CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED		
		155486	B. WI	NG		11/06	/2023		
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD  131 S 10TH ST  MIDDLETOWN, IN 47356					
	T				1		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL  PLICE IDENTIFYING INFORMATION	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE		
E 0000				IAG			DATE		
Bldg  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 11/06/23  Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600		E 00	000	K 000 This plan of correction is submitted to serve as a credit allegation of compliance in association with stated complidates. Preparation and/or execution of this plan of corre does not constitute an admiss or agreement, the provider of	etion ction				
	AIM Number: 100289600  At this Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 45 certified beds. At the time of the survey, the census was 10.				conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because required by state and federalaw.	se it			
E 0026 SS=C Bldg	403.748(b)(8), 41	6.54(b)(6), 418.113(b)( aiver Declared by Secretary							
-	failed to ensure the (EEP) include the r waiver declared by with section 1135 c care and treatment identified by emerg accordance with 42	view and interview, the facility Emergency Preparedness Plan ole of the LTC facility under a the Secretary, in accordance of the Act, in the provision of at an alternate care site gency management officials in CFR 483.73(b) (8). This ould affect all occupants.	E 00	026	Tag E 026  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Any resident could be affected when a policy is not find pertaining to the Emergency Preparedness. Middletown Nursing and Rehabilitation Cereation (s) will be accomplished to the propertion of the Emergency Preparedness.	<b>n</b> oe ound	11/25/2023		

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

TITLE

follows section 1135, but by not

(X6) DATE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/06/2023	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	131 S	ADDRESS, CITY, STATE, ZIP COD 10TH ST ETOWN, IN 47356	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  Tiew and interview with the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Environmental Serv Administrator on 11 11:45 a.m., the EPP facility under a wair in accordance with			having a policy could be confuto the charge nurse if not awa the situation. A policy stating facility follows section 1135 has been added to the EPP.  How other residents having	re of the as
	Director searched the plan and stated the p	w, the Environmental Services are facility's emergency disaster policy was not in the manual.		potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: The facility has implemented a pole	ne be ve icy
	and Administrator a	vironmental Services Director nd again at the exit conference ntal Services Director and nt.		stating that we will follow the waiver, and this will keep curr residents and any residents the may be moved to our facility during a catastrophe safe.	ent nat
				What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: A policy for 1135 has been added the Emergency Preparedness Plan. The Administrator will continue to review the EPP annually and ensure all policies are correct.	ed to
				How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: The Administrator continue to review the EPP annually and inform the staff onew policy.	ut will

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
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			COMPLETED	
		155486	B. W	NG	11/06	11/06/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			10TH ST			
MIDDI E.	TOWN NURSING A	ND REHABILITATION CENTER			ETOWN, IN 47356			
WIIDDEL	- TOWN NOROING	TENNOISI TON GENTER		WIIDDL				
(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 APPROPRIATI	E	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
					By what date the systemic			
					changes for each deficiency			
				will be completed:				
					was corrected November 16, 2	023.		
E 0044								
E 0041		s(e), 485.542(e), 485.62						
SS=F	Hospital CAH and	LTC Emergency Power						
Bldg	D 1 1						11/25/2020	
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements			041	Tag E 041		11/25/2023	
	found in the Health Care Facilities Code, NFPA				What corrective action(s) will			
		y Code in accordance with 42			be accomplished for those			
		This deficient practice could			residents found to have been			
	affect all building of	-			affected by the deficient			
	affect an building c	arrect air bunding occupants.			<b>practice:</b> Any resident could be harmed in the event of a power			
	Findings include:				outage and there is no back-up			
	Findings include:				power. The entire facility is ran			
	Based on record rev	view and interview with the			the generator, but the generator	•		
	Environmental Serv				could be faulty if it is running ba			
		1/06/23 between 9:00 a.m. and			fuel. The facility will have	au .		
		imentation of an annual fuel			Schaeffer's test our generator f	iuel		
	· ·	diesel generator was available			annually.	uoi		
		ility has 1 generator, which is			aay.			
		on interview at the time of			How other residents having the	ne .		
		fuel quality testing for the			potential to be affected by the			
	· ·	or could not be located and the			same deficient practice will be			
	_	cialist stated that the supplier			identified and what corrective			
	told him that they to	reat the fuel and an annual test			action(s) will be taken:			
	was not necessary.				Fortunately, no residents have			
					been harmed by the generator	fuel		
	This finding was ac	knowledged at the time of			not being tested. The generator			
	discovery by the Er	nvironmental Services Director			has worked perfectly during any			
	and Administrator	and again at the exit conference			power outage or during a load	-		
	with the Environme	ental Services Director and			The Maintenance Director will			
	Administrator prese	ent.			monitor that the fuel is checked	I		
					annually to ensure the safety of	f all		
					residents.			

