TENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155226	B. WING		06/26/2024	
	PROVIDER OR SUPPLIER	S & REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP COD I CAPITOL AVE JAPOLIS, IN 46202		
(V4) ID	CIDAMADV	CTATEMENT OF DEFICIENCIE	ID.	T	(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	•	CY MUST BE PRECEDED BY FULL	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE	
L 0000						
Bldg	conducted by the In accordance with 42  Survey Date: 06/26  Facility Number: 0  Provider Number: 100  At this Emergency Capitol Nursing & I found in compliance Preparedness Requi Medicaid Participat CFR 483.73.  The facility has 123 the survey, the cens	00131 155226 274910 Preparedness survey, North Rehabilitation Center was e with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 67.	E 0000	To whom it may concern for, the provider requests a desk reviet lieu of an in person PSR for elevable 4yph21. Please let me know it any questions or if additional information is needed to assist a desk review if granted.  Thank you	ew in vent f you	
K 0000	Quantity Tee view Con	ducted on 07/02/24				
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/26 Facility Number: 0 Provider Number: AIM Number: 1000	00131 155226 274910	K 0000	To whom it may concern for, to provider requests a desk reviel lieu of an in person PSR for each 4yph21. Please let me know it any questions or if additional information is needed to assist a desk review if granted.  Thank you	ew in vent f you	
	At this Life Safety (	Code survey, North Capitol	1			

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

TITLE (X6) DATE

Roland Todd Mann Executive Director 07/18/2024

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 disclodays 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.

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STATEME	NT OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155226	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	CO	(X3) DATE SURVEY COMPLETED 06/26/2024	
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP CO CAPITOL AVE APOLIS, IN 46202	)D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)		(X5) COMPLETION DATE	
	Nursing and Rehab in compliance with in Medicare/Medic Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This four story faci Type II (000) const The facility has a fi detection in the corr the corridor. The faller in the fire sleeping rooms. The unit beds. Vent unifloor in Rooms 319 capacity of 123 and of this visit.  All areas where res were sprinklered. The building providing was not sprinklered.	ilitation Center was found not Requirements for Participation aid, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies.  lity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to acility has smoke detectors re alarm system in all resident the facility has a total of 15 vent at beds are located on the third of through 326. The facility has a I had a census of 67 at the time  idents have customary access The facility has one detached facility storage services which					
K 0161 SS=F Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, ur 19.1.6.2 through 19.1.6.4, 19.1.6.5						

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Event ID:

