PRINTED: 01/05/2023

DEPARTMENT OF HEALTH AND HU	FORM APPROVED			
CENTERS FOR MEDICARE & MEDIC		OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED
	155807	B. WI	ING	10/04/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
			1747 N RURAL ST	

	PROVIDER OR SUPPLIER HEALTH CARE CENTER		N RURAL ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000				
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.	E 0000		
	Survey Date: 10/04/22 Facility Number: 000388			
	Provider Number: 155807 AIM Number: 100454140			
	At this Emergency Preparedness survey, Rural Health Care 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 50 certified beds. At the time of the survey, the census was 40.			
	Quality Review completed on 10/11/22			
	The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:			
E 0006 SS=F Bldg	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a) (1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) (1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) (1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §485.68(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

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

TITLE (X6) DATE

Olivia Winston Administrator 12/20/2022

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	SHOULD BE COMPLETE	
TAG	§485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2), [(a) Emergency P develop and main preparedness pla and updated at le must do the follow (1) Be based on a facility-based and assessment, utiliz approach.* (2) Include strateg emergency events assessment. * [For Hospices at Plan. The Hospice maintain an emery that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strateg emergency events assessment, inclu the consequences disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main	and include a documented, community-based risk ting an all-hazards gies for addressing identified by the risk at \$418.113(a):] Emergency is must develop and gency preparedness plan ewed, and updated at least is plan must do the and include a documented, community-based risk ting an all-hazards gies for addressing is identified by the risk adding the management of its of power failures, natural inter emergencies that would its ability to provide care.		TAG	DEFICIENCY)		DATE
	preparedness pla	n that must be reviewed,					1

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CENTERS 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		COMPLETED	
		155807	B. WING		10/04/2022	
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST JAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG .	and updated at lead of the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment.	ast annually. The plan must Ind include a documented, community-based risk ing an all-hazards ing missing residents. Injes for addressing is identified by the risk Injes for addressing Injes for a		what corrective action/s		
	failed to maintain a plan that was (1) ba documented, facility risk assessment, uti including missing restrategies for addressidentified by the risk with 42 CFR 483.7. In the Survey & Ce 19-06-ALL dated 0 Medicare and Medi Appendix Z of the Streflect changes to a diseases to the defin	view and interview, the facility in emergency preparedness sed on and includes a y-based and community-based lizing an all-hazards approach, esidents and (2) included ssing emergency events k assessment in accordance 3(a) (1) and 42 CFR 483.73(a) (2). rtification memo QSO: 2/01/19, the Centers for caid Services (CMS) updated State Operations Manual to dd emerging infectious nition of all-hazards approach g for using an all-hazards	E 0006	what corrective action(s will be accomplished for those residents found to have been affected by the deficient practi. The facility emergency preparedness plan has been updated to include a reevaluar and documented, facility-base and community-based risk assessment, utilizing an all-hazards approach, includin missing residents and (2) inclustrategies for addressing emergency events identified brisk assessment.	ice; ted ed ed ug uded by the	

approach should also include emerging infectious

the potential to be affected by the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	- I	SURVEY LETED -/2022
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP C N RURAL ST NAPOLIS, IN 46218	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF disease (EID) threa Influenza, Ebola, Z	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION ts. Examples of EIDs include ika Virus and others". This ould affect all occupants.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) same deficient practice identified and what cor action(s) will be taken;	OULD BE PPROPRIATE will be	(X5) COMPLETION DATE
	Findings include: Based on review of documentation date Administrator and t during record review on 10/04/22, a docu community-based r emerging infectious available for review current "Hazard Vu for the facility. Bas record review, the Aemergency prepared did not address eme (EID) as part of the community-based r by the CMS Survey 19-06-ALL. This finding was re	"Emergency Operations Plan" d 02/04/22 with the he Maintenance Director w from 9:20 a.m. to 11:55 a.m. umented facility-based and isk assessment addressing a disease (EID) threats was not v. EID was not included in the lnerability Assessment (HVA)" sed on interview at the time of Administrator agreed dness program documentation origing infectious diseases facility-based and isk assessment as mandated v. & Certification memo QSO:		This alleged deficiency potential to affect all Re The facility emergency preparedness plan has updated to include a re and documented, facili and community-based assessment, utilizing a all-hazards approach, i missing residents and strategies for addressir emergency events ider risk assessment - what measures into place and what system changes will be made to that the deficient practice recur; The Administrator or decomplete a monthly regardless assessment to ensith assessment reflect facilities current emerges how the corrective will be monitored to endeficient practice will not i.e., what quality assurate program will be put into Results will be brought the Maintenance Direct designee for follow up 6 months, or until 100% compliance is achieved by what date the	esidents. s been evaluated ty-based risk n including (2) included ng ntified by the will be put stemic to ensure ce does not esignee will view of the paredness sure that ed the ency state. ve action(s) sure the ot recur, ance o place; and to QAPI by tor or and review x 6 d.	

