PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER | (X2) MULTIPI<br>A. BUILDIN | E CONSTRUCTION  G                     | (X3) DATE SURVEY  COMPLETED           |  |  |
|---|--|---|----------------------------|---------------------------------------|---------------------------------------|--|--|
| 154052  |  |   | B. WING                    |                                       |                                       |  |  |
|   | PROVIDER OR SUPPLIER   |   | 701                        | EET ADDRESS, CITY, STATE, ZII WALL ST | P COD                                 |  |  |
| PORTER  | -STARKE SERVICI  | ES INC  | VAI                        | _PARAISO, IN 46383                    |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION   |   | ID<br>PREFI<br>TAG         | CROSS-REFERENCED TO TH                | N SHOULD BE COMPLETION HE APPROPRIATE |  |  |
| E 0000  | KEGGE/ITOKT OK   | LEGO IDENTIL TINO IN ORGANITATION                   | 1710                       |                                       | DITE                                  |  |  |
| Bldg  | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.15.  Survey Dates: 10/18-19/22  Facility Number: 005585 Provider Number: 154052 AIM Number: N/A  At this Emergency Preparedness survey, Porter Starke Services, Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 482.15  The facility has 16 certified beds. At the time of the survey, the census was 2. |   | E 0000                     |                                       |                                       |  |  |
|   | Quality Review con   | npleted on 10/21/22                                 |                            |                                       |                                       |  |  |
| K 0000  |  |   |                            |                                       |                                       |  |  |
| Bldg. 01  | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b).  Survey Dates: 10/18-19/22  Facility Number: 005585 Provider Number: 154052 AIM Number: N/A  At this Life Safety Code Survey, Porter-Starke Services, Inc. was found not in compliance with Requirements for Participation in   |   | K 0000                     |                                       |                                       |  |  |

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

TITLE (X6) DATE

Andrew Nielsen Chief Financial Officer 11/04/2022

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D7O221 Facility ID: 005585 If continuation sheet Page 1 of 7

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

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  154052 |  | r í   | JILDING | 01                  | COMPL<br>10/19/   | ETED |                            |
|--|--|---|---------|---------------------|---|------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER                         |  |   |         | STREET A            | DDRESS, CITY, STATE, ZIP COD<br>LL ST   |      |                            |
| PORTER-STARKE SERVICES INC                           |  |   |         |                     | RAISO, IN 46383   |      |                            |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | Œ    | (X5)<br>COMPLETION<br>DATE |
|  | Life Safety from Fir<br>National Fire Protec<br>Life Safety Code (L<br>Health Care Occupa<br>edition of the Nation<br>(NFPA) 99, Health of<br>Building 01, a two s<br>to be of Type II (11<br>sprinklered. The in-<br>separated from the r | A 42 CFR Subpart 482.41(b), re, the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies, as well at the 2012 and Fire Protection Association Care Facilities Code.  Story structure was determined 1) construction and was fully patient facility was not remaining building by a Fire |         |                     |   |      |                            |
|  | the entire facility wa<br>existing health care<br>fire alarm system wa<br>corridors and spaces<br>building is protected<br>generator providing   |   |         |                     |   |      |                            |
| K 0161   | NFPA 101   | •   |         |                     |   |      |                            |
| Bldg. 01   | Building Construct<br>Building Construct<br>2012 EXISTING<br>Building constructi   | ion Type and Height ion Type and Height on type and stories meets less otherwise permitted by 9.1.6.7   |         |                     |   |      |                            |
|  | Construct 1 I (442), I of stories  sprinklered 2 II (111)  | tion Type (332), II (222) Any number non-sprinklered and One story  |         |                     |   |      |                            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  154052 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction<br>01   | (X3) DATE SURVEY  COMPLETED  10/19/2022   |                      |  |  |
|--|--|---|---|---|----------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER PORTER-STARKE SERVICES INC  |  |   | STREET ADDRESS, CITY, STATE, ZIP COD 701 WALL ST VALPARAISO, IN 46383 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE |  |  |
|  | non-sprinklered  | Maximum 3 stories   |   |   |                      |  |  |
|  | 3 II (000)<br>non-sprinklered<br>4 III (211)<br>sprinklered<br>5 IV (2HH)<br>6 V (111)   | Not allowed  Maximum 2 stories  |   |   |                      |  |  |
|  | throughout by an automatic system 9.7. (See 19.3.5) Give a brief descr construction, the respective passements, floors located, location of dates of approval small floor plan of Based on observation failed to maintain the facility. This all occupants within Findings include:  Based on observation of the facility from Facilities Director, boiler room had a Futhree inch in diame second floor of the time of observation of the time of observation of the time of observation automatical systems. | Maximum 1 story  s must be sprinklered approved, supervised in accordance with section iption, in REMARKS, of the number of stories, including on which patients are of smoke or fire barriers and Complete sketch or attach the building as appropriate. On and interview, the facility he building construction type deficient practice could affect in the facility.  The on on 10/18/2022 during a tour 12:45 p.m. to 1:50 p.m. with the the concrete ceiling in the EVC pipe penetrating through a ter hole leading up to the facility. Based on interview at tion, the Facilities Director in open vertical penetration | K 0161  | The deficiency was corrected 10/25/2022 by injecting Firestocaulking into the gap/hole. The hole is completely filled as of 10/25/2022 and it is not anticipated that there will be a need for any further action. To deficiency will be prevented for recurring in the future by regul weekly inspection of the ceilin any further gaps or holes are discovered, they will be caulked re-caulked with Firestop-grade caulk. The Facilities Director, Steven Ochoa, was responsib | his om lar g. If     |  |  |