non-sprinklered and

4YPH21

Facility ID: 000131

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	01	COMPL	ETED
		155226	B. WING	i		06/26/	2024
				TDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			CAPITOL AVE		
NORTH (	CAPITOL NURSING	G & REHABILITATION CENTER			APOLIS, IN 46202		
1401(111)		S & REITABLEITATION OF THE R	<u> </u>	. 101/11/	, u OLIO, IIV 70202	-	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
	sprinklered						
	0 " (444)	One ata					
	2 II (111)	One story					
	non-sprinklered	Maximum 3 atorica					
	sprinklered	Maximum 3 stories					
	sprinklered						
	3 II (000)	Not allowed					
	non-sprinklered	140t anoved					
	4 III (211)	Maximum 2 stories					
	sprinklered						
	5 IV (2HH)						
	6 V (111)						
	<b> </b>						
	7 III (200)	Not allowed					
	non-sprinklered						
	8 V (000)	Maximum 1 story					
	sprinklered						
	•	s must be sprinklered					
		approved, supervised					
		in accordance with section					
	9.7. (See 19.3.5)	· · · · · · · · · · · · · · · · · · ·					
		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	K 016	1	K 161		07/23/2024
		building construction type	15 010	1	1. 191		011231202 <del>1</del>
		e as listed in Table 19.1.6.1.			What corrective actions will	be	
		ires a sprinklered building, four			accomplished for those	-	
	_	eight, to be Type II (222), Type			residents found to have beer	,	
	I (332) or Type I (4	42). This deficient practice			affected by this deficient		
	could affect all resid	dents, staff and visitors.			practice?1. On 7/18/2024 a ne	ew	
					FSES was completed using		
	Findings include:				NFPA 101A, Guide on		
					Alternative Approaches to Li	fe	
		ons with the Maintenance			Safety, 2001 Edition, post		
	Director during a to	our of the facility from 1:00 p.m.			correction of items other tha	n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155226	B. Wl	ING		06/26/	
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER		2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR to 4:15 p.m. on 06/2 building was constr was determined to be suspended ceiling a by Room 203, Room unprotected. This relassification of Typat the time of the obdirector stated there construction type si Safety Code survey bearing walls consistent.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 26/24, this four story sprinklered ucted of unprotected steel and be Type II (000) construction. aring wall above the bove the north stairwell door in 302 and Room 402 was esults in a construction type be II (000). Based on interview disservations, the Maintenance was no change in the ince the most recent Life and agreed interior load sted of unprotected steel.  The reviewed with the Executive sintenance Director during the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  noted on K161. 2. How will yo identify other residents that have the potential to be affected by this deficient practice?All residents and visitors have the potential to be affected by this deficient practice. 3. What measures will be put in place or what systemic changes will be ma to ensure that this deficient practice does not recur? The facility completed a FSES worksheet on 7/18/2024 whice resulted in all items in Worksheet 4.7.9 checked as "Yes" and all items in Worksheet 4.7.10 being identified as "Met". The 4/28/2023 FSES demonstrate the level of fire safety is equivalent to that prescribed by NFPA 101, Life Safety Coo for Healthcare Occupancies. Executive Director will ensur a FSES worksheet is comple annually.	de h s de 4.	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: SOR SECURITY THREAT king arrangements for the teeds of the patient are					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155226	B. W	ING		06/26	/2024
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD  CAPITOL AVE		
NODTH	CADITOL NILIDOINI	C & DELIABILITATION CENTED					
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	used, only one loo	cking device shall be					
	permitted on each	n door and provisions shall					
	be made for the ra	apid removal of occupants					
	by: remote contro	l of locks; keying of all					
	locks or keys carried by staff at all times; or 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						
	ARRANGEMENT						
	•	king arrangements for the					
	1	ne patient are used, all of					
		curity Locking requirements					
	_	addition, the locks must be					
		at fail safely so as to					
	· ·	of power to the device; the					
		ed by a supervised					
		er system and the locked					
		d by a complete smoke					
	· ·	(or is constantly monitored					
		cation within the locked					
	1 '	the sprinkler and detection					
	_	nged to unlock the doors					
	upon activation.	0.050 714 40 4					
		.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
	• •	delayed-egress locking					
	1 -	in accordance with					
		permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
	· ·	or an approved, supervised					
	automatic sprinkle 18.2.2.2.4, 19.2.2						
	*						
		ROLLED EGRESS					
	LOCKING ARRAI						
	Access-Controlled	d Egress Door assemblies					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155226	B. W	ING	_	06/26/	2024
NAME OF P	PROVIDER OR SUPPLIER	}	•		ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
					CAPITOL AVE		
NORTH (	CAPITOL NURSING	G & REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		lance with 7.2.1.6.2 shall					
	be permitted.	0.4					
	18.2.2.2.4, 19.2.2						
		ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS					
	Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted						
		es in buildings protected					
		approved, supervised					
		approved, supervised ection system and an					
		ised automatic sprinkler					
	system.	ised automatic sprinkler					
	18.2.2.2.4, 19.2.2	2.4					
		on and interview, the facility	K O	222	What corrective actions will be		07/23/2024
		means of egress through 3 of	11.0		accomplished for those		0772372021
		ly accessible for residents			residents found to have been		
		iagnosis requiring specialized			affected by this deficient	-	
		Doors within a required means			practice?		
	-	be equipped with a latch or			All doors identified during the	tour	
	-	ne use of a tool or key from the			missing and entry/exit code ha		
	-	otherwise permitted by LSC			been corrected with the		
	19.2.2.2.4. Door-lo	ocking arrangements shall be			appropriate codes posted.		
	permitted in accord	ance with 19.2.2.5.2. This			2. How will you identify othe	r	
	deficient practice co	ould affect over 20 residents,			residents that have the		
	staff and visitors if	needing to exit the facility.			potential to be affected by th	nis	
					deficient practice		
	Findings include:				All visitors and resident have		
					potential to be affected by this	3	
		ons with the Maintenance			deficiency.		
	_	our of the facility from 1:00 p.m.					
	•	26/24, the door set to the			All entry/exit door have been		
		apitol Street entrance on the			audited by maintenance		
		floor dining room exit to the			department and any missing t		
	_	tyard, and the corridor door to			appropriate codes have been		
		second floor by Room 203			corrected		
		as a facility exit with an exit			3. What measures will be put	t in	
	-	Street courtyard had a			place or what systemic		
		ch was locked but could be			changes will be made to		
		a code to release the gate to			ensure that this deficient		
	open. Each of the e	exit doors could be opened by	1		practice does not recur?		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155226	B. W	ING		06/26	/2024
		1	1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			CAPITOL AVE		
NORTH (	CAPITOL NI IRSINI	G & REHABILITATION CENTER			APOLIS, IN 46202		
NONTH	CAT IT OF MONOIM	O & REHABILITATION CLIVIER		וואטואוו	7.11 OLIO, 114 70202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	-	a keypad to release the door			. The maintenance departmen	ıt	
	•	code to release the exit doors			in-serviced on ensuring door of	codes	
		sted at the exit doors. Based			are posted at all times. The		
		time of the observations, the			maintenance director or desig	nee	
		tor stated residents who need			will audit weekly to ensure no		
	to be in a secure wing are housed on the third floor and agreed the code to release the exit doors				doors are missing the appropr		
					entry/exit codes . Audits to en	sure	
	to open was not pos	sted at the exit doors.			door codes are posted will be		
					conducted each week.		
	-	e reviewed with the Executive					
		aintenance Director during the			4. How the corrective action(		
	exit conference.				will be monitored to ensure t	:he	
					deficient practice will not		
	3.1-19(b)				recur, i.e. what quality		
					assurance program will be p	ut	
					into place?		
					A egress QAPI Tool will be		
					utilized weekly x 4 weeks,		
					monthly x 6 months, and quar	-	
					thereafter for one year with re		
					reported to the Quality Assura		
					and Performance Improvemen	nt	
					Committee overseen by the		
					Executive Director. If a thresh		
					of 95% is not achieved, an act		
					plan will be developed to ensu	ire	
					compliance		
K 0232	NEDA 101						
SS=E	NFPA 101 Aisle, Corridor, or	· Damp Width					
SS−⊑ Bldg. 01		•					
Diay. 01	Aisle, Corridor or 2012 EXISTING	ranp wuun					
		e or corridore (clear or					
		s or corridors (clear or					
	· · · · · · · · · · · · · · · · · · ·	ving as exit access shall be					
		I maintained to provide the					
		val of nonambulatory patients					
		cept as modified by					
	19.2.3.4, exceptio	ONS 1-0.	1				I