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	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	l ′	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIE		<u> </u>	1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218	1	
(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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
					changes for each deficiency be completed. 10/28/22	will	
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital mus standby power sy emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485 (e) Emergency ar The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency gene generator must b the location requi Care Facilities Co Interim Amendme 12-4, TIA 12-5, al Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or buildi 482.15(e)(2), §48 Emergency gene The [hospital, CA implement the em	d LTC Emergency Power tion for Participation: and standby power systems. It implement emergency and restems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1) section. 625(e) and standby power systems. and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) reator location. The elocated in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, and NFPA 110, when a new or when an existing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		COMPI	(X3) DATE SURVEY COMPLETED 10/04/2022				
		155807	B. W	ING		10/04	12022
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
RURAL I	HEALTH CARE CEI	NTER			RURAL ST APOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	S DI AN OF CODDECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Facilities Code, N Code.	nd in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3)					
	Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must						
	have a plan for ho	w it will keep emergency					
		perational during the					
	emergency, unles	s it evacuates.					
	*[For hospitals at §482.15(h), LTC at						
	(0)	CAHs §485.625(g):]					
		corporated by reference in					
		oproved for incorporation by					
		Director of the Office of the					
		n accordance with 5 U.S.C.					
	` '	2 part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National ords Administration					
		mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:	11 VA, Gall 202-14 1-0000, Ol					
	0	es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
	document in the F	· · · · · · · · · · · · · · · · · · ·					
	announce the cha						
		Protection Association, 1					
	Batterymarch Par	k,					
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.	-					
	(i) NFPA 99, Heal	th Care Facilities Code,					
	2012 edition, issue	ed August 11, 2011.					
	(ii) Technical inter	im amendment (TIA) 12-2 to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, and the second	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLI	
		155807	B. W	ING		10/04/2	2022
	PROVIDER OR SUPPLIEF			1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012. (x) TIA 12-3 to NF 22, 2013.	FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					
	(xiii) NFPA 110, S Standby Power Sy including TIAs to a 2009 Based on record rev interview; the facili emergency power s maintenance requir Care Facilities Cod Code in accordance This deficient pract staff and visitors. Findings include: Based on review of Checks & Testing" Administrator and t during record revie on 10/04/22, weekly	standard for Emergency and systems, 2010 edition, chapter 7, issued August 6, view, observation and ty failed to implement the ystem inspection, testing and tements found in the Health e, NFPA 110, and Life Safety with 42 CFR 483.73(e)(2). ice could affect all residents, "Weekly Generator System documentation with the he Maintenance Director from 9:20 a.m. to 11:55 a.m. by generator inspection of 06/20/22 was not available for	E 00	041	what corrective action(s will be accomplished for those residents found to have been affected by the deficient practive Weekly generator system documentation and monthly generator system documentation will be included going forward has been maintained for the sof all resident's post Life Safet Survey and will continue to be maintained weekly and month how other residents have	ice; ice; iup item ion and afety ty e	10/28/2022

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 10/04	LETED
	PROVIDER OR SUPPLIEI HEALTH CARE CE		1747 N	ADDRESS, CITY, STATE, ZIP CO N RURAL ST NAPOLIS, IN 46218	OD	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
IAG	review. In addition Generator System Cload testing documnatural gas fired en September 2022 was Based on interview the Administrator a agreed weekly and documentation for 2022 was not availated observations with the during a tour of the p.m. on 10/04/22, the fired emergency gebuilding near the structure of the structure of the properties of the propert	n, based on review of "Monthly Checks & Testing" monthly entation for the facility's nergency generator for as also not available for review. That the time of record review, and the Maintenance Director monthly load testing the aforementioned periods in able for review. Based on the Maintenance Director facility from 11:55 a.m. to 1:20 the facility has one natural gas nerator located outside the moking shed.	IAG	the potential to be affect same deficient practice identified and what corn action(s) will be taken; This alleged deficiency potential to affect all Re Weekly generator system documentation and mo generator system document	cted by the a will be rective has the esidents. Sem onthly mentation and are up ator system onthly mentation orward and or the safety se Safety se to be monthly. Will be put stemic to ensure ce does not ctor or a monthly se facility sess risk that the she facilities se. We action(s) sure the ot recur, ance o place; and to QAPI by tor or and review x	DATE

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218	
RURAL	HEALTH CARE CEN	NIER	INDIAN	NAPOLIS, IN 46218	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
K 0000				compliance is achieved. by what date the sys changes for each deficience be completed. 10/28/22	
Bldg. 01	Licensure Survey w Department of Heal 483.70(a). Survey Date: 10/04 Facility Number: 0 Provider Number: 100- At this Life Safety C Center was found in Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one story facility one story on	00388 155807 454140 Code survey, Rural Health Care ot in compliance with	K 0000		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218		
(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 0225 SS=E Bldg. 01	All areas where resist were sprinklered. As services were sprinklered. As services were sprinklered wooden shed provided and the state of the state	dents have customary access all areas providing facility dered except one detached ding facility storage. Impleted on 10/11/22 Okeproof Enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility of 1 exit discharges with stairs handrails. LSC 7.2.2.4.1.6 of shall be permitted to have a conly. This deficient practice of residents, staff and visitors if facility from the main entrance. Ons with the Maintenance cur of the facility from 11:55 of 10/04/22, three of the six steps of the observations, the or agreed the exit discharge of the observations, the or agreed the exit discharge of the six steps of the observations, the or agreed the exit discharge of the observations, the or agreed the exit discharge of the observations of the obser	K 0225	Based on observation and interview, the facility failed to ensure 1 of 1 exit discharges stairs were provided with handrails. LSC 7.2.2.4.1.6 sta existing stairs shall be permitt to have a handrail on one side only. This deficient practice of affect over 20 residents, staff visitors if needing to exit the facility from the main entrance what corrective action(s will be accomplished for those residents found to have been affected by the deficient pract The facility has received 3 bid repair the handrail and is curre awaiting the repair. how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could a over 20 residents, the facility I	10/28/2022 with tes ed e buld and e. s) e ice; ss to ently ving the e ffect	
	Office Manager and the Maintenance Director during the exit conference.			received 3 bids to repair the handrail and is currently await		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIE		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SE COMPLETION DATE	
	3.1-19(b)			the repair. what measures will be into place and what systemic changes will be made to enthat the deficient practice do recur; The Maintenance Director of designee will complete a movisual check x 6 months to ethe handrail is in proper contand working properly. how the corrective active will be monitored to ensure deficient practice will not redice, what quality assurance program will be put into place Results will be brought to Quality the Maintenance Director of designee for follow up and reform the months, or until 100% compliance is achieved. by what date the systic changes for each deficiency be completed.	sure poes not or ponthly ensure adition ction(s) the cur, ce; and API by review x	
K 0227 SS=E Bldg. 01	escapes, alternat of refuge are in a provisions 7.2.5 t 18.2.2.6 to 18.2.2 Based on observati failed to ensure 1 of	r Exits ageways, fire and slide ing tread devices, and areas ccordance with the	K 0227	 what corrective action will be accomplished for tho residents found to have been accomplished. 	se)