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What measures will be put into

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/06/2023	
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	131 S	r address, city, state, zip cod 10TH ST LETOWN, IN 47356	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0000				place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will have fuel tested annually. Every time the generator is refueled, the Maintenance Director will refer annual fuel test to see when the next test is due.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place: The Maintenance Director will have the fuel test annually. Every time the general is refueled, the Maintenance Director will review the annual test to see when the next test due. During our quarterly QA upcoming maintenance need be discussed to ensure compliance.  By what date the systemic changes for each deficiency will be completed: Schaeffer representative pulled a fuel son November 9, 2023. The reare now pending.	e ve the ne er the the the the ted erator al fuel t is , any s will
Bldg. 02	Survey was conduc	e Recertification and Licensure sted by the Indiana Department lance with 42 CFR 483.90(a).	K 0000	K 000 This plan of correction is submitted to serve as a credi	ble

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> B. WING			COMPLETED 11/06/2023	
		155486	B. WI			1 1/06/	2023
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
MIDDI E	LUMN NI IDSING V	ND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356				
			1		_ 1 O v v 1 v , 11 v + 7 0 0 0		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5)	
TAG	*	R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ΓE	COMPLETION DATE
					allegation of compliance in		
	Survey Date: 11/06	5/23			association with stated comple	tion	
	Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600				dates. Preparation and/or		
					execution of this plan of correct		
					does not constitute an admission agreement, the provider of	on	
					conclusion set facts on the		
	At this Life Safety	At this Life Safety Code survey, Middletown			statement of deficiencies. The		
		ilitation Center was found not			plan of correction is prepared		
	in compliance with Requirements for Participation				and/or executed solely becaus	e it	
	in Medicare/Medicaid, 42 CFR Subpart 483.90(a),				is required by state and federa	ıl	
	•	re and the 2012 edition of the			law.		
	National Fire Protection Association (NFPA) 101,						
	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.						
	Treatm care occupi	ancies and 110 I to 10.2.					
	This facility consist	ted of the south wing, a					
	one-story wing dete	ermined to be of Type V (111)					
		lly sprinkled, and the north					
		ring determined to be Type II					
		and fully sprinkled. The facility					
	-	tem with smoke detection in sopen to the corridors,					
	_	s open to the corridors, toke detectors in the twelve					
		he North Wing (Old Hall), and					
		letectors in the fifteen resident					
		Wing (New Hall) which are					
	electrically wired to	an audible signal at the					
		e facility has a capacity of 45					
	and had a census of	10 at the time of this visit.					
	All arong whore rog	idents have customary access					
		all areas providing facility					
	services were sprinl						
	1,						
	Quality Review cor	mpleted on 11/13/23					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 02	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/06/2023			
		ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		131 S 1	ADDRESS, CITY, STATE, ZIP COD OTH ST ETOWN, IN 47356		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