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19.2.3.4, 19.2.3.5

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155226	B. W	NG		06/26/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEI	3			CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER		INDIANAPOLIS, IN 46202			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLI	ETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	
		view, observation, and	K 0	232	What corrective actions will	be 07/23	/2024
		ity failed to meet the clear width			accomplished for those		
	_	f 2 third floor corridors or met			residents found to have bee	י ן	
	an exception per 19.2.3.4(4). LSC Section				affected by this deficient		
	19.2.3.4(4) states projections into the required width shall be permitted for wheeled equipment,				practice?	_	
	_				All corridors identified as bein		
	*	the following conditions are			obstructed have been correct		
	met:	uinment door not reduce the			The three Hoyer lifts stored in		
		uipment does not reduce the corridor width to less than 60			corridor outside the DNS have	;	
	inches.	corridor width to less than 60			been removed.		
		occupancy fire safety plan and			2. How will you identify othe residents that have the		
		ddress the relocation of the			potential to be affected by the	ic	
		during a fire or similar			deficient practice	15	
	emergency.	during a fire of similar			All visitors and residents on the		
		uipment is limited to the			third floor have the potential to		
	following:	diplicit is innited to the			affected by this deficiency.	, be	
	i. Equipment in use	and carts in use			All corridors/aisles have been		
		ncy equipment not in use			audited to ensure they are no		
		ransport equipment			obstructed and meet the	,	
		cice could affect over 10			clearance requirements.		
	_	visitors if needing to exit the			3. What measures will be pu	in	
	third floor of the fa				place or what systemic		
		,			changes will be made to		
	Findings include:				ensure that this deficient		
					practice does not recur?		
	Based on review of	the "Fire/Explosion			Staff to be in-serviced on ens	uring	
	Emergency Action	Plan" section of the			all aisles/corridors are free fro	~ I	
	"Emergency Prepar	redness Program"			obstruction at all times. The	ED	
	documentation date	ed 01/24/24 with the			or designee will audit weekly	o	
	Administrator and	the Maintenance Director			ensure corridors/aisles are no	t	
	during record revie	w from 9:30 a.m. to 12:20 p.m.			obstructed.		
	on 06/26/24, the he	alth care occupancy fire safety					
	_	relocation of wheeled			4. How the corrective action	s)	
		fire or similar emergency.			will be monitored to ensure	he	
	_	ementioned documentation			deficient practice will not		
		uipment in the corridor should			recur, i.e. what quality		
	be located out of th	e path of egress: shower room			assurance program will be p	ut	
		ased on observations with the			into place?		
	Maintenance Direc	tor during a tour of the facility			A corridor QAPI Tool will be		

ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155226	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/26/2024	
	PROVIDER OR SUPPLIER	S & REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP COD I CAPITOL AVE NAPOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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	
	Hoyer lifts were sto Director of Nursing near the stairwell de facility exit with an wheeled equipment width in the path of corridor to 45 inche time of the observa Director agreed the equipment reduced corridor width of th inches. These findings were	enter in the corridor outside the services on the third floor outside the services on the third floor outside was marked as a exit sign. The storage of the in the corridor restricted the segress in the eight foot wide as. Based on interview at the tions, the Maintenance aforementioned wheeled the clear unobstructed are corridor to less than 60.  The reviewed with the Executive annual management of		utilized weekly x 4 weeks, monthly x 6 months, and quar thereafter for one year with re reported to the Quality Assura and Performance Improvemed Committee overseen by the Executive Director. If a thresh of 95% is not achieved, an action plan will be developed to ensuronmental compliance	sults ance nt old tion	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alar Records of system and testing are re 9.6.1.3, 9.6.1.5, N Based on observation	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	What corrective actions will accomplished for those	be 07/23/2024	
	that it had accurate accordance with the 2012 edition, Section	time and date information in requirements of NFPA 101, ons 19.3.4 and 9.6 and NFPA 72, ons 14.1 and 14.1.1. This		residents found to have been affected by this deficient practice?  Fire panels that were identified		

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deficient practice could affect all residents, staff

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show inaccurate times have been

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155226	B. WI	NG		06/26/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			CAPITOL AVE		
NORTH (	CAPITOL NURSING	G & REHABILITATION CENTER			APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 COM	PLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		OATE
	and visitors.				reset and now display the corr	ect	
					times		
	Findings include:				2. How will you identify other	•	
					residents that have the		
		ons with the Maintenance			potential to be affected by th	is	
	Director during a tour of the facility from 1:00 p.m.				deficient practice		
	-	26/24, the remote fire alarm			All visitors and resident have t	he	
	-	second floor nurse's station			potential to be affected by this		
	-	y as 15:07 at 2:27 p.m. In			deficiency.		
		ire alarm system control panel electrical room on the first			All fire panels have been audit		
		of day as 16:27 at 3:46 p.m.			and all times are now showing		
	Based on interview				correctly by the Maintenance Director.		
		aintenance Director agreed			3. What measures will be put	in	
		m control panels for the facility			place or what systemic	"	
	displayed the incorr				changes will be made to		
	displayed the meen	eet time of day.			ensure that this deficient		
	These findings were	e reviewed with the Executive			practice does not recur?		
	_	aintenance Director during the			All fire panels have been audi	ted	
	exit conference.	2			and all times are now showing		
					correctly. The maintenance		
	3.1-19(b)				department in-serviced on		
					ensuring fire alarm panels are		
					displaying the correct time. The	ne	
					maintenance director or design	nee	
					will audit weekly to ensure fire		
					panel time displays are checke	ed	
					and are accurate <del>. Audits will b</del>		
					conducted each week x 4, the		
					monthly x4, then as needed if	<del>no-</del>	
					trends are identified.		
						<u> </u>	
					4. How the corrective action(	-	
					will be monitored to ensure t	ne	
					deficient practice will not		
					recur, i.e. what quality		
					assurance program will be p	ut	
					into place?		
					A Fire alarm QAPI Tool will be	†	
					utilized weekly x 4 weeks,		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155226	(X2) MULTIPI A. BUILDIN B. WING	le construction ig <u>01</u>	(X3) DATE SURVEY COMPLETED 06/26/2024
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER	201	EET ADDRESS, CITY, STATE, ZIP COD 10 N CAPITOL AVE DIANAPOLIS, IN 46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPE	(X5) COMPLETION DATE
				monthly x 6 months, and quathereafter for one year with reported to the Quality Assurand Performance Improvement Committee overseen by the Executive Director. If a threst of 95% is not achieved, an aplan will be developed to encompliance	esults rance ent hold ction
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with None Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR	supply source  RKS information on non-required or partial r system.			
	1. Based on observation failed to ensure 1 of were replaced every tested every 5 years calibrated gauge. Number of the second of	tion and interview, the facility 6 sprinkler system gauges 7 years or documented as by comparison with a FPA 25, Standard for the and Maintenance of rotection Systems, 2011 2.1 states gauges shall be	K 0353	What corrective actions will accomplished for those residents found to have be affected by this deficient practice?  The sprinkler gauge identified during the tour has been repeated appropriate documentate.	en ed laced

