STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING -- B. WING	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/07/21 Facility Number: 013126 Provider Number: 155823 AIM Number: 201256070 At this Emergency Preparedness survey, Southpointe Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 99. Quality Review completed on 12/09/21	E 0000		
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: 12/07/21 Facility Number: 013126 Provider Number: 155823 AIM Number: 201256070 At this Life Safety Code survey, Southpointe	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Healthcare Center 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 100 and had a census of 99 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 12/09/21		respond to the allegations of noncompliance cited during a Life Safety Recertification and State Licensure survey on December 7th, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. This facility respectfully requests a desk review/paper compliance in lieu of a Post Survey Revisit and has included documentation to confirm the facility has corrected the issues and implemented systems to prevent reoccurrence.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lighting systems was maintained in accordance with LSC 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	K 0291	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be*	12/30/2021

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	intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, Maintenance Director and Administrator in Training during a tour of the facility from 1:00 p.m. to 3:50 p.m. on 12/07/21, the battery operated lighting system installed in the weatherproof shell for the facility's emergency generator located outside the building on the west side of the property failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director stated he tests the light regularly on a monthly basis but agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		*identified and what corrective actions will be taken?* All residents had the potential to be affected by the alleged deficient practice. The battery powered emergency lighting system located at the emergency generator was repaired on 12.9.21 by facility generator vendor (Evapar). The light was tested again immediately as well as the next day and found to be functioning properly. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Maintenance Director will conduct an ongoing 30 second monthly functional test of all facility emergency battery backup lighting systems and include documentation of this testing in facility TELS logbook. ED in-serviced maintenance director on 12.17.2021 on requirement of life safety code K291 as well as the procedure for conducting the monthly test to ensure all emergency battery backup lighting is functioning properly. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive Director/designee will conduct an audit of random	

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			emergency lighting systems to ensure proper functioning when tested. Executive Director/designee will also conduct an audit of the TELS logbook documentation to ensure compliance with completion of the required monthly emergency battery backup lighting test by the Maintenance Director. These audits will be completed monthly for three (3) months then quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	
K 0324 SS=D 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			

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	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 to ensure 1 of 1 kitchen range hood fire suppression systems was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 Edition, Section 10.2.6 states automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (1) NFPA 12 (2) NFPA 13 (3) NFPA 17 (4) NFPA 17A NFPA 17A, Section 4.3.1.5 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials. Section 4.3.1.6 states the protection device shall blow out upon agent discharge. This deficient practice could affect over two staff and visitors in the kitchen. Findings include: Based on observations with the Executive Director, Maintenance Director and Administrator in Training during a tour of the facility from 1:00 p.m. to 3:50 p.m. on 12/07/21, three of three discharge nozzle caps for the facility's kitchen hood fire suppression systems were not in place. One of the three nozzle caps was missing and the other two nozzle	K 0324	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* This alleged deficient practice could have affected over two staff and visitors in the kitchen. A certified contractor inspected the facility's kitchen hood fire suppression system on 12.17.2021 and replaced three discharge nozzle blow off caps. This system was fully functional and passed the inspection. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* The facility has a task entered in the TELS software program to have the kitchen hood fire suppression system inspected every six months. Facility Maintenance Director will visualize the kitchen hood fire suppression system immediately following	12/30/2021

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	caps were affixed to the nozzle but were not covering the discharge nozzle. Based on interview at the time of the observations, the Maintenance Director agreed nozzle caps were not in place for the kitchen range hood fire suppression systems three discharge nozzles. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		completion of this inspection to ensure that discharge nozzle blow off caps are present and affixed to the nozzle. In addition, the Kitchen manager will complete periodic visual inspections to ensure the nozzle caps are present and affixed. Both Maintenance Director and Kitchen Manager were educated on the purpose of having the discharge nozzle caps in place for fire prevention and the need for these additional visual inspections. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* ED/designee will conduct visual inspections of the kitchen hood fire suppression system to ensure discharge nozzle caps are present and affixed. These inspections will be conducted weekly for eight (8) weeks, then monthly for three (3) months and then each quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on 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 (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded	K 0353	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the 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 identified sprinkler is scheduled to be replaced by SafeCare on 12.30.21. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*	12/30/2021

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	with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 600 Hall Breakroom. Findings include: Based on observations with the Executive Director, Maintenance Director and Administrator in Training during a tour of the facility from 1:00 p.m. to 3:50 p.m. on 12/07/21, one of the two ceiling mounted sprinklers in the 600 Hall Breakroom had a black liquid substance on the deflector and appeared to be leaking. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned automatic sprinkler location appeared to be leaking. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance director will continue to complete a weekly in-house fire sprinkler visual inspection in accordance to instructions provided by TELS. This will be recorded on TELS logbook for documentation of completion. ED in-serviced maintenance director on 12.17.2021 on requirement of life safety code K353 as well as the procedure for visually inspecting all sprinkler heads for signs of leakage/corrosion. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive Director/designee will conduct an audit of random sprinkler heads throughout facility to ensure that sprinklers do not show signs of leakage and are free of foreign materials. Executive Director/designee will also conduct an audit of the TELS logbook documentation to ensure compliance with completion of the required weekly in-house fire sprinkler visual inspection by the Maintenance Director. These audits will be completed weekly for eight (8) weeks, then monthly for three (3) months and then each quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for	

