PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		15G300	B. WING		11/08/2021
NAME OF E	PROVIDER OR SUPPLIER		STREE	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	ROVIDER OR SUPPLIER		110 V	/ PIKE ST	
	TIONAL SERVICES			TNSVILLE, IN 46151	<u>.</u>
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
E 0000					
Bldg					
Diag.	An Emergency Prer	paredness Survey was	E 0000		
		diana Department of Health	L 0000		
	in accordance with	-			
	Survey Date: 11/08	3/21			
	Facility Number: 0	00819			
	Provider Number:				
	AIM Number: 1002				
	At this Emergency	Preparedness Survey,			
	Transitional Service	es Sub LLC was found not in			
	compliance with En	nergency Preparedness			
	Requirements for M	ledicare and Medicaid			
	Participating Provid	lers and Suppliers, 42 CFR			
	483.475.				
	The facility has 8 ce	ertified beds. At the time of			
	the survey, the cens				
	Quality Review con	npleted on 11/09/21			
E 0039	403 748(4)(2) 444	6.54(d)(2), 418.113(d)(2),			
_ 0039	. , . ,	2.15(d)(2), 483.475(d)(2),			
Bldg		102(d)(2), 485.625(d)(2),			
Diag	, , , ,	727(d)(2), 485.920(d)(2),			
		1.12(d)(2), 494.62(d)(2)			
	EP Testing Requir				
		18.113(d)(2), §441.184(d)			
	(2), §460.84(d)(2),				
		- , , , ,			
	§483.73(d)(2), §483.475(d)(2), §484.102(d) (2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)				
	(2), §494.62(d)(2).				
	-	6.54, CORFs at §485.68,			
	OPO, "Organization	ons" under §485.727,			
				l	<u> </u>

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

TITLE (X6) DATE

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.

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

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	NSTRUCTION	(X3) DATE COMPL	ETED		
		15G300	B. W			11/08	2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
			-				(W.5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)	i	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	DATE	
IAG		20, RHCs/FQHCs at	+	IAG	Districtive!		DATE	
	_	RD Facilities at §494.62]:						
	3401.12, and LOI	ab i domines at 3404.02].						
		acility] must conduct ne emergency plan						
		ility] must do all of the						
	following:							
		full-scale exercise that is						
	community-based							
	1 ' '	nunity-based exercise is						
		nduct a facility-based e every 2 years; or						
		lity] experiences an actual						
	. ,	ade emergency that						
		of the emergency plan,						
		mpt from engaging in its						
		munity-based or individual,						
	1	tional exercise following						
	the onset of the ad	•						
		ditional exercise at least						
	every 2 years, opp							
	full-scale or function	onal exercise under						
	paragraph (d)(2)(i) of this section is						
	conducted, that m	ay include, but is not						
	limited to the follow	•						
	` '	scale exercise that is						
	· ·	or individual, facility-based						
	functional exercise	•						
	(B) A mock disaste							
		rcise or workshop that is						
	discussion using a	and includes a group						
		emergency scenario, and						
		tatements, directed						
	· ·	pared questions designed						
	to challenge an er							
	_	acility's] response to and						
	_ , , ,	ntation of all drills, tabletop						
		ergency events, and revise						
							<u> </u>	

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 2 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

				INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		15G300	B. W	ING		11/08	/2021
NAME OF F	DOMDED OF CIRPLICA		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER	X.		110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\\L	DATE
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	`					
		spices that provide care in					
		e. The hospice must					
		to test the emergency plan					
	· ·	The hospice must do the					
	following:						
		a full-scale exercise that is					
	community based						
	l ` '	nunity based exercise is not					
		ict an individual facility					
		exercise every 2 years; or					
		experiences a natural or ency that requires					
		mergency plan, the hospital					
		igaging in its next required					
		nity-based exercise or					
		pased functional exercise					
	1	et of the emergency event.					
	_	dditional exercise every 2					
	1 ' '	e year the full-scale or					
	1 *	e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		scale exercise that is					
	1 ' '	or a facility based					
	functional exercise	<u>.</u>					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and					
	a set of problem s	tatements, directed					
		pared questions designed					
	to challenge an e	mergency plan.					
	(3) Testina for hos	spices that provide inpatient					
	1 ' '	hospice must conduct					
	1	he emergency plan twice					
		5 71					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 3 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC (X4) ID SIMARRY STATIMINT OF DETICINATIS TAG RECULTORY OR LEGACIJATORY OLS LEGACITY OF THE CONTROL OF THE CON	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
STREET ADDRESS, CITY, STATE, ZIPCODE TRANSITIONAL SERVICES SUB LLC WHO DEPTICENCY MUST BE PRECEDED BY PULL TAG REQUIATORY OF INCREMENTAL OF CORRECTION AND TO THE PRECEDENCY OF THE PRECEDENCY	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING		COMPL	ETED
TRANSITIONAL SERVICES SUB LLC (Xi) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG FREFIX			15G300	B. W	ING		11/08/	2021
TRANSITIONAL SERVICES SUB LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG FREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREFI					STREET A	ADDRESS CITY STATE ZIP CODE		
TRANSITIONAL SERVICES SUB LLC (X4) D SUMMARY STATEMENT OF DEFICIENCES (RECH DEFICIENCY MUST BE PRECEDED BY FULL RECHAL TORY OR LSC (DESTRIPTION INFORMATION) Per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise, or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scanic, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. **Teor PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d); [2) Testing, The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises is to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must conduct exercises.	NAME OF P	NAME OF PROVIDER OR SUPPLIER						
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conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:		- ,	- , , -					
twice per year. The [PRTF, Hospital, CAH] must do the following:								
must do the following:			- · · · · · · · · · · · · · · · · · · ·					
(I) Participate in an annual full-scale			_					
i i i i i i i i i i i i i i i i i i i		i (i) Participate in a	n annuai tuii-scale					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 4 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE : COMPL 11/08/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE	
	(A) When a common to accessible, confacility-based functions are mergency that responding in its new community based functional exercise emergency event. (ii) Conduct are exercise or and the limited to the follow (A) A second full-community-based facility-based functionally-based facility-based functions (B) A money (C) A tabletop is led by a facilitate discussion, using a clinically-relevant a set of problem is messages, or prepto challenge an error (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded. *[For PACE at §46 (2) Testing. The Pacced conduct exercises at least annually. The participate in a exercise that is confidence in a exercise that is confidence.	dospital, CAH] Itual natural or man-made quires activation of the the [facility] is exempt from kt required full-scale or individual, facility-based or following the onset of the an [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed bared questions designed mergency plan. The [facility's] response to amentation of all drills, and emergency events sility's] emergency plan, as 100.84(d):] ACE organization must to test the emergency plan The PACE organization						

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 5 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G300	B. W	ING		11/08	/2021
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF F	ROVIDER OR SUPPLIER			110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	nduct an annual individual,					
	facility-based fund						
	, ,	rperiences an actual					
		ade emergency that					
		of the emergency plan,					
		npt from engaging in its next					
		community based or					
	-	based functional exercise					
	_	et of the emergency event.					
	` '	n additional exercise every he year the full-scale or					
	•	e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to						
		scale exercise that is					
	, ,	or individual, a facility					
	based functional e						
	(B) A mock disas						
	` '	ercise or workshop that is					
	, ,	and includes a group					
	discussion, using	- ·					
	_	emergency scenario, and					
	a set of problem s	tatements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	nergency plan.					
	(iii) Analyze the F	ACE's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the PACE's emero	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	(2) The [LTC facili	ty] must conduct exercises					
	to test the emerge	ency plan at least twice per					
	year, including un	announced staff drills					
	using the emerger	ncy procedures. The [LTC					
	facility, ICF/IID] m	ust do the following:					
		ın annual full-scale					
	exercise that is co	mmunity-based; or					
	, ,	unity-based exercise is					
	not accessible, co	nduct an annual individual,					
	l		1				I