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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	JILDING	01	COMPL	ETED
		155807	B. W	ING		10/04	2022
						<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					RURAL ST		
RURAL F	HEALTH CARE CEN	NTER		INDIAN	APOLIS, IN 46218		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	walls or railings. LS	SC 7.2.5.3.3 states ramps and			affected by the deficient practi	ce;	
	landings with drop-	offs shall have curbs, walls,			The facility has received 3 bid		
		ng surfaces that prevent people			repair the exit ramp and is		
		ne edge of the ramp. Curbs or			currently awaiting the repair.		
		less than 4 inches in height.			· how other residents hav	vina .	
	This deficient practice could affect over 20				the potential to be affected by	_	
	_	visitors if needing to use the			same deficient practice will be		
	exit by Room 26.				identified and what corrective		
	Call by Robin 20.				action(s) will be taken;		
	Findings include:				This deficient practice could a	ffect	
					over 20 residents, staff and vis		
	Based on observations with the Maintenance				if needing to use the exit by Re		
	Director during a tour of the facility from 11:55			26. The facility has received 3 bids			
	a.m. to 1:20 p.m. on 10/04/22, the exit discharge by				to repair the exit ramp and is	bido	
	•	ling with a drop off from the			currently awaiting the repair.		
		the grass below and also had			· what measures will be p	nut.	
	-	not provided with a curb, wall			into place and what systemic	Jul	
	-	np. Both the landing and the			changes will be made to ensur	ro	
		vare affixed to the concrete			that the deficient practice does		
	_	insert the posts for where a			recur;	5 1101	
		been in place. Based on			The Maintenance Director or		
		e of the observations, the			designee will complete a mont	hlv	
		or agreed the exit discharge			visual check x 6 months to en	-	
		ith a curb, a wall or a railing at			the ramp is in proper condition		
	the drop off and for				working properly.	i aiiu	
	the drop on and for	the ramp.			how the corrective actio	n(c)	
	This finding was rev	viewed with the Business			will be monitored to ensure the	` '	
	_	I the Maintenance Director			deficient practice will not recur		
	during the exit confe				i.e., what quality assurance	,	
	during the exit com	crence.			program will be put into place;	and	
	3.1-19(b)				Results will be brought to QAF		
	J.1-17(U)				the Maintenance Director or	гру	
						iow v	
					designee for follow up and rev	ICW X	
					6 months, or until 100%		
					compliance is achieved.	nio.	
					by what date the system		
					changes for each deficiency w	'III	
					be completed.		
			l		10/28/22		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 10/04/2022		
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218	
(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 0291 SS=F	NFPA 101 Emergency Lightir	ng	ING		DATE
Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1	g of at least 1-1/2-hour ed automatically in .9.			
	1. Based on record rinterview; the facilit testing for all batter with LSC 7.9. Sect emergency lighting be conducted as foll (1) Functional testin with a minimum of weeks between tests seconds, except as c 7.9.3.1.1(2). (2) The test interval extended beyond 30 authority having jur (3) Functional testin for a minimum of 1 lighting system is be (4) The emergency fully operational for 7.9.3.1.1(1) and (3). (5) Written records shall be kept by the authority having jur This deficient practistaff and visitors.	ag shall be conducted monthly, 3 weeks and a maximum of 5 s, for not less than 30 otherwise permitted by shall be permitted to be days with the approval of the isdiction. ag shall be conducted annually 1/2 hours if the emergency attery powered. lighting equipment shall be the tests required by of visual inspections and tests owner for inspection by the	K 0291	What corrective action(s) will accomplished for those reside found to have been affected be deficient practice; - 30 second duration of functional testing of Battery Operated Emergency Lights a Monthly Exit and Emergency Check documentation will be included going forward and habeen maintained for the safety all resident's post Life Safety Survey and will continue to be maintain monthly. 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; - This deficiency has the potential to affect all residents. The maintenance director or designee will complete weekly.	ents by the the and Light as y of e
	Findings include: Based on review of	"Battery Operated Emergency		rounding will be conducted by maintenance director/designe ensure that all battery-operate	e to
	Light Test Log for (Year) - 2022" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to			Emergency Lights and Monthl Exit and Emergency Light Che are functional and working	ly
	11:55 a.m. on 10/04	/22, ten battery operated lights		properly.	