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|   |   | X1) PROVIDER/SUPPLIER/CLIA        |   | (X2) MULTIPLE CONSTRUCTION |   |                           | (X3) DATE SURVEY |  |
|---|---|-----------------------------------|---|----------------------------|---|---------------------------|------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMB  154052      |   | IDENTIFICATION NUMBER             |   | JILDING<br>ING             | NG <u>01</u>  |                           | COMPLETED        |  |
|   |   | 104002                            | B. WING 10/19/2022  |                            |   |                           |                  |  |
| NAME OF PROVIDER OR SUPPLIER PORTER-STARKE SERVICES INC |   |                                   | STREET ADDRESS, CITY, STATE, ZIP COD 701 WALL ST VALPARAISO, IN 46383 |                            |   |                           |                  |  |
| (X4) ID   | SUMMARY STATEMENT OF DEFICIENCIE  |                                   |   | ID                         | 1   |                           | (X5)             |  |
| PREFIX  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION through the concrete ceiling, and he would get the hole filled in as soon as possible.  |                                   |   | PREFIX                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE |                           | COMPLETION       |  |
| TAG   |   |                                   |   | TAG                        | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE                        | DATE             |  |
|   |   |                                   |   |                            | correcting the deficiency and   | will                      |                  |  |
|   |   |                                   |   |                            | be responsible for preventing a   |                           |                  |  |
|   |   |                                   |   |                            | future recurrence of this   | future recurrence of this |                  |  |
|   |   | viewed with the Facilities        |   |                            | deficiency.   |                           |                  |  |
|   | Director at the exit  | conference.                       |   |                            |   |                           |                  |  |
| K 0355  | NFPA 101  |                                   |   |                            |   |                           |                  |  |
|   | Portable Fire Extir   | nguishers                         |   |                            |   |                           |                  |  |
| Bldg. 01  | Portable Fire Extir   | _                                 |   |                            |   |                           |                  |  |
|   | Portable fire extinguishers are selected,   |                                   |   |                            |   |                           |                  |  |
|   | installed, inspected, and maintained in   |                                   |   |                            |   |                           |                  |  |
|   | accordance with NFPA 10, Standard for   |                                   |   |                            |   |                           |                  |  |
|   | Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10   |                                   |   |                            |   |                           |                  |  |
|   | 1. Based on observation and interview, the facility   |                                   | K 0   | 255                        | For the fire extinguisher that w  | 126                       | 11/08/2022       |  |
|   | failed to ensure 1 of 1 portable fire extinguishers in  |                                   | I K U   | 333                        | found in the dosing room and  | 143                       | 11/06/2022       |  |
|   | the dosing room were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket |                                   |   |                            | sitting on the floor, it was mou  | nted                      |                  |  |
|   |   |                                   |   |                            | on a hanger intended for that   |                           |                  |  |
|   |   |                                   |   |                            | model on 10/25/2022. The fire   | Э                         |                  |  |
|   |   |                                   |   |                            | safety inspection company that  |                           |                  |  |
|   |   |                                   |   |                            | Porter-Starke Services, Inc. us   | ses,                      |                  |  |
|   |   |                                   |   |                            | Allegiant Fire Protection, was  |                           |                  |  |
|   |   |                                   |   |                            | notified of the deficiency and v  | VIII                      |                  |  |
|   | _   | ourpose. (3) In a cabinet or wall |   |                            | inspect for fire extinguisher placement during their annual   |                           |                  |  |
|   |   |                                   |   |                            | inspections. In addition, the   |                           |                  |  |
|   | recess. This deficient practice could affect staff in the dosing room.  |                                   |   |                            | Porter-Starke maintenance   |                           |                  |  |
|   |   |                                   |   |                            | department will add the review  | v of                      |                  |  |
|   | Findings include:   |                                   |   |                            | fire inspection location to their   |                           |                  |  |
|   |   |                                   |   |                            | monthly inspection checklists.  |                           |                  |  |
|   |   | ons during a tour of the facility |   |                            | These two procedures should   |                           |                  |  |
|   | with the Facilities Director on 10/18/22 at 1:35 p.m.   |                                   |   |                            | prevent a recurrence of this  |                           |                  |  |
|   | the ABC portable fire extinguisher located in the dosing room was sitting on the floor. Based on interview at the time of observation, the Facilities Director agreed the extinguisher was sitting on the   |                                   |   |                            | deficiency in the future. The   |                           |                  |  |
|   |   |                                   |   |                            | individual responsible for  | for                       |                  |  |
|   |   |                                   |   |                            | correcting the deficiency and to preventing its recurrence is the   |                           |                  |  |
|   | floor and not mount   |                                   |   |                            | Facilities Director, Steven Och   |                           |                  |  |
|   | moor and not mount  |                                   |   |                            | i dominos Director, oteven Oci  | ioa.                      |                  |  |
|   | This finding was re-  | viewed with the Facilities        |   |                            | For the fire extinguisher that h  | ad                        |                  |  |
|   | Director at the exit  |                                   |   |                            | an annual inspection date of M  |                           |                  |  |