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155226	B. W	ING		06/26/2024	
		l	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			CAPITOL AVE		
NORTH (	CAPITOL NURSIN	G & REHABILITATION CENTER			APOLIS, IN 46202		
			ı		, , , , , , , , , , , , , , , , , , ,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE	
		ears or tested every 5 years by			now available. The sprinkler h	ead	
	-	calibrated gauge. Gauges not			in the laundry room has been		
		3 percent of the full scale shall			cleaned		
		eplaced. This deficient practice			2. How will you identify othe	r	
		could affect all residents, staff, and visitors in the facility.			residents that have the		
	•				potential to be affected by the	lis	
					deficient practice All visitors and residents have	tho	
	Findings include:						
	Rased on observati	ons with the Maintenance			potential to be affected by this defi ciency.		
		our of the facility from 1:00 p.m.			All sprinkler heads were		
	_	26/24, the manufacture date of			inspected by Maintenance to	,	
		the face of the antifreeze loop			ensure sprinkler heads were		
		auge in the third floor			clean by the Maintenance		
		tage room. A sticker was			Director		
		e stating the "Date Installed"			3. What measures will be pu	t in	
		e sticker was left blank in			place or what systemic	`	
		r Replace". No recalibration			changes will be made to		
	_	as affixed to the sprinkler			ensure that this deficient		
		sed on interview at the time of			practice does not recur?		
		ne Maintenance Director			The maintenance departmen	t to	
	agreed the antifree	ze sprinkler system gauge was			be in-serviced on ensuring		
	more than five year				sprinkler head gauges are		
	documentation of s	sprinkler system gauge			tested/replaced and all sprink	ler	
		alibration was not available for			heads are free of debris. The		
	review.				maintenance director will insp	ect	
					all sprinkler heads to ensure t	hey	
	_	re reviewed with the Executive			are clean. The maintenance		
	Director and the M	aintenance Director during the			director or designee will audit		
	exit conference.				weekly to ensure sprinkler ga	uges	
					and sprinkler heads are in		
	3.1-19(b)				compliance.		
					l		
		ration and interview, the facility			4. How the corrective action	` '	
		of 1 sprinkler heads loaded with			will be monitored to ensure	the	
	_	were replaced in accordance			deficient practice will not		
		FPA 25, Standard for the			recur, i.e. what quality	4	
		s, and Maintenance of			assurance program will be p	out	
		Protection Systems, 2011			into place?		
	Edition, Section 5.2	2.1.1.1 states sprinklers shall not	1		A Sprinkler system qapi Tool	WIII	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155226	B. W	ING		06/26/2024	
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		2010 N	CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	-	ige; shall be free of corrosion,			be utilized weekly x 4 weeks,		
		aint, and physical damage; and the correct orientation (e.g.,			monthly x 6 months, and quart	-	
		or sidewall). Furthermore, at			thereafter for one year with res reported to the Quality Assura		
		tler that shows signs of any of			and Performance Improvemen		
	the following shall				Committee overseen by the	ıL	
	(1) Leakage	be replaced.			Executive Director. If a threshold	old.	
	(2) Corrosion				of 95% is not achieved, an act		
	(3) Physical Damag	ge.			plan will be developed to ensu		
		the glass bulb heat responsive			compliance		
	element						
	(5) Loading						
	(6) Painting unless	painted by the sprinkler					
	manufacturer.						
	In lieu of replacing	sprinklers that are loaded with					
	dust, it is permitted	to clean sprinklers with					
	compressed air or b	y a vacuum provided that the					
		touch the sprinkler.					
	_	ice could affect over 2 staff					
	and visitors in the I	Laundry.					
	Findings include:						
	Based on observation	ons with the Maintenance					
		our of the facility from 1:00 p.m.					
		26/24, the sprinkler head					
	-	ndry behind the dryers was					
		ased on interview at the time of					
		e Maintenance Director					
	agreed the automati	ic sprinkler head was loaded					
	with a foreign mate	rial.					
	These findings were	e reviewed with the Executive					
		aintenance Director during the					
	exit conference.	G					
	3.1-19(b)						
K 0361	NFPA 101						
SS=E	Corridors - Areas	Open to Corridor					