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			further recommendations.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure unattended soiled linen receptacles in 3 of 11 means of egress were stored in a room protected as a hazardous area in accordance with 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director during the initial walk through of the facility from 8:35 a.m. to 8:50 a.m. on 12/07/21, unattended soiled linen and trash bins were stored in the corridor outside Room 707, 709, 814, 905 and 907. Documentation of the	K 0754	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* The alleged deficient practice could affect over 20 residents, staff, and visitors. Facility immediately removed all containers in question as	12/30/2021

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	capacity of the bins was not affixed to each bin. Based on interview at the time of the observations, the Maintenance Director stated he believed they might be 33 gallon capacity but did not know if the capacity of each bin exceeded 32 gallons. Based on observations with the Executive Director, Maintenance Director and Administrator in Training during a tour of the facility from 1:00 p.m. to 3:50 p.m. on 12/07/21, soiled linen and trash bins were stored in the corridor outside Room 603, 604, 707, 709, 905 and 907. The trash and soiled linen bins outside Room 905 and 907 were stored within six feet of one another. Each bin was partially filled with soiled linen or trash and was unattended. The capacity by volume of each bin was not labeled or identified on the bin. Based on interview at the time of the observations, the Executive Director and the Maintenance Director stated the bins are stored in the corridor and agreed the bins were not stored in a room protected as a hazardous area when unattended. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		identified during the survey. Facility confirmed that the containers in question are 32 gallon capacity. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?* Facility will replace the soiled linen and trash containers identified during the survey with different receptacles that do not exceed 32 gallons in capacity. In addition, the facility will cease to have one trash and one soiled linen container in each hallway, opting instead to have one or the other to ensure compliance with the prescribed capacity per square footage. ED in-serviced maintenance director on 12.17.2021 on requirement of life safety code K754 and allowable soiled linen and trash receptacle capacities. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Maintenance Director/designee will conduct rounds to ensure that unattended soiled linen and trash receptacles are stored in a hazardous area room and not on hallways. These rounds will be completed weekly for eight (8) weeks, then monthly for three (3) months and then each quarterly	

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			thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were complete. NFPA 80, Standard for Fire Doors and Other Opening Protectives Section 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated	K 0761	*What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were affected by the alleged deficient practice. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?* The alleged deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage room near the Maintenance office. An audit has been completed to identify all oxygen storage and transfilling rooms and there is only the one room identified during the survey. The facility's maintenance director completed a fire door inspection for the oxygen storage room on 12.13.21 to ensure compliance. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does*	12/30/2021

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SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

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	from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the Maintenance Office. Findings include: Based on review of "Fire/Smoke Door Inspection" documentation dated October 2021 with the Maintenance Director during record review from 8:50 a.m. to 12:40 p.m. on 12/07/21, fire door inspection documentation for the facility within the most recent twelve month period did not include doors to oxygen storage rooms. Based on interview at the time of record review, the Maintenance Director stated the facility has one oxygen storage and transfilling room. Based on observations with the Executive Director, Maintenance Director and Administrator in Training during a tour of the facility from 1:00 p.m. to 3:50 p.m. on 12/07/21, the corridor door to the oxygen storage and transfilling room near the Maintenance Office had a 1-hour minute fire resistance rating label affixed to the hinge side of the door. Four liquid oxygen containers and		*not recur?* The facility has identified all doors to be inspected on a facility layout to track inspections and this has been updated to include the oxygen storage room. Executive Director has in-serviced the maintenance director on completion of the annual fire/smoke door inspection utilizing the Fire/Smoke Door Inspection form. *How the corrective action will be monitored to ensure the deficient practice will not recur (i.e. – what QA program will be put into place)?* Executive Director/designee will conduct an audit of the Fire/Smoke Door Inspection forms for all required doors to ensure compliance with completion of the annual fire door testing by the Maintenance Director. This audit will be completed monthly for one month and then quarterly thereafter. Results of the audit will be reported, reviewed, and trended for compliance throughout the facility Quality Assurance Committee for a minimum of six (6) months for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING 01 B. WING	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	fourteen 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of record review and of the observations, the Maintenance Director agreed annual fire door inspection documentation for the facility within the most recent twelve month period did not include the door to the oxygen storage and transfilling room near the Maintenance Office. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			