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		1	T		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155807	B. WING		10/04/2022
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	2		N RURAL ST	
DIIDAI L	HEALTH CARE CE	NITED		NAPOLIS, IN 46218	
KUKAL F	IEALTH CARE CEI	NIEU	INDIAN	NAF OLIO, IN 40210	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	were noted in the fa	cility. Monthly functional			
	testing documentati	on for August 2022 and		What measures will be put int	o
	September 2022 for	the ten battery operated lights		place and what systemic char	
	was not available for	or review. In addition, annual		will be made to ensure that th	-
		al testing documentation for		deficient practice does not red	
		ated lights in the facility		'	,
		ent twelve month period was		- Weekly rounding will b	e
		or review. Based on interview		conducted by the maintenance	
		d review, the Administrator		director/designee to ensure th	
	agreed monthly and annual functional testing			battery-operated Emergency	lat all
documentation for all ten battery operated lights			Lights and Monthly Exit and		
for the aforementioned periods was not available			Emergency Light Check are		
	for review. Based on observations with the			functional and working proper	lv.
	Maintenance Director during a tour of the facility			How the corrective action(s) v	-
		1:20 p.m. on 10/04/22, ten		monitored to ensure the defici	
		hting systems were noted in			
				practice will not recur, i.e., wh	
	-	n battery operated light		quality assurance program wi	ii be
		respective test button was		put into place; and	
		he battery operated light			
		lor outside Room 16 and		- Results will be brought	
	outside Room 21.			QA by maintenance director for	
				follow up and review for 6mor	iths,
	_	viewed with the Business		or until 100% compliance is	
	_	d the Maintenance Director		achieved.	
	during the exit conf	erence.			
	2.1.10(1)			By what date the systemic	
	3.1-19(b)			changes for each deficiency v	VIII
				be completed.	
		ation and interview, the facility			
		f 10 battery powered		- 10/28/22	
		systems was maintained in			
		SC Section 7.9. LSC 7.9.2.6			
		ted emergency lights shall use			
		of rechargeable batteries			
	_	ble facilities for maintaining			
		arged condition. Batteries			
	used in such lights	or units shall be approved for			
	their intended use a	nd shall comply with NFPA 70			
		ode. This deficient practice			
		dents, staff and visitors.			

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MUI A. BUII B. WIN	LDING	INSTRUCTION 01	(X3) DATE COMPL 10/04/	ETED
	PROVIDER OR SUPPLIER			1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Director during a to a.m. to 1:20 p.m. or lighting systems we each battery operated respective test buttor battery operated lig outside Room 16 ar interview at the tim Maintenance Direct two battery powered each failed to illuming button was pushed in the time of the ti	viewed with the Business I the Maintenance Director					
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NF should be included 1. Based on record interview; the facility documentation for to fall battery operators was complete.	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. review, observation and	K 030	00	What corrective action(s) will accomplished for those reside found to have been affected beficient practice; Preventative maintenance of battery-operated smoke alarn	ents by the all	10/28/2022

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if not required by the Code, shall be maintained.

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documentation post life safety