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 6 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULT A. BUILD B. WING		NSTRUCTION	(X3) DATE : COMPL 11/08/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	an actual natural of that requires active plan, the LTC facili engaging its next of community-based functional exercise emergency event. (ii) Conduct an act that may include, lifeliowing: (A) A second full-community-based based functional executional executional executional executions. (B) A mock disast (C) A tabletop executed by a facilitator discussion, using clinically-relevant a set of problem singuished as the first of problem in the first of the f	lity] facility experiences or man-made emergency ation of the emergency ity is exempt from required a full-scale or individual, facility-based of following the onset of the diditional annual exercise out is not limited to the scale exercise that is or an individual, facility exercise; or ere drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and tatements, directed exercises, and emergency plan. TC facility] facility's naintain documentation of exercises, and emergency the [LTC facility] facility's as needed. 483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the manual full-scale exercise						

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 7 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE COMPL 11/08/	ETED	
	PROVIDER OR SUPPLIER		•	110 W P	DDRESS, CITY, STATE, ZIP CODE PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
	requires activation the ICF/IID is exer next required full-sindividual, facility-following the onse (ii) Conduct an adithat may include, following: (A) A second full-scommunity-based facility-based function (B) A mock disaste (C) A tabletop exeled by a facilitator discussion, using clinically-relevant a set of problem smessages, or prepto challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a cois not accessible, individual, facility-levery 2 years; or. (B) If the HHA natural or man-mare requires activation.	tional exercise; or er drill; or roise or workshop that is and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed mergency plan. F/IID's response to and tation of all drills, tabletop ergency events, and revise gency plan, as needed. 4.102] HHA must conduct me emergency plan at the HHA must do the full-scale exercise that is for or ommunity-based exercise					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 8 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COM	e survey Pleted 8/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	individual, facility in following the onse (ii) Conduct an advers, opposite the functional exercise of this section is conclude, but is not (A) A second community-based facility-based function is led by a facilitate discussion, using clinically-relevant a set of problem s messages, or prepto challenge an er (iii) Analyze the HI maintain documer exercises, and emthe HHA's emergen (d)(2) Testing. The exercises to test the OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency plan. I actual natural or mergency plan. I actual	limited to the following: full-scale exercise that is or an individual, tional exercise; or saster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed bared questions designed mergency plan. HA's response to and ditation of all drills, tabletop ergency events, and revise ency plan, as needed. 66.360] e OPO must conduct me emergency plan. The						

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 9 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPL		
		15G300	B. W	NG		11/08/	2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΤE	(X5) COMPLETION DATE	
	maintain documer exercises, and em the [RNHCl's and as needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paperat least annually. If you discussion I narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversality failed to core emergency plan at I ICF/IID facility mu (i) Participate in an that is community-based functions. When a community accessible, conduct facility-based functions. If the ICF/IID facility is exempt for required full-scale is individual, facility-exercise for 1 year factual event.	PO's response to and attation of all tabletop bergency events, and revise OPO's] emergency plan, 3.748]: Part RNHCI must conduct the emergency plan. The bergency plan. The bergency plan. The bergency exercise is a sed by a facilitator, using a serelevant emergency plan. The bergency plan bergency plan bergency plan. The bergency plan bergency plan bergency events, and revise regency plan, as needed bergency plan, as needed bergency plan, as needed bergency plan, as needed bergency plan bergency plan, as needed berg	E 04	039	The QIDP, Program Supervisor and staff in the home have beer retrained to ensure Emergency Preparedness Plan training exercises are completed annuas required. There is a schedin the home that has been reviewed to be followed to ensull trainings are completed as required and that documentatic is kept in the Home Safety Boand available for immediate review. Persons Responsible: Program Supervisor, QIDP	en y ally ule sure on ok	12/08/2021	