	TAG	Based on observation failed to ensure the Lounge exit was reason without a clinical dissecurity measures. Of egress shall not be lock that requires the egress side unless of 19.2.2.2.4. Door-loopermitted in accordade ficient practice confirmed in accordate ficient practice of the edition of the exit the state of the exit of the	ons during a tour of the facility ntal Services Director on 1:45 a.m. and 1:30 p.m., the narked as a facility exit, was I and could be opened by t code but the code was not knowledged at the time of vironmental Services Director and again at the exit conference ntal Services Director and	K 0	TAG 222	Tag K222 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FO THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: All residents could be affected in event of an emergency that requires evacuation if the door are unable to be opened. In the event of an evacuation all resistaff and visitors must be able open the doors even if they are locked doors. Doors must be a after 15 seconds and/or if a keypad is present the code must be accessible. Middletown Nursing and Rehab will ensure keypads have the code visible the event of an emergency. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE WILL IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: The key code to a keypads will be made visible be making and label and posting above or on top of the keypads WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL IS MADE TO ENSURE THAT TH DEFICIENT PRACTICE DOES NOT RECUR: The Environment Specialist will create a label with the key code and post on top of above all keypads to ensure the is visible to all staff and visitors.	I(S) OR TO THE the rs e dent, to e able ust e all in  BE L all by s. BE intal ith of or nat it	DATE 11/25/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/06/2023			
	PROVIDER OR SUPPLIEF	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0321 SS=E	NFPA 101 Hazardous Areas	- Enclosure		the event that there is an evacuation and residents need be removed.  HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE TIDEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT IN PLACE: During the next scheduled QAPI meeting, the posting of key codes will be discussed and ensured that it been completed.  BY WHAT DATE THE SYSTE CHANGES WILL BE COMPLETED: The label was completed on November 8, 20	HE TO has		
Bldg. 02	Based on observation failed to ensure 1 or such as storage room properly working so deficient practice corresidents, as well as Findings include:  Based on observation with the Environment 11/06/23 between 1 "Covid Room" man square feet, contain items, such as, pape cardboard boxes. T	on and interview, the facility f over 5 hazardous area doors, ms, were provided with elf-closing devices. This ould affect more than 10	K 0321	Tag K 321  What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice: Using any room as storage, or in this case as our "Covid-19 room", can be very harmful in the event of a fire fresidents. All doors must secuclose especially when the roo contains combustible materia. The covid room door will have self-closing hinge installed.  How other residents having	n  or all urely m I.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155486 B. WING 11/06/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 131 S 10TH ST MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE potential to be affected by the This finding was acknowledged at the time of same deficient practice will be discovery by the Environmental Services Director identified and what corrective and Administrator and again at the exit conference action(s) will be taken: Having a with the Environmental Services Director and room containing an abundance of Administrator present. combustible material must be monitored very closely. If the room 3.1-19(b) would ever catch fire it will spread very quickly if not contained properly. All staff will be re-educated to ensure all storage doors close after leaving. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator and Environment Specialist will do random walk-thru's, and be sure any storage door is not in compliance is fixed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: During quarterly QA meetings any repairs that the aide's and nurses notice will be passed onto the Environmental Specialist at the point. By what date the systemic changes for each deficiency will be completed: The hinge was installed November 16, 2023.