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155807	B. W	'ING		10/04/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF				RURAL ST		
RURAL H	HEALTH CARE CE	NTER			IAPOLIS, IN 46218		
	Г				, - 	1	075
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	code recertification has been		DATE
		Fire Alarm and Signaling Code, Maintenance and Tests states					
	· · · · · · · · · · · · · · · · · · ·				maintained for the safety of all		
		nent shall be maintained and e with the manufacturer's			residents and will continue to		
		ns and per the requirements			maintain and tested in accorda		
	1 -				with the manufacturer's publis	nea	
	_	PA 72, 14.2.1.1.1 Inspection,			instructions and per the		
	_	nance programs shall satisfy this Code and conform to the			requirements of chapter 14		
					How other regidents having the	_	
		turer's published instructions.			How other residents having the		
	This deficient practice could affect all residents, staff, and visitors.				potential to be affected by the		
	starr, and visitors.				same deficient practice will be	;	
	Findings include: Based on review of "Weekly Smoke Detector				identified and what corrective		
					action(s) will be taken;		
					- This deficiency has the	:	
		ion dated 02/04/22 with the			potential to affect all residents		
	Administrator and t	he Maintenance Director			resident was affected. Weekly		
	during record review	w from 9:20 a.m. to 11:55 a.m.			review will be conducted by th		
	on 10/04/22, residen	nt room battery operated smoke			maintenance director/designe		
	detector preventive	maintenance documentation			ensure that all documentation		
	for the four month p	period of January 2022 through			the preventative maintenance	of all	
	March 2022 and aft	er 08/22/22 was not available			battery-operated smoke alarm	ıs in	
	for review. Based of	on interview at the time of			resident rooms is complete an	ıd up	
	record review, the A	Administrator agreed testing			to date.		
		pattery operated smoke			What measures will be put into	0	
		prementioned periods in 2022			place and what systemic chan	iges	
	was not available for	or review. In addition, annual			will be made to ensure that the	e	
		ning documentation for the			deficient practice does not rec	ur;	
	most recent twelve	month period was also not					
		y. Based on observations with			- Weekly review will be		
		rector during a tour of the			conducted by the maintenance	e	
	1	a.m. to 1:20 p.m. on 10/04/22,			director/designee to ensure th		
		mentation affixed to the Kidde			documentation for the prevent	ative	
		y operated smoke alarm			maintenance of all		
	installed on the ceiling in resident sleeping Room				battery-operated smoke alarm	ıs in	
		leeping Room 12 stated to test			resident rooms is complete an	nd up	
	the device weekly a	nd to clean the device			to date.		
	annually.				How the corrective action(s) w	/ill be	
					monitored to ensure the defici	ent	
	This finding was re	viewed with the Business			practice will not recur, i.e., who	at	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155807	B. W	NG		10/04/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			RURAL ST		
RURAL H	HEALTH CARE CEI	NTER			APOLIS, IN 46218		
			1		02.0,02.0		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		d the Maintenance Director			quality assurance program will	be	
	during the exit conf	Terence.			put into place; and		
	2.1.10(1)						
	3.1-19(b)				Results will be brought to QA I	-	
	2 D1 1	41 4 1 4 (2 11			maintenance director for follow	•	
	2. Based on observation and interview, the facility				and review for 6months, or uni		
	failed to replace 2 of over 20 battery operated smoke alarms installed in resident sleeping rooms				100% compliance is achieved.		
	in accordance with NFPA 72. NFPA 72, 2010						
	Edition, Section 14.4.8.1 states unless otherwise				By what data the avatamia		
	recommended by the manufacturer's published				By what date the systemic changes for each deficiency w	ill	
	instructions, single- and multiple-station smoke				be completed.	111	
	alarms shall be replaced when they fail to respond				be completed.		
	to operability tests but shall not remain in service				- 10/28/22		
	longer than 10 years from the date of manufacture.				- 10/20/22		
		ice could affect over 10					
	residents, staff and						
	residents, starr and						
	Findings include:						
	Based on observation	ons with the Maintenance					
	Director during a to	our of the facility from 11:55					
	a.m. to 1:20 p.m. or	n 10/04/22, manufacturer's					
	documentation affix	xed to the Kidde Model i9010					
	battery operated sm	oke alarm installed on the					
	ceiling in resident s	leeping Room 10 stated the					
	unit was manufactu	red 02/17/12. An installation					
	date of 07/26/12 wa	as written on the back of each					
	device. Manufactur	rer's documentation affixed to					
	the Kidde Model i9	010 battery operated smoke					
		he ceiling in resident sleeping					
		unit was manufactured					
		llation date of 07/26/12 was also					
		of the device. Each battery					
	-	rm stated "replace unit within					
		ion date". Based on interview					
		oservations, the Maintenance					
	_	two smoke alarms were each					
	more than ten years	old.					