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 10 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	<u></u>	COMPL	ETED
		15G300	B. WI	NG		11/08/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDER'S BLANGE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE	DATE
	include, but is not li	mited to the following:					
	a. A second full-sca	le exercise that is					
		r an individual, facility-based					
	functional exercise.						
	b. A mock disaster of	drill; or					
		se or workshop that is led by					
	-	ludes a group discussion led					
	by a facilitator, usin						
	-	emergency scenario, and a set					
	of problem statemer	nts, directed messages, or					
	-	designed to challenge an					
	emergency plan.						
		F/IID facility's response to					
	and maintain docum	nentation of all drills, tabletop					
	exercises, and emer	gency events, and revise the					
	ICF/IID facility's en	nergency plan, as needed in					
	accordance with 42	CFR 483.475(d)(2). This					
		ould affect all occupants.					
	Findings include:						
		the facility's Emergency					
		on 11/08/21 between 10:15					
	-	with the Area Director					
		provided emergency					
		nentation, however it was					
		was documentation provided					
		onse to the COVID-19					
		gency, however, the facility					
	_	de documentation of an					
		to test the emergency					
		Based on interview at the					
		w, the Area Director					
	-	vas unable to provide					
	documentation of an	n additional exercise.					
	TEL: (* 1:	t didd A St.					
		viewed with the Area Director					
	during the exit conf	erence.					
			1				

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 11 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		ľ	JILDING	01		LETED 5/2021	
	PROVIDER OR SUPPLIER		<u> </u>	110 W F	NDDRESS, CITY, STATE, ZIP CODE PIKE ST NSVILLE, IN 46151	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 0000							
Bldg. 01			K 0	000			
	Facility Number: 0 Provider Number: AIM Number: 100	15G300					
	Services Sub, LLC with Requirements 42 CFR Subpart 48. Fire and the 2012 ed Protection Associat	Code survey, Transitional was found not in compliance for Participation in Medicaid, 3.470(j), Life Safety from dition of the National Fire ion (NFPA) 101, Life Safety er 33, Existing Residential eupancies.					
	sprinklered. The fa with heat detectkion detection on all level bedrooms, all living	ity with a basement was fully cility has a fire alarm system in the attic and smoke els including corridors, areas and the basement. The ty of 8 and had a census of 7 arvey.					
	(E-Score) using NF	evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the n E-Score of 2.4.					
	Quality Review con	npleted on 11/09/21					
K S100 Bldg. 01	NFPA 101 General Requirem General Requirem						

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 12 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01			ETED
		15G300			11/08/	2021	
		1.0000				, ,	
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					PIKE ST		
TRANSITIONAL SERVICES SUB LLC			MARTII	NSVILLE, IN 46151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2012 EXISTING						
	List in the REMAF	RKS section any LSC					
	Section 33.1 or 33	3.2 General Requirements					
	that are not addre	essed by the provided					
		eficient. This information,					
	•	olicable Life Safety Code or					
		tation, should be included					
	on Form CMS-256						
		on and interview, the facility	KS	100	The exhaust fan/vent in the		12/08/2021
		f 2 bathroom exhaust vent	1 12 2	100	upstairs bathroom of the home	_	12/00/2021
		t/dirt. NFPA 101 at 33.1.1.3			was cleaned of buildup on	•	
	refers to Chapter 4,				11/10/21 by a local contractor		
	_	whenever or wherever an			The vent will be monitored at I		
						easi	
	device, equipment,	-			monthly and cleaned out as	of	
		of protection, or any other			needed to prevent the buildup	OI	
	_	for compliance with the			lint to prevent the risk of fire		
	_	Code, such device, equipment,			danger.		
	-	arrangement, level of			Persons Responsible: Progra	m	
	_	feature shall thereafter be			Supervisor, QIDP		
		the Code exempts such					
		deficient practice could					
	affect all occupants	in the facility.					
	Findings include:						
	Based on observation	ons on 11/08/21 between					
	10:15 a.m. and 12:3	30 p.m. during a tour of the					
		ea Director, the exhaust vent					
	fan in the second flo						
		with lint/dirt, which could					
	-	leaned on a regular basis.					
		at the time of observation,					
		greed there was a substantial					
		built up in the second floor					
	bathroom exhaust v						
	oaumoom canaust v	one rall.					
	This finding was ra	viewed with the Area Director					
	during the exit conf						
	auring the exit coll	toronee.					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 13 of 20