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	K MEDICAKE & MEDIC				ONIB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ſ	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED		
		155486	B. WING		11/06/2023		
	PROVIDER OR SUPPLIEI	R AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE NAME OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
K 0361	NFPA 101						
SS=E	Corridors - Areas	Open to Corridor					
Bldg. 02		·					
	Based on observation	on and interview, the facility	K 0361	Tag K 361	11/25/2023		
	failed to ensure 1 o	f 1 business offices with					
	pass-through windo	ows greater than 20 square		What corrective action(s) will			
	inches met the requ	irements of spaces open to the		be accomplished for those			
	corridor. LSC 19.3.6.1(7) states that spaces other			residents found to have been			
	than patient sleepin	ng rooms, treatment rooms, and		affected by the deficient			
	hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection			practice: Middletown Nursing a	nd		
				Rehabilitation Center will have			
				Granau add another smoke			
				detector in business office 2.			
	system in accordan	ce with 19.3.4, and (b) Each		How other residents having th	ie e		
	space is protected b	by an automatic sprinklers, and		potential to be affected by the			
	(c) The space does	not to obstruct access to		same deficient practice will be	•		
	required exits. LCs	S 19.3.6.5.1 states miscellaneous		identified and what corrective			
	openings, such as n	nail slots, pharmacy		action(s) will be taken: This			
	1 -	ows, laboratory pass-through		could affect residents in the eve	ent		
		ier pass-through windows,		that a fire starts in the "the 2nd			
		to be installed in vision panels		business office", because there			
		pecial protection, provided that		nothing to detect the smoke. The			
	both of the following	_		fire could spread to other parts	of		
		area of openings per room does		the building without detecting			
		es squared (0.015 m2).		smoke soon enough.			
		re installed at or below half the					
		loor to the room ceiling.		What measures will be put into	0		
	1	tice could affect staff and up to		place and what systemic			
	10 residents.			changes will be made to			
				ensure that the deficient			
	Findings include:			practice does not recur: When			
	D 1 1	1		Granua comes back to the facili			
		ons during a tour of the facility		we will have them install another			
	with the Environmental Services Director on 11/06/23 between 11:45 a.m. and 1:30 p.m., the			smoke detector in the "business	8		
				office 2".			
		ad pass-through windows that		l			
	_	by electrically supervised		How the corrective action(s)			
I	<ul> <li>automatic smoke de</li> </ul>	etection. Based on interview at	Ī	will be monitored to ensure th	e i		

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the time of observation, the Environmental

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deficient practice will not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/06/2023			
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(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		
K 0363 SS=E Bldg. 02	than 20 square inch not protected by ele smoke detection.  This finding was ac discovery by the Er and Administrator a	e windows were each greater es and the business office was extrically supervised automatic knowledged at the time of extriconnental Services Director and again at the exit conference ental Services Director and ent.		recur, i.e., what quality assurance program will be p into place: Administrator and Environmental Specialist will o walk thru prior to Granau comi to the facility to make sure the is not anything extra we need have them do.  By what date the systemic changes for each deficiency will be completed:	do a ing re		
	failed to ensure all compediment to closificame and would respect to the series of the	n #104 et near the Nurses station knowledged at the time of avironmental Services Director and again at the exit conference ental Services Director and	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: If a resident's door of fire door does not latch proper that could potentially allow sm to enter in the event of fire and affect residents presiding both that particular room or corridor. The latches for both resident m#104 door and the fire door habeen fixed.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: In the event that there is smoke in the building all doors must be propertioned.	or cly ooke d in r. coom ave  the e oe		

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3.1-19(b)

