STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155228	A. BUILDING -- B. WING	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

(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: 04/30/24 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 At this Emergency Preparedness survey, Willows of Richmond was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 87 certified beds. At the time of the survey, the census was 51. Quality Review completed on 05/01/24	E 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask our consideration for paper compliance.	
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: 04/30/24 Facility Number: 000133 Provider Number: 155228 AIM Number: 100266080 At this Life Safety Code survey, Willows of Richmond was found not in compliance with	K 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Please accept this Plan of Correction as Credible	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Merry Goodwin	HFA	05/16/2024

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	155228	A. BUILDING 01 B. WING	04/30/2024

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WILLOWS OF RICHMOND	2070 CHESTER BLVD RICHMOND, IN 47374

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 87 and had a census of 51 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. One detached all metal storage garage was not sprinkled. Quality Review completed on 05/01/24		Allegations of Compliance. We respectfully ask our consideration for paper compliance.	
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			

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	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 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			

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	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. 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 all exits was 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 15 all visitors and residents if needing to exit the facility. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 04/30/23 between 11:50 p.m. and 2:15 p.m., the front entrance door, marked as facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted. The MD stated that is was posted recently and someone must have removed it in the last day or so. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present. 3.1-19(b)	K 0222	It has and will continue to be the practice of this facility to ensure the means of egress through all exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures. Although this deficient practice could affect all visitors, staff and residents if needing to exit the facility, no one was directly affected by this. Maintenance Director reprinted code stickers on all locked exterior doors to reflect that special knowledge is not required to exit (Attachment 1). Maintenance Director or Designee will check to make sure code stickers are still on exterior doors 2 X a week for 6 weeks, 1 time a week for 4 weeks and then once a month thereafter (Attachment 2). Any ongoing issues will be brought to morning IDT meeting and appropriate measures put in place.	05/01/2024

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 2	K 0321	It has and will continue to be the policy of this facility to that hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with	05/01/2024

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	residents, as well as staff and visitors in the Business Office. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 04/30/23 between 11:50 p.m. and 2:15 p.m., the Business Office, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and 15 cardboard boxes. The corridor door to this office door did not self-close and latch into the door frame. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director present. 3.1-19(b)		3/4 –hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.71. While there was a potential that all residents, staff and visitors could have been affected, there was no one directly affected by this practice. The Maintenance Director removed the excess cardboard boxes from the business office (Attachment 3). The maintenance supervisor or designee will perform an office storage audit 2 X per week for 6 weeks, 1 X per week for 4 weeks and I X a month thereafter (Attachment 4). Any ongoing issues will be addressed immediately and discussed in the quarterly QA meeting.	