E CO	ONSTRUCTION		IB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION					12/07	
		155823	D. W			12/07	/2021
NAME OF	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP CODE		
				4904 V	VAR ADMIRAL DRIVE		
SOUTH	POINTE HEALTHC	ARE CENTER		INDIAN	NAPOLIS, IN 46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
					thereafter. Results of the auc	it will	
					be reported, reviewed, and		
					trended for compliance throu	ahout	
					the facility Quality Assurance	-	
					Committee for a minimum of		
					(6) months for further		
					recommendations.		
K 0761							
SS=E							
Bldg. 01							
	Based on record re	eview, observation and	K 0	761	What corrective action will be	;	12/30/202
	interview; the faci	lity failed to ensure annual			accomplished for those resid	ents	
	inspection and test	ing of all fire door assemblies			found to have been affected	by	
	-	FPA 80, Standard for Fire			the deficient practice?		
		Opening Protectives Section			No residents were affected b	y the	
	5.2.1 states fire do	or assemblies shall be			alleged deficient practice.	-	
	-	ed not less than annually, and a			How other residents having t	he	
		he inspection shall be signed			potential to be affected by the	9	
		ction by the AHJ. NFPA 80,			same deficient practice will b		
		loor assemblies shall be			identified and what corrective		
		from both sides to assess the			actions will be taken?		
	overall condition of	of door assembly.			The alleged deficient practice	;	
					could affect over 10 residents		
		states as a minimum, the			staff and visitors in the vicinit	y of	
	following items sh				the oxygen storage room nea	-	
		or breaks exist in surfaces of			Maintenance office. An audit		
	either the door or f				been completed to identify al	I	
		light frames, and glazing			oxygen storage and transfillir	ng	
		d securely fastened in place, if			rooms and there is only the c	ne	
	so equipped.	a hinaga handaaraa ay l			room identified during the su	vey.	
		e, hinges, hardware, and			The facility's maintenance di	ector	
		reshold are secured, aligned,			completed a fire door inspect	ion	
	-	der with no visible signs of			for the oxygen storage room	on	
	damage. (4) No parts are m	issing or broken			12.13.21 to ensure complian	ce.	
		issing or broken. es do not exceed clearances			What measures will be put in	to	
	(5) Door clearance listed in 4.8.4 and				place and what systemic		
		g device is operational; that is,			changes will be made to ens	ure	
		g device is operational; that is, npletely closes when operated			that the deficient practice doe		
	uie active door con	inprotory croses when operated	1		1 '		1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155823	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		COMI	(X3) DATE SURVEY COMPLETED 12/07/2021	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIF	P CODE		
SOUTHF	POINTE HEALTHC	ARE CENTER		WAR ADMIRAL DRIVE ANAPOLIS, IN 46237			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)	TAG			DATE	
	 closes before the a (8) Latching hardw door when it is in t (9) Auxiliary hardw prohibit operation or frame. (10) No field modiassembly have been label. (11) Gasketing and are inspected to verify the deficient prace residents, staff and oxygen storage and Maintenance Office Findings include: Based on review of Inspection'' docum with the Maintenaar review from 8:50 a 12/07/21, fire door for the facility with month period did r storage rooms. Baar record review, the the facility has one transfilling room. the Executive Direct and Administrator facility from 1:00 12/07/21, the corristorage and transfil Maintenance Office resistance rating laboration. 	r is installed, the inactive leaf ctive leaf. vare operates and secures the the closed position. ware items that interfere or are not installed on the door fications to the door in performed that void the dege seals, where required, rify their presence and tice could affect over 10 visitors in the vicinity of the d transfilling room near the		not recur? The facility has ident to be inspected on a to track inspections a been updated to inclu oxygen storage room Director has in-servio maintenance director completion of the and fire/smoke door inspe- utilizing the Fire/Smo Inspection form. <i>How the corrective a monitored to ensure practice will not recu</i> . <i>QA program will be p</i> <i>place)?</i> Executive Director/de conduct an audit of the Fire/Smoke Door Ins forms for all required ensure compliance w completion of the and testing by the Mainte Director. This audit of completed monthly for and then quarterly th Results of the audit of for compliance throug facility Quality Assura Committee for a mini (6) months for further recommendations.	facility layout and this has ude the n. Executive ced the r on nual ection oke Door <i>ction will be</i> <i>the deficient</i> <i>r (i.e. – what</i> <i>out into</i> esignee will he spection doors to vith nual fire door enance will be or one month ereafter. will be and trended ghout the ance imum of six		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155823	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 12/07/2021	
NAME OF PROVIDER OR SUPPLIER SOUTHPOINTE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237			
X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	time of record revie the Maintenance D door inspection doo within the most rec not include the doo transfilling room ne This finding was re	Based on interview at the ew and of the observations, irector agreed annual fire cumentation for the facility eent twelve month period did or to the oxygen storage and ear the Maintenance Office. eviewed with the Executive aintenance Director during				

If continuation sheet Page 13 of 13