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

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

| NAME OF PROVIDER OR SUPPLIER  PORTER-STARKE SERVICES INC  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  2. Based on observation and interview, the facility failed to ensure all portable fire extinguishers were given maintenance at periods not more than on eyear apart. NTPA 10, the Standard for Portable Fire Extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance was performed, identifies the name of the agency performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff.  Findings include:  Based on an observation with the Facilities Director agreed the fire extinguishers annual inspection date of May 2020. Based on interview at the time of observation, the Facilities Director agreed the fire extinguisher's annual inspection was past due.  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 154052 |   | A. BU   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |        | (X3) DATE SURVEY COMPLETED 10/19/2022   |   |            |  |
|--|---|---|---|--|--------|---|---|------------|--|
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  2. Based on observation and interview, the facility failed to ensure all portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year; at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 deficiens extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff.  Findings include:  Based on an observation with the Facilities Director on 10/18/2022 at 1:35 p.m., the tag on the ABC fire extinguisher in the dosing room had an annual inspection date of May 2020. Based on interview at the time of observation, the Facilities Director agreed the fire extinguisher's annual |   |   |   | 701 WALL ST                                      |        |   |   |            |  |
| 2. Based on observation and interview, the facility failed to ensure all portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the person performing the work, and identifies the person performing the work. This deficient practice could affect staff.  Findings include:  Based on an observation with the Facilities Director on 10/18/2022 at 1:35 p.m., the tag on the ABC fire extinguisher in the dosing room had an annual inspection date of May 2020. Based on interview at the time of observation, the Facilities Director agreed the fire extinguishers annual   | PREFIX  | (EACH DEFICIEN  | ICY MUST BE PRECEDED BY FULL  |  | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA  | TE  | COMPLETION |  |
| This finding was reviewed with the Facilities Director at the exit conference.   |   | 2. Based on observation failed to ensure all given maintenance year apart. NFPA I Fire Extinguishers, that fire extinguishers maintenance at inte at the time of hydro indicated by an insunctification. Section maintenance as a the extinguisher that is assurance that a fire effectively and safe damage or condition any repair or replace hydrostatic testing or required. Section 7. shall have a tag or limiticates the month performed, identifies work, and identifies work, and identifies performing the woraffect staff.  Findings include:  Based on an observe Director on 10/18/2 ABC fire extinguish annual inspection dinterview at the time Director agreed the inspection was past. | ation and interview, the facility portable fire extinguishers were at periods not more than one 10, the Standard for Portable at Section 7.3.1.1.1 requires ers shall be subjected to rvals of not more than 1 year, estatic test, or when specifically poection or electronic on 3.3.15 defines extinguisher corough examination of the fire intended to give maximum extinguisher will operate ally and to determine if physical in will prevent its operation, if ement is necessary, and if or internal maintenance is 3.3 states each fire extinguisher abel securely attached that and year the maintenance was est the person performing the state name of the agency k. This deficient practice could attion with the Facilities for extinguisher's annual due. |  |        | inspection, Allegiant Fire Protection, is scheduled to vis our facility on 11/8/2022 to ins and tag that fire extinguisher. Allegiant Fire Protection has be notified that it is critical to inclu the fire extinguisher in question their annual inspections. Local staff were reminded that there fire extinguisher in that room a that it is critical to maintain that fire extinguisher in working ord In addition, an employee of our maintenance staff will accomp our fire inspection company we they perform their annual inspection to ensure that they not fail to inspect one of our fire extinguishers. This should pre a recurrence of this missed inspection. The individual responsible for correcting this deficiency and for preventing to | pect een ude n in al is a und t der. ur any hen do re event |            |  |