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sealed and close to prevent

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY  COMPLETED  11/06/2023
	PROVIDER OR SUPPLIEI	ND REHABILITATION CENTER	131 S <sup>2</sup>	ADDRESS, CITY, STATE, ZIP COD 10TH ST ETOWN, IN 47356	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				smoke inhalation. The latches have been fixed and adjusted both deficient doors.	
				What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: All s will be permitted to notify the Environmental Specialist in the event they notice a door not working properly. These are a doors and rooms that nursing, housekeeping and dietary stat may enter and notice an issue.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: During quarterly conceinings if the staff notices are new issues, it will immediately brought to the Environmental Specialist's attention if it has realready been done.  By what date the systemic changes for each deficiency will be completed: The fire delatch and room #104 latch were both fixed on November 10, 20	taff e II If . he ut A ny be oot
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills				
		view and interview, the facility narterly fire drills on	K 0712	Tag K 712	11/25/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED			ETED	
		155486	B. WI	ING		11/06/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			OTH ST		
MIDDLET	TOWN NURSING A	ND REHABILITATION CENTER	MIDDLETOWN, IN 47356				
(V4) ID	CIBBAADS	CT A TEMENT OF DEFICIENCIE			<u> </u>	1	(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		d at unexpected times under		IAG	What corrective action(s) wil		DATE
	*	This deficient practice could			be accomplished for those	'	
		staff and visitors in the facility.			residents found to have been	,	
	arreet arr restaemes,	starr and visitors in the racinty.			affected by the deficient	.	
	Findings include:				<b>practice:</b> The fire alarm system	m l	
					must work properly at all times		
	Based on record rev	Based on record review and interview with the			An improper operating fire ala		
	Environmental Services Director and				could affect all residents and s		
	Administrator on 11	1/06/23 between 9:00 a.m. and			in the event of an actual		
	11:45 a.m., 7 of 12	quarterly fire drills were			emergency. To ensure the fire		
conducted near the end of the month, between the					alarm works properly it must b	е	
	27th and 30th day of the month. These conditions				test periodically. The		
do not allow fire drills to be conducted at on					Environmental Specialist does	the	
	unexpected and unpredictable days.				quarterly tests per regulation,		
					in order to keep the staff unaw		
	_	knowledged at the time of			to the best of his ability he will		
		vironmental Services Director			spread out the testing more th	an	
		and again at the exit conference			before.		
		ental Services Director and			l	.	
	Administrator prese	ent.			How other residents having t		
	2.1.10/1				potential to be affected by th		
	3.1-19(b)				same deficient practice will to identified and what corrective		
					action(s) will be taken: All	e	
					residents and staff could be		
					affected during a fire. The staf	<sub>f</sub>	
					must be aware of their	.	
					surroundings at all times; so a		
					great practice is by doing fire		
					drills. Staff and residents must	t be	
					unaware of the drill in order to		
					properly test their ability to		
					function during an actual		
					emergency.		
					What measures will be put in	ito	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur: The		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 11/06/2023		
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE		
K 0761	NFPA 101			Environmental specialist will spread the days and try for different times when doing the drills. There will be some difficults. There will be some difficults when performing late second third shifts, because of the stabeing so aware of everyone in out of the building.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place: Fire drills will also discussed during quarterly Quimeetings.  By what date the systemic changes for each deficiency will be completed: Changes have been made immediately	culty and aff n and  the  but be A		
SS=F Bldg. 02	Based on observation interview, the facilities inspection and testing were completed in a communicating oper required by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approvassemblies and fire	on, records review, and ty failed to ensure annual ang all fire door assemblies accordance of LSC 19.1.1.4.1.1 anings in dividing fire barriers but 1.1 shall be permitted only in the protected by approved for assemblies. (See also Section spenings required to have a fire and the standard of the standa	K 0761	Tag K 761  IDR - Please See Attachment  What corrective action(s) wide accomplished for those residents found to have been affected by the deficient practice:  Grunau inspected doors. Please attachment.  How other residents having potential to be affected by the deficient practice:	II n ase the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/06/2023				
NAME OF PROVIDER OR SUPPLIER			-		ADDRESS, CITY, STATE, ZIP COD	-		
MIDDLETOWN NURSING AND REHABILITATION CENTER				131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies				same deficient practice will			
					identified and what corrective	/e		
					action(s) will be taken:			
		nd tested not less than			What measures will be put in	nto		
	annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies				place and what systemic changes will be made to ensure that the deficient			
	shall be visually ins	spected from both sides to			practice does not recur:			
		ondition of door assembly.  tates as a minimum, the						