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STATEMEN	T 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
		155807	B. W	ING		10/04/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			RURAL ST		
RIIRAI L	HEALTH CARE CEI	NTER			IAPOLIS, IN 46218		
TOTAL I	ILALIII OAKL OLI	WILK		INDIAN			
(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	ATE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		viewed with the Business					
	Office Manager and the Maintenance Director						
	during the exit conf	during the exit conference.					
	3.1-19(b)						
K 0343	NFPA 101						
SS=F	Fire Alarm Systen						
Bldg. 01	Fire Alarm - Notific	cation					
	2012 EXISTING						
	Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected						
		- -					
		prinkler system. Occupant					
		vided automatically in					
		9.6.3 by audible and visual					
	signals.						
	In critical care areas, visual alarms are sufficient. The fire alarm system transmits						
		tically to notify emergency					
	forces in the even						
	9.7.1.1(1)	.1, 19.3.4.3.2, 9.6.4,					
	` '	on and interview, the facility	K 0	2.42	· what corrective action	(c)	11/08/2022
		f 1 fire alarm systems was	K U	343	will be accomplished for tho		11/06/2022
		rdance with LSC 19.3.4.3.2			residents found to have been		
		Notification and LSC 9.6.1.3.			affected by the deficient	•	
		es fire department notification			practice;		
		ned in accordance with LSC			The fire alarm system trouble		
	-	requires a fire alarm system to be			mode status has been		
		d maintained in accordance			investigated and is repaired.		
		ional Electrical Code and NFPA			· how other residents		
	· ·	larm Code. NFPA 72, Section			having the potential to be		
	· ·	that system defects and			affected by the same deficien	nt	
	_	be corrected. This deficient			practice will be identified and		
	practice could affec	et all residents, staff and			what corrective action(s) will		
	visitors.				be taken;		
					This deficient practice could a	ffect	
	Findings include:				all residents, staff and visitors		
					fire alarm system trouble mod	е	
	Based on observation	ons with the Maintenance			status has been investigated a	and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022	
	ROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST JAPOLIS, IN 46218	
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR Director during the facility at 9:15 a.m. control panel locate the trouble mode an interview at the time Maintenance Direct the facility within the Maintenance Direct works but has been silenced when he start The Maintenance Direct was not sure if it was line. At 1:00 p.m. of facility, the Mainten off-premises fire ala Central Security, to to activate the fire a system worked. Ba Central Security recallarm system has not monitoring entity si Maintenance Direct alarm box by the extendility by Room 26 the fire alarm system the building and relequipped with magning release with fire ala on interview with the receptionist at 1:10 system did not send manual fire alarm but This finding was recoffice Manager and	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION initial walk through of the on 10/04/22, the main fire alarm d at the nurse's station was in d was silenced. Based on e of the observations, the or stated he started working at he last week or two. The or stated the fire alarm system in the trouble mode and harted working at the facility. his both phone line issue but has both phone lines or just one on 10/04/22 during a tour of the hance Director contacted the harm monitoring company, put the system on test in order larm system to see if the hased on interview with the here a signal to the hance January 2022. The or activated a manual fire hit door to the outside of the hast 1:05 p.m. which activated here, sounded all horn/strobes in heased all doors which were hetic releasing devices set to has same Central Security here, the facility's fire alarm an alarm signal for the hox activation. Wiewed with the Business he Maintenance Director	1747 N	RURAL ST	ade ated ated ated by w up ntil d. d. ble on che ted n
	during the exit conf 3.1-19(b)	erence.		with the updated plan of correction date. 11/8/22	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155807	B. WI	NG		10/04/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY S	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	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0351	NFPA 101						
SS=E	Sprinkler System -	· Installation					
Bldg. 01	Spinkler System - 2012 EXISTING	Installation					
		nd hospitals where required					
	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA						
	•	ne Installation of Sprinkler					
	Systems.						
In Type I and II construction, alternative		nstruction. alternative					
	protection measures are permitted to be						
	•	inkler protection in specific					
	areas where state or local regulations prohibit						
	sprinklers.						
	•	ders are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	6 square feet and	sprinkler coverage covers					
	the closet footprint	t as required by NFPA 13,					
	Standard for Instal	llation of Sprinkler					
	Systems.						
	19.3.5.1, 19.3.5.2,	19.3.5.3, 19.3.5.4,					
	19.3.5.5, 19.4.2, 1	9.3.5.10, 9.7, 9.7.1.1(1)					
	Based on observation	on and interview, the facility	K 0	351	 what corrective action(s)	10/28/2022
		spray pattern for sprinkler			will be accomplished for those		
		ructed in 1 of 1 oxygen			residents found to have been		
	storage and transfill	ing rooms in accordance with			affected by the deficient practi	ce;	
		A 13, 2010 edition, Section			The sprinkler heads are no lon	iger	
	•	lers shall be located so as to			obstructed in the oxygen stora	ge	
	minimize obstructio	ons to discharge as defined in			and transfilling room.		
		Section 8.5.5.3 or additional			 how other residents hav 	-	
		rovided to ensure adequate			the potential to be affected by		
	•	ard. Sections 8.5.5.2 and			same deficient practice will be		
	8.5.5.3 do not permi				identified and what corrective		
		ructions less than or equal to			action(s) will be taken;		
		sprinkler deflector or in a			This deficient practice could af		
	-	re than 18 inches below the			over 20 residents, staff and vis	itors	
		hat prevent the spray pattern			in the vicinity of the oxygen		
	from fully developing	ng. This deficient practice			storage and transfilling room b	y	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR could affect over 20 the vicinity of the o room by the main ex Findings include: Based on observation Director during a to a.m. to 1:20 p.m. or boxes were stored o up to the sidewall m the oxygen storage of main entrance to the the room obstructed the sprinkler in the observation Director agreed the obstruct the sprinkler This finding was rev	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Presidents, staff and visitors in exigen storage and transfilling intrance to the facility. Ons with the Maintenance our of the facility from 11:55 in 10/04/22, stacked cardboard on the floor up against the wall counted sprinkler installed in and transfilling room by the expectation from the sprinkler spray pattern of the sprinkler spray pattern of the sprinkler spray pattern of the sprinkler in the room would be spray pattern. Wiewed with the Business in the Maintenance Director	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) the main entrance to the facil The sprinkler heads are no loo obstructed in the oxygen stor and transfilling room. what measures will be into place and what systemic changes will be made to ensit that the deficient practice doe recur; The Maintenance Director or designee will complete a week visual review of the oxygen s and transfilling room to ensur sprinkler heads are not obstructed. how the corrective actif will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place Results will be brought to QA the Maintenance Director or designee for follow up and reform the months, or until 100% compliance is achieved.	put ure es not ekly torage re that on(s) ne ur, e; and uPl by	
K 0363 SS=E Bldg. 01	than required encl exits, or hazardou of smoke and are	corridor openings in other osures of vertical openings, s areas resist the passage made of 1 3/4 inch wood or other material		 by what date the syste changes for each deficiency be completed. 10/28/22 		

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022				
	PROVIDER OR SUPPLIEI HEALTH CARE CE		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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		
	minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller In CMS regulation. It apply to auxiliary flammable or come Clearance between covering is not extended to complying the doors complying the door closed with a second the	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain abustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red 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 in sprinklered compartments actions in area or fire is or frames in window Parts 403, 418, 460, 482, as details of doors such as ings, automatics closing	V 0363	what corrective action(s	10/28/2022		
	failed to ensure 1 o resist the passage o practice could affect	on and interview, the facility f over 30 corridor doors would f smoke. This deficient et over 20 residents, staff and ity of the resident sleeping	K 0363	what corrective action(s will be accomplished for those residents found to have been affected by the deficient praction The corridor door of room 12 by	ce;		