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		15G300	B. WING 11/08/202			2021	
				CED FEET	A PARTICLE CONT. CT. TE. CO. CO.		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
TDANIGIT	TONAL OFFINIOFO	OUR LLO			PIKE ST		
TRANSITIONAL SERVICES SUB LLC			MARIII	NSVILLE, IN 46151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K S353	NFPA 101						
	Sprinkler System -	- Maintenance and Testing					
Bldg. 01	Sprinkler System -	- Maintenance and Testing					
	2012 EXISTING (F	Prompt)					
	NFPA 13 and 13R	R Systems					
	All sprinkler syster	ms installed in accordance					
	with NFPA 13, Sta	andard for the Installation of					
	Sprinkler Systems	, and NFPA 13R, Standard					
	for the Installation	of Sprinkler Systems in					
	Residential Occup	pancies Up To and					
	Including Four Sto	ories in Height, are					
	inspected, tested a	and maintained in					
	accordance with N	IFPA 25, Standard for					
	Inspection, Testing	g and Maintenance of					
	Water Based Fire	Protection System.					
	NFPA 13D System	ns					
	Sprinkler systems	installed in accordance					
	with NFPA 13D, S	tandard for the Installation					
	of Sprinkler Syster	ms in One- and					
	Two-Family Dwelli	ings and Manufactured					
	Homes, are inspec	cted, tested and maintained					
	in accordance with						
	requirements of N						
		s inspected monthly (NFPA					
	25, section 13.3.2)	•					
		ected monthly (NFPA 25,					
	section 13.2.71).						
		s inspected quarterly					
	(NFPA 25, section	•					
		s tested semiannually					
	(NFPA 25, section	•					
	•	sory switches tested					
		PA 25, section 13.3.3.5).					
	•	lers inspected annually					
	((NFPA 25, section						
		spected annually (NFPA					
	25, section 5.2.2).						
	• •	angers inspected annually					
	(NFPA 25, section	•					
	Buildings insp	ected annually prior to					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 14 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>			COMPL	COMPLETED	
		15G300	B. WING 11/08/2021			2021		
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹						
TRANSITIONAL SERVICES SUBJECT					PIKE ST			
TRANSITIONAL SERVICES SUB LLC				MARTII	NSVILLE, IN 46151			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE	
	freezing weather f	for adequate heat for water						
		A 25, section 5.2.5).						
		ative sample of fast						
		rs are tested at 20 years						
	(NFPA 25, section							
		ative sample of dry pendant						
		ed at 10 years (NFPA 25,						
	section 5.3.1.1.15	• •						
		olutions are tested annually						
	(NFPA 25, section							
	1 '	es are operated through						
		d returned to normal						
		5, section 13.3.3.1).						
		tems of OS&Y valves are						
		y (NFPA 25, section						
	13.3.4).	, ,						
	· '	stems extending into						
		s of the building are						
	· ·	and maintained (NFPA 25,						
	section 13.4.4).	(
	·	system last checked and						
	necessary mainte	_						
		names promosa						
	B. Show who prov	vided the service						
	B. Gliow who prov	nada and del vide.						
	C. Note the source	e of the water supply for						
	the automatic spri							
		inition dystorii.						
	(Provide in REMA	RKS information on						
	l '	non-required or partial						
	automatic sprinkle							
		.5.8, 9.7.5, 9.7.7, 9.7.8,						
	and NFPA 25	.0.0, 0.7.0, 0.7.7, 0.7.0,						
		ration and interview, the	KS	252	Koorsen went to the home on		12/08/2021	
		sure 4 of over 30 sprinkler	KS	333	11/17/21 to observe the sprink	lers	12/06/2021	
	1	were free of corrosion,			cited in the survey. A quote w			
	· ·	substance. NFPA 25,			be obtained for the repair of th			
	*	spection, Testing, and			sprinkler heads and once			
		spection, Testing, and ster-Based Fire Protection			approved, the work will be			
					completed to ensure the home	ie		
	Systems at 3.2.1.1.	l requires sprinklers to be	1		Completed to ensure the nome	: 15		