	following items sha				How the corrective action(s) will be monitored to ensure			
	(1) No open holes or breaks exist in surfaces of				deficient practice will not			
	either the door or frame.				recur, i.e., what quality			
		light frames, and glazing beads ely fastened in place, if so			assurance program will be p	out		
	equipped.	ery fastefied in place, if so			into place:			
		, hinges, hardware, and			By what date the systemic			
	noncombustible threshold are secured, aligned,				changes for each deficiency	'		
	and in working order with no visible signs of damage.				will be completed:			
	(4) No parts are mis				IDR			
	` '	do not exceed clearances						
	listed in 4.8.4 and 6	3.1.7. device is operational; that is,						
		pletely closes when operated						
	from the full open p	position.						
	(7) If a coordinator closes before the ac	is installed, the inactive leaf						
		are operates and secures the						
	door when it is in th	ne closed position.						
		vare items that interfere or						
	prohibit operation a frame.	re not installed on the door or						
		ications to the door assembly						
	have been performe	ed that void the label.						
		edge seals, where required, are						
		their presence and integrity. ice could affect all residents.						
	inis actionin pract	100 Todia diloct dil Todiacino.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 11/06/2023		
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	131 S 1	ADDRESS, CITY, STATE, ZIP COD IOTH ST ETOWN, IN 47356		
(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	
K 0918	Environmental Serv Administrator on 11 11:45 a.m., no docu inspection for the fi available for review the tour fire door as the newly construct building meet. Base records review and Environmental Serv fire door inspection last year.  This finding was ac discovery by the En and Administrator a	mentation of an annual re door assemblies was re. Based on observation during semblies were observed where ed dining room area and old and on interview at the time of observation, the rices Director stated the annual was not completed within the knowledged at the time of overonmental Services Director and again at the exit conference and Services Director and				
SS=F Bldg. 02	Based on record reversities failed to ensure an aperformed for 1 of 1 generator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA110, State Standby Power Syst NFPA 110, Section	riew and interview, the facility annual fuel quality test was I facility's diesel-powered 9, Health Care Facilities Code, in 6.5.4.1.1.2 states Type 2 EES I System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states e performed in accordance indard for Emergency and terms, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests	K 0918	Tag K 918  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Any resident could be harmed in the event of a power outage and there is no back-upower. The entire facility is rail the generator, but the generatic could be faulty if it is running by fuel. The facility will have	n De er up n by tor	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/06/2023		
NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	DATE		
	practice could affect all residents.			Schaeffer's test our generator annually.			
	Based on record re Environmental Ser Administrator on 1 11:45 a.m., no door quality test for the for review. The fac Diesel fired. Based records review, the diesel fired general Environmental Spe told him that they t was not necessary.  This finding was a discovery by the E and Administrator with the Environmental	Findings include:  Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 generator, which is Diesel fired. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located and the Environmental Specialist stated that the supplier told him that they treat the fuel and an annual test was not necessary.  This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present.		How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken:  Fortunately, no residents have been harmed by the generate not being tested. The generate has worked perfectly during a power outage or during a load. The Maintenance Director will monitor that the fuel is checked annually to ensure the safety residents.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will have fuel tested annually. Every time the generator is refueled, the Maintenance Director will refer annual fuel test to see when the next test is due.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place: The Maintenance Director will have the fuel test annually. Every time the generator is refueled, the Maintenance Director will refer the annual for the place is refueled, the Maintenance Director will refer the annual for the place is refueled, the Maintenance Director will refer the annual for the place is refueled, the Maintenance Director will refer the annual for the place is refueled, the Maintenance Director will refer the annual for the place is refueled, the Maintenance Director will refer the annual for the place is refueled.	ne be //e  e or fuel dor inny d test. I ed of all  nto  e re the he  the  the  the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/06/2023		
NAME OF PROVIDER OR SUPPLIER MIDDLETOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  131 S 10TH ST  MIDDLETOWN, IN 47356				
· ·	ACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
					test to see when the next test due. During our quarterly QA, upcoming maintenance needs be discussed to ensure compliance.  By what date the systemic changes for each deficiency will be completed: Schaeffer representative pulled a fuel sa on November 9, 2023. The resare now pending.	any will	

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