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

PRINTED: 01/05/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155807 B. WING		01	COMPLETED 10/04/2022			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD RURAL ST		
RURAL H	HEALTH CARE CEN	ITER	INDIAN	APOLIS, IN 46218		
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Room 12. Findings include: Based on observation Director during a to a.m. to 1:20 p.m. on half inch in diamete door handle for the sleeping Room 12 a passage of smoke. It of the observations, agreed the corridor Room 12 would not this finding was revenue.	ons with the Maintenance ar of the facility from 11:55 to 10/04/22, three separate one or holes were noted above the corridor door to resident and would not resist the Based on interview at the time the Maintenance Director door to resident sleeping resist the passage of smoke.		been repaired. how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could afforward over 20 residents, staff and visin the vicinity of the resident sleeping Room 12. The corridor door of room 12 has been repaired. what measures will be printor place and what systemic changes will be made to ensure that the deficient practice does recur; Monthly review x 6 months will conducted by the maintenance director/designee to ensure the corridor is in good repair and war maintain resistance of passage smoke. how the corrective action will be monitored to ensure the deficient practice will not recurrive., what quality assurance program will be put into place; Results will be brought to QA is maintenance director for follow and review for 6 months, or untanges for each deficiency we be completed.	fect sitors or out e s not be e e vill e of oy up iii	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=D Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1. Based on observation failed to ensure electrical outlet box 18 were properly w accordance with NF utilities to comply w requires electrical with NFPA 70, Nat 70, 2011 Edition at Requirements states located in branch ci III of Article 210. Crequirements shall be through (F). (A) Grounding Typ and 20-ampere brand grounding type. Grounding-type reconcircuits of the vowhich they are rated 210.21(B)(2) and Texception: Nongrouinstalled in accordate (B) To Be Grounde connectors that have conductor contacts connected to an eque Exception No. 1: Reference of the service of the volume of the property of the	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 on and interview, the facility strical receptacles in 1 of 3 es in resident sleeping Room fired and grounded in FPA 70. LSC 19.5.1 requires with Section 9.1. LSC 9.1.2 riring and equipment to comply ional Electrical Code. NFPA 406.4 General Installation receptacle outlets shall be recuits in accordance with Part General installation be in accordance with 406.4(A) e. Receptacles installed on 15- tich circuits shall be installed only obtage class and current for d, except as provided in Table table 210.21(B)(3). Inding-type receptacles	K 0511	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practic. The electrical receptacle in Resident sleeping room 18 has been repaired. how other residents havi the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 18. The electrical receptacle in Resident sleeping room 18 has been repaired. what measures will be proposed into place and what systemic changes will be made to ensure that the deficient practice does recur; Weekly review will be conducted by the maintenance director/designee to ensure electrical receptacles are proposed wired and grounded.	re; ang he fect e nt ut e not ed

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022			
ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218					
SUMMARY (EACH DEFICIENT REGULATORY OF Exception No. 2: Repermitted by 406.4(C) Methods of Grogrounding conductor cord connectors shat to the equipment groircuit supplying the The branch-circuit provide an equipment which the equipment contacts of the receconnected. Informational Note acceptable grounding Informational Note existing branch circuit provide and equipment of the existing branch circuit provide and informational Note acceptable grounding. This deficient pract staff and visitors in Findings include: Based on observation Director during a total a.m. to 1:20 p.m. or receptacles in the window in reside each found to have with an Ideal Indust testing device. Bast the observations, the agreed the testing deforementioned elementioned elementioned elementioned elementioned staff.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eplacement receptacles as (D). counding. The equipment or contacts of receptacles and all be grounded by connection counding conductor of the e receptacle or cord connector. wiring method shall include or ent grounding conductor to not grounding conductor ptacle or cord connector are No. 1: See 250.118 for ng means. No. 2: For extensions of courts, see 250.130. ice could affect 2 residents, resident sleeping Room 18. Tons with the Maintenance four of the facility from 11:55 in 10/04/22, two of two electrical rall mounted outlet box under lent sleeping Room 18 were a "hot neutral" when tested tries UL listed circuit tester ed on interview at the time of the Maintenance Director	1747 N	RURAL ST	ne ur, e; and by w up ntil d.			
during the exit conf 3.1-19(b)							