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 15 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í		DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPL	
		15G300	B. W	ING		11/08/	2021
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SUITEIEN			110 W F	PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DD 044DD 14 DV 144 D 000 D		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	free of paint and co	rrosion. 5.2.1.1.2 requires			in compliance. The sprinklers	will	
	any sprinkler that sl	nows signs of paint or			be observed during semi-annเ	ıal	
		eplaced. This deficient			inspections and repaired timel	y if	
	practice could all cl	ients and staff.			deficiencies are found.		
					Persons Responsible: Program		
	Findings include:				Supervisor, QIDP		
ı	Based on observation	ons on 11/08/21 between					
		0 p.m. during a tour of the					
		ea Director, the following was					
	noted:	,					
	a. Two sprinkler he	eads in the kitchen covered					
		a gooey black substance.					
	-	ad in the first floor bathroom					
	was covered with co						
	-	ad in the only bedroom on the					
	first floor had paint						
		at the time of observations,					
		greed the sprinkler heads					
	substance.	corrosion, paint, and a foreign					
	substance.						
	This finding was re	viewed with the Area Director					
	during the exit conf	erence.					
		ation and interview, the					
	<u>-</u>	sure only one type of					
	1 1	uick response or standard					
	-	alled in 1 of 1 dining room.					
		tion, Installation of Sprinkler					
	Systems, Section 8.	nklers are installed, all					
		compartment shall be					
	_	ess otherwise permitted in					
		tion 8.3.3.4 states when					
		d systems are converted to					
		or residential sprinklers, all					
		partmented space shall be					
		cient practice could affect					
	clients.						
			ı				

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet

Page 16 of 20

) ´		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300			A. BUILDING 01 B. WING			COMPLETED 11/08/2021	
		15G300	B. W			11/08/	2021
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE PIKE ST			
TRANSITIONAL SERVICES SUB LLC				NSVILLE, IN 46151			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:						
	Based on observation	ons on 11/08/21 between					
		30 p.m. during a tour of the					
		ea Director, the dining room					
	•	one quick response sprinkler					
		ard response residential					
		sed on interview at the time of					
	•	ea Director acknowledged the					
	· ·	uipped with a quick response					
		a standard response residential					
	sprinkler head.	•					
	•						
	This finding was re	viewed with the Area Director					
	during the exit conf	Perence.					
K S362	NFPA 101						
	Corridors - Constr	ruction of Walls					
Bldg. 01	Corridors - Constr	ruction of Walls					
	2012 EXISTING (
	,	indicated below, corridor					
	walls shall meet a						
		ng sleeping rooms have a					
		r fire resistance rating,					
	which is considere	ed to be achieved if the					
	partitioning is finis	hed on both sides with lath					
	and plaster or ma	terials providing a					
	15-minute therma	l barrier.					
	* Sleeping room	doors are substantial					
	doors, such as the	ose of 1-3/4 inch thick,					
	solid-bonded woo	d-core construction or					
	other construction	of equal or greater					
	stability and fire in	itegrity.					
	* Any vision pan	els are fixed fire window					
	assemblies in acc	ordance with 8.3.4 or are					
	wired glass not ex	ceeding 9 square feet each					
	in area and install	ed in approved frames.					
	This requirement:	shall not apply to corridor					
		oke partitions in accordance					