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

PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | r í   | (X2) MULTIPLE CONSTRUCTION |                        |   | (X3) DATE SURVEY |                         |  |
|--|--|---|----------------------------|------------------------|---|------------------|-------------------------|--|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER 154052  |                            | A. BUILDING 03 B. WING |   |                  | COMPLETED<br>10/19/2022 |  |
|  |  | 10-1002   | В. W1                      |                        |   | 10/13            | 72022                   |  |
| NAME OF I  | PROVIDER OR SUPPLIEF   | R   |                            | 701 WA                 | ADDRESS, CITY, STATE, ZIP COD   |                  |                         |  |
| PORTER   | R-STARKE SERVIC  | ES INC  |                            |                        | RAISO, IN 46383   |                  |                         |  |
| (X4) ID  |  | STATEMENT OF DEFICIENCIE  |                            | ID                     | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)                    |  |
| PREFIX<br>TAG  | `  | CY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION              |                            | PREFIX<br>TAG          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE              | COMPLETION<br>DATE      |  |
| K 0000   | REGULATORT OF  | CESC IDENTIFTING INFORMATION  |                            | TAU                    |   |                  | DATE                    |  |
|  |  |   |                            |                        |   |                  |                         |  |
| Bldg. 03   | conducted by the In<br>accordance with 42<br>Survey Dates: 10/1<br>Facility Number: 0<br>Provider Number:  | 8-19/22<br>05585<br>154052  | K 00                       | 000                    |   |                  |                         |  |
|  | AIM Number: N/A  At this Life Safety Code Survey, Porter-Starke Services, Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 39, Existing Business Occupancies.  Building 03, a one story, non-sprinklered structure had a fire alarm system with smoke detection in the corridors. |   |                            |                        |   |                  |                         |  |
|  | Quality Review cor   | npleted on 10/21/22   |                            |                        |   |                  |                         |  |
| K 0000   |  |   |                            |                        |   |                  |                         |  |
|  |  |   |                            |                        |   |                  |                         |  |
| Bldg. 04   | 1  | Recertification Survey was diana Department of Health in CFR 482.41(b). | K 0                        | 000                    |   |                  |                         |  |
|  | Survey Dates: 10/1   | 8-19/22   |                            |                        |   |                  |                         |  |
|  | Facility Number: 0<br>Provider Number:<br>AIM Number: N/A  | 154052  |                            |                        |   |                  |                         |  |

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Event ID:

D7O221

Facility ID: 005585

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

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|   | T OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>154052 | · ′ | JILDING   | onstruction<br>04  | (X3) DATE<br>COMPI<br>10/19 | ETED                       |
|---|---|---|-----|---|--|-----------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER PORTER-STARKE SERVICES INC |   |   |     | 701 WA  | ADDRESS, CITY, STATE, ZIP COD<br>ALL ST<br>RAISO, IN 46383 |                             |                            |
| (X4) ID<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  |   |     | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |                             | (X5)<br>COMPLETION<br>DATE |
|   | At this Life Safety Code Survey, Porter-Starke Services, Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 39, Existing Business Occupancies.  Building 04, a one story, non-sprinklered structure had a fire alarm system with smoke detection in the corridors.  Quality Review completed on 10/21/22 |   |     |   |  |                             |                            |

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