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i i					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ı	JILDING	01	COMPLETED	
	155226		B. WI	ING		06/26/	/2024
	PROVIDER OR SUPPLIER	G & REHABILITATION CENTER		2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Corridors - Areas	Open to Corridor					
	Spaces (other tha	n patient sleeping rooms,					
	treatment rooms a	and hazardous areas),					
	waiting areas, nur	se's stations, gift shops,					
	and cooking facilit	ies, open to the corridor are					
	in accordance with	n the criteria under 18.3.6.1					
	and 19.3.6.1.						
	18.3.6.1, 19.3.6.1						
		on and interview, the facility	K 0	361	What corrective actions will	be	07/23/2024
		f 1 therapy room on the fourth			accomplished for those		
	_	from the corridor by a			residents found to have beer	า	
		resisting the passage of			affected by this deficient		
	-	n a sprinklered building, or met			practice?		
		0.3.6.1(7). LSC 19.3.6.1(7) states			The annular space surroundir	-	
	-	an patient sleeping rooms,			the door handle in the therapy		
		d hazardous areas shall be			room has been corrected. No		
	-	and unlimited in area,			other issues identified.		
		pace and corridors which the			2. How will you identify other	r	
		the same smoke compartment			residents that have the		
		electrically supervised			potential to be affected by th	IS	
		tection system in accordance			deficient practice	_	
		Each space is protected by an s, and (c) The space does not			All visitors and residents in the		
	-	o required exits. This deficient			therapy room have the potenti be affected by this deficient	ai to	
		t over 5 residents, staff and			practice. Maintenance director	c varill	
	-	apy Room on the fourth floor.			audit all annular space	WIII	
	visitors in the There	the region of the fourth froot.			surrounding the door handles		
	Findings include:				3. What measures will be put	in	
	i mumgs meruue.				place or what systemic		
	Based on observation	ons with the Maintenance			changes will be made to		
		our of the facility from 1:00 p.m.			ensure that this deficient		
	_	26/24, the annular space			practice does not recur?		
	-	or handle for the corridor door			The maintenance department	t to	
	_	m on the fourth floor would			be in-serviced on ensuring		
		ge of smoke. The corridor was			corridors are separated from		
		e annular space when the			rooms by a smoke resistant		
	_	y closed and latched position.			partition. The maintenance		
	Based on interview				director or designee will audit		
	observations, the M	aintenance Director agreed			weekly to ensure compliance i	in	
		the Therapy Room would not			corridors and rooms for annua		

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

PRINTED: 07/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155226		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/26/2024	
	ROVIDER OR SUPPLIER	& REHABILITATION CENTER	2010 N	ADDRESS, CITY, STATE, ZIP COD I CAPITOL AVE NAPOLIS, IN 46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	the fully closed and These findings were	Smoke when the door was in latched position.  e reviewed with the Executive intenance Director during the		4. How the corrective actions will be monitored to ensure a deficient practice will not	· ·
	3.1-19(b)			recur, i.e. what quality assurance program will be p into place?  A Corridor qapi Tool will be ut weekly x 4 weeks, monthly x 6 months, and quarterly thereaf for one year with results repor to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a thresh of 95% is not achieved, an ac plan will be developed to ensucompliance	ilized 5 ter ted old tion
K 0363 SS=E Bldg. 01	than required enclexits, or hazardour of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or com	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain			

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155226		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/26/2024		
	PROVIDER OR SUPPLIER	& REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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		
	doors complying vif provided with a control of the door closed with a policy of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratification of the control of the passed on observation failed to ensure 1 of the resident sleeping roclosing and latching would resist the passed on observation in the vicinity 212.  Findings include:  Based on observation of the corridor door of the corridor	ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire sor frames in window  Parts 403, 418, 460, 482,  AS details of doors such as angs, automatics closing  on and interview, the facility of over 40 corridor doors to coms had no impediment to generate to the door frame and sage of smoke. This deficient to over 20 residents, staff and and the staff and the over the facility from 1:00 p.m. 26/24, the latching mechanism of the resident sleeping Room defined the latching plate on	K 0363	What corrective actions will accomplished for those residents found to have been affected by this deficient practice?  The door near room 212 was corrected and now latches to resist the passage of smoke. hanger was removed. No other issues issues noted.  2. How will you identify other residents that have the potential to be affected by the deficient practice. This deficient practice could a over 20 residents, staff and vi	The er r		