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 17 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/08/2021			
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	sprinklers in accorboth sides of the vinstances, there is type or size of gla In Prompt Evacuar rooms shall be seroute by smoke particles. Sleeping arranger in sleeping rooms nonresident staff audibility of the alsufficient to awake sleeping. In previously apprigroup achieves are using the board a NFPA 101A, Guid Approaches to Lift shall be separated walls and doors the 33.2.3.6 Based on observation failed to ensure combedrooms would rear This deficient pract staff and visitors. Findings include: Based on observation failed to ensure combedrooms would rear This deficient pract staff and visitors. Findings include: Based on observation failed to ensure combedrooms would rear this deficient pract staff and visitors. Findings include:	parated from the escape artitions in accordance with ments that are not located shall be permitted for members, provided that the arm in the sleeping area is en staff that might be coved facilities, where the n E-score of three or less and care methodology of	K S362	The door cited in the survey the was short for the door frame verpaired on 11/10/21. Any fut repairs of doors in the home verbe measured to fit the door frames to ensure safety of the home. Persons Responsible: Program Supervisor, QIDP	vas ure vill		

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING <u>01</u>			COMPLETED	
		15G300	B. W	B. WING			11/08/2021	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			1				
TRANSITIONAL SERVICES SUBJECT				PIKE ST				
TRANSITIONAL SERVICES SUB LLC			WARTII	NSVILLE, IN 46151				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Director said the do	or to room #6 was just						
	replaced because the	e previous door had been						
	damaged. She furth	ner said the current door is						
	probably only a tem	porary door until the						
	replacement door is	delivered.						
	This finding was rev	viewed with the Area Director						
	during the exit confe							
	_		İ					
K S712	NFPA 101							
	Fire Drills							
Bldg. 01	Fire Drills							
	1. The facility mus	t hold evacuation drills at						
	least quarterly for	each shift of personnel						
	and under varied o	conditions to:						
	a. Ensure that al	ll personnel on all shifts are						
	trained to perform	assigned tasks;						
	b. Ensure that al	ll personnel on all shifts are						
	familiar with the us	se of the facility's						
	emergency and di	saster plans and						
	procedures.							
	2. The facility mus	t:						
	a. Actually evacı	uate clients during at least						
	one drill each year	r on each shift;						
	b. Make special	provisions for the						
	evacuation of clier	nts with physical						
	disabilities;							
	c. File a report a	nd evaluation on each						
	drill;							
	d. Investigate all	problems with evacuation						
	drills, including acc	cidents and take corrective						
	action; and							
	e. During fire dri	lls, clients may be						
	_	fe area in facilities certified						
	under the Health 0	Care Occupancies Chapter						
	of the Life Safety (
		neet the requirements of						
		and (2) of this section for						
		ef staff that they utilize.						
	42 CFR 483.470(i)							

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

Event ID: GMYL21 Facility ID: 000819

If continuation sheet Page 19 of 20

PRINTED: 11/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G300		(X2) MULTIPLE (A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 11/08/2021			
	PROVIDER OR SUPPLIER FIONAL SERVICES SUB LLC	110 W	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		The QIDP, Program Supervisor and staff in the home have been retrained to ensure fire evacual drills are completed monthly as required. There is a schedule the home that has been review to be followed to ensure all drill are completed as required and that documentation is kept in the Home Safety Book and available for immediate review. Persons Responsible: Program Supervisor, QIDP	en stion s in ved lls l he			

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

Event ID:

GMYL21 Facility ID: 000819

If continuation sheet Page 20 of 20