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[ ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER					1	COMPLETED	
155226		B. W	ING		06/26/	2024		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					CAPITOL AVE			
NORTH (	CAPITOL NURSIN	G & REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46202			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ch prevented the corridor door			in the vicinity of resident sleep	oing		
		and latching into the door frame			Room 212. All doors were			
		e multiple times. A hanger for			checked for proper latching by	y the		
		orage on the door was placed			maintenance director.			
	_	door which prevented the door			3. What measures will be pu	t in		
		The door closed and latched			place or what systemic			
		when the hanger was			changes will be made to			
		n interview at the time of the			ensure that this deficient			
	· ·	Maintenance Director agreed			practice does not recur?			
		resident sleeping Room 212			The maintenance departmen			
	had an impediment to closing and latching into				be in-serviced on ensuring al			
	the door frame and would not resist the passage				doors latch properly to prever			
	of smoke.				passage of smoke. All staff w			
	Th C. 1:	i did- d Tdi			inserviced on ensure exit doo			
	_	re reviewed with the Executive			latch properly and there are n			
	exit conference.	aintenance Director during the			impediments to ensure closing	g of		
	exit conference.				the door by maintenance			
	2 1 10(b)				director/designee. The			
	3.1-19(b)				maintenance director or designate will audit weekly to ensure do			
					opening to a corridor are in	UIS		
					compliance with code.			
					Compliance with code.			
					4. How the corrective action	(s)		
					will be monitored to ensure			
					deficient practice will not			
					recur, i.e. what quality			
					assurance program will be p	ut		
					into place?			
					A Corrirdor qapi Tool will be			
					utilized weekly x 4 weeks,			
					monthly x 6 months, and quar	-		
					thereafter for one year with re			
					reported to the Quality Assura			
					and Performance Improvement	nt		
					Committee overseen by the			
					Executive Director. If a thresh			
					of 95% is not achieved, an ac			
					plan will be developed to ensu	ure		
			1		compliance			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
	155226		B. WING		<u> </u>	06/26/	
	PROVIDER OR SUPPLIED	R & REHABILITATION CENTER	1	2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that I Nonrated protecti are permitted. Do fixed fire window are self-closing or require latching, a in the direction of provides a minimu for swinging or ho 19.3.7.6, 19.3.7.8 Based on observati failed to ensure 1 o would restrict the m 20 minutes. LSC, s doors in smoke bar Section 8.5.4. LSC in smoke barriers to only the minimum operation which is the movement of si could affect over 20 on the first floor.  Findings include:  Based on observati Director during a to		K 037	74	What corrective actions will accomplished for those residents found to have been affected by this deficient practice?  The east doors on the first flo have been corrected and now self close. No other issues identified.  2. How will you identify other residents that have the potential to be affected by the deficient practice.  This deficient practice could at all staff and visitors on the first floor.  All doors were checked by the maintenance director to ensure	or fully r iis ffect t	07/23/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			COMPLETED	
155226		B. W	B. WING			06/26/2024	
				CENTER	A DODDEGG CHEV CHARE THE COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
NODTH	OADITOL NILIDOINI	O O DELIABILITATION CENTED			CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	corridor door set or	the first floor by the reception			doors fully self close.		
	desk failed to fully	self close when tested to close			3. What measures will be put	in	
	multiple times. The	e meeting edge of the east door			place or what systemic		
	kept hitting the mee	eting edge of the west door			changes will be made to		
	which prevented the	e east door from fully closing.			ensure that this deficient		
	Based on interview	at the time of the			practice does not recur?		
	observations, the M	laintenance Director agreed			The maintenance department	: to	
		corridor door set did not fully			be in-serviced on ensuring all		
	close when tested to	o close multiple times.			doors in smoke barriers fully o		
					properly to prevent the passag	•	
	1	e reviewed with the Executive			smoke. The maintenance dire		
		aintenance Director during the			or designee will audit weekly t	0	
	exit conference.				ensure all doors in smoke bar	riers	
					are in compliance.		
	3.1-19(b)						
					4. How the corrective action(		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e. what quality		
					assurance program will be p	ut	
					into place?		
					A smoke barrier qapi Tool will	be	
					utilized weekly x 4 weeks,	4l	
					monthly x 6 months, and quar	•	
					thereafter for one year with re-		
					reported to the Quality Assura		
					and Performance Improvemer Committee overseen by the	IL	
					Executive Director. If a thresh		
					of 95% is not achieved, an act		
					plan will be developed to ensu		
					compliance	ıı <del>C</del>	
					Compliance		
K 0914	NFPA 101						
SS=D		s - Maintenance and				ļ	
Bldg. 01	Testing						
	•	s - Maintenance and					
	Testing						
	_	ceptacles at patient bed					
		ere deep sedation or general					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155226		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       06/26/2024			ETED		
NAME OF PROVIDER OR SUPPLIER  NORTH CAPITOL NURSING & REHABILITATION CENTER			2010 N	ADDRESS, CITY, STATE, ZIP COD CAPITOL AVE APOLIS, IN 46202			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	initial installation, Additional testing defined by docum Receptacles not I these locations are exceeding 12 mo (LIM), if installed, less than or equal the LIM test switch activates both vis LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repain containing date, r results. 6.3.4 (NFPA 99) Based on record re interview; the facil nonhospital-grade of annual testing in 1 replaced with hosp 70, The National E Article 517.18(B) s shall be provided w receptacles. They s single, duplex, or of combination of the four or more, shall so identified. It is total, immediate re non-hospital grade however, that non- replaced with hosp modification of use	ninistered, are tested after replacement or servicing. is performed at intervals mented performance data. isted as hospital-grade at re tested at intervals not inths. Line isolation monitors are tested at intervals of to 1 month by actuating the per 6.3.2.6.3.6, which ual and audible alarm. For automated self-testing, this formed at intervals less 2 months. LIM circuits are a.2 after any repair or electric distribution system. Intained of required tests and is or modifications, noom or area tested, and wiew, observation, and ity failed to ensure electrical receptacles that failed of over 40 resident rooms were intal-grade receptacles. NFPA electrical Code, 2011 Edition, at states each patient bed location with a minimum of four hall be permitted to be of the uadruplex type, or any three. All receptacles, whether be listed "hospital grade" and not intended that there be a placement of existing receptacles. It is intended, thospital grade receptacles be ital grade receptacles upon expression, or as existing placement. This deficient	K 09	914	What corrective actions will I accomplished for those residents found to have beer affected by this deficient practice?  The receptacle in room 303 hibeen replaced with a hospital grade receptacle. No other issidentified.  2. How will you identify other residents that have the potential to be affected by the deficient practice.  This deficient practice could at the two residents residing in roads. All receptacles were check to ensure meet the hospital grarequirement by the maintenant director.	as sues r is ffect com cked ade	07/23/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	ETED
		155226	B. WIN	IG		06/26	
		100220	D. WIIV			00/20/	
NAME OF F	DOMINED OF CLIPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	K		2010 N	CAPITOL AVE		
NORTH	CAPITOL NURSING	G & REHABILITATION CENTER	l		APOLIS, IN 46202		
11011111							
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	practice could affect	ct 2 residents in Room 303.			3. What measures will be pu	t in	
	1				place or what systemic	•	
	Findings include:				changes will be made to		
	rindings include.				_		
	D 1 '	CHD 4 1 TH 4' H			ensure that this deficient		
		f "Receptacle Testing"			practice does not recur?		
		ed 04/11/24 with the Executive			The maintenance departmen		
		aintenance Director during			be in-serviced on ensuring all		
		9:30 a.m. to 12:20 p.m. on			receptables are tested routine	ely	
	06/26/24, electrical	l receptacles in an outlet box in			and replaced with hospital gra	ade	
	resident sleeping R	loom 303 failed annual			receptacles. The maintenanc	e	
	inspection and testi	ing and was listed as "To be			director or designee will audit		
	_	Corner" for "If Fail: Corrective			weekly to ensure receptables		
		interview at the time of record			in compliance. Audits will be		
		nance Director stated he was			conducted each week x 4, the	an.	
	· ·	tacles which failed the 04/11/24			monthly x4, then as needed if		
	_				-	110	
	annual inspection v	-			trends are identified.		
	hospital-grade rece	-					
		the Maintenance Director			4. How the corrective action		
	_	e facility from 1:00 p.m. to 4:15			will be monitored to ensure	the	
		all electrical receptacle outlet			deficient practice will not		
	boxes in Room 303	3 were not hospital grade.			recur, i.e. what quality		
					assurance program will be p	out	
	These findings wer	re reviewed with the Executive			into place?		
	Director and the M	aintenance Director during the			A Electrical systems qapi Too	l will	
	exit conference.	Ž.			be utilized weekly x 4 weeks,		
					monthly x 6 months, and quar	terly	
	3.1-19(b)				thereafter for one year with re	-	
	[ 17(0)				reported to the Quality Assura		
					and Performance Improvement		
					· ·	H	
					Committee overseen by the		
					Executive Director. If a thresh		
					of 95% is not achieved, an ac		
					plan will be developed to ensu	ure	
					compliance		

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