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST IAPOLIS, IN 46218	
(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
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are perkept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2.1.2 Based on record revinterview; the faciliar plan that addressed written fire plans. It health care occupant provide for the follor (1) Use of alarms (2) Transmission of (3) Emergency photo (4) Response to alar (5) Isolation of fire (6) Evacuation of sir (7) Evacuation of sir (7) Evacuation of sir (8) Preparation of fire evacuation (9) Extinguishment Section 19.2.3.4(4) width shall be permit provided that all of met: (a) The wheeled equal to the composition of the control of the co	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew, observation and ty failed to provide a written all components in 1 of 1 LSC 19.7.2.2 requires a written cy fire safety plan that shall owing: alarm to fire department the call to fire department me call to fire department me mediate area moke compartment coors and building for	K 0711	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; The fire safety plan was revised to cover the location of doors for evacuation purposes. 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; All residents, staff, and visitors have the potential to be affected. None were affected. fire safety plan was revised to cover the location of fire doors evacuation purposes. What measures will be put into	nts y the s f fire s. e The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155807	B. W	B. WING			10/04/2022	
				_				
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					RURAL ST			
RURAL F	HEALTH CARE CE	NIER		INDIAN	APOLIS, IN 46218			
(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 APPROPRI		(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	(b) The health care	occupancy fire safety plan and			place and what systemic chan	aes		
	` '	ldress the relocation of the			will be made to ensure that the	_		
	wheeled equipment during a fire or similar				deficient practice does not rec			
	emergency.				·	,		
		uipment is limited to the			- The Maintenance direc	tor		
	following:	•			or designee shall monitor mon			
	i. Equipment in use	and carts in use			that the fire safety plan has be	•		
		ncy equipment not in use			reviewed and all staff have be			
	iii. Patient lift and t				in-serviced on 12-14-18 on pr			
		ice could affect all occupants.			policy and procedure during a			
					or evacuation.			
	Findings include:							
	Based on review of "Emergency Operations				How the corrective action(s) w	/ill be		
		b Tasks: Fire" documentation			monitored to ensure the defici-			
	dated 02/04/22 with	the Administrator and the			practice will not recur, i.e., who	at		
	Maintenance Direct	for during record review from			quality assurance program wil			
	9:20 a.m. to 11:55 a	a.m. on 10/04/22, the written fire			put into place; and			
	safety plan did not a	address the relocation of						
	wheeled equipment	during a fire or similar			- Results will be brought	to		
	emergency. The af	orementioned fire safety plan is			QA by maintenance director for			
	part of the facility's	Emergency Preparedness			follow up and review for 6mon	ths,		
	Program documenta	ation which was documented			or until 100% compliance is			
	as the most recent r	eview occurring on 02/04/22.			achieved.			
	Based on interview	at the time of record review,						
	the Administrator a	greed the written fire safety			_			
	plan did not address	s the relocation of wheeled			By what date the systemic			
	equipment during a	fire or similar emergency.			changes for each deficiency w	/ill		
	Based on observation	ons with the Maintenance			be completed.			
	Director during a to	our of the facility from 11:55						
	a.m. to 1:20 p.m. or	10/04/22, Hoyer lifts were			- 10/28/22			
		or up against the wall outside						
		nd Room 15 and were not in use.						
		not in use was stored in the						
	corridor outside Ro	om 8.						
	This finding was re	viewed with the Business						
	_	l the Maintenance Director						
	during the exit conf	erence.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022		
		100007			DDRESS, CITY, STATE, ZIP COD	10/04/	<u> </u>
	PROVIDER OR SUPPLIER HEALTH CARE CEN		1	1747 N	RURAL ST APOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	3.1-19(b)						
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills are drills are staff is familia aware that drills are outine. Where drills are drills alarms. 19:00 PM and 6:00 announcement material audible alarms. 19:7.1.4 through 1. Based on record of facility failed to do staff training documprocedures on the seand on the third shift Section 19:7.1.6 requarterly on each s	9.7.1.7 review and interview, the cument quarterly fire drills or mentation on fire drill econd shift for 1 of 4 quarters fit for 2 of 4 quarters. LSC quires drills to be conducted nift under varied conditions. ice affects all residents, staff	K 071	2	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; Facility has maintained documentation of all fire drills documentation of activation of fire alarm system for fire drills conducted between 6:00am and 9:00pm post survey. 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; This deficient practice affects all residents, staff and visitors. None were affected. A of fire drills compliance to	nts y the and the nd	10/28/2022
		ourth quarter (October,			schedule, and documentation	of	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 10/04/2022	
NAME OF I	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	-	
				N RURAL ST		
RURALI	HEALTH CARE CEI	NIER	INDIA	ANAPOLIS, IN 46218		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
TAG		er) 2021 and in the third	TAG		DATE	
	· ·	st, September) 2022 was also		activation of the fire alarm sy will be monitored monthly by		
		view. Based on interview at the		maintenance director and/or		
		ew, the Administrator stated the		designee.		
		ee shifts per day and agreed		What measures will be put in	nto	
		fire drill or staff training on fire		place and what systemic cha		
		the aforementioned shifts and		will be made to ensure that	~	
	quarters was not available for review.			deficient practice does not re		
	This finding was reviewed with the Business Office Manager and the Maintenance Director					
				- Maintenance director		
	during the exit conference.			been in-serviced on fire-drill		
				schedule and documentation		
	3.1-19(b)			activation of the fire alarm sy for fire drills conducted betw		
	3.1-17(0)			6:00am and 9:00pm. Audit of		
	2 Based on record	review and interview, the		drills compliance to schedule		
		equately document quarterly		documentation of activation		
	fire drills conducted			fire alarm system will be	or the	
	a. first shift for 2 of			monitored monthly by		
	b. second shift for 1	-		maintenance director and/or		
		.6 requires drills to be		designee		
		on each shift under varied		-		
		ficient practice affects all		How the corrective action(s)	will be	
	residents, staff and			monitored to ensure the defi		
				practice will not recur, i.e., w	/hat	
	Findings include:			quality assurance program v	vill be	
				put into place; and		
	Based on review of	"Chosen Healthcare Fire				
	Drill/Report" docur			- Results will be broug		
		he Maintenance Director		QA by maintenance director		
	-	w from 9:20 a.m. to 11:55 a.m.		follow up and review for 6mo	onths,	
		nentation for the first shift fire		or until 100% compliance is		
		2/06/21 and on 04/08/22 did		achieved.		
		e of day the drill was		<u> </u>		
		entation for the second shift		By what date the systemic		
		on 02/09/22 also did not		changes for each deficiency	Will	
		day the drill was conducted.		be completed.		
		at the time of record review,		40/00/00		
		tated the facility operates three		- 10/28/22		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	ľ í	JILDING	nstruction 01	(X3) DATE COMPL 10/04/	ETED
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD RURAL ST		
RURAL I	HEALTH CARE CEN	ITER			APOLIS, IN 46218		
(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)	ATE	(X5) COMPLETION DATE
	of day the drill was This finding was rev	drills did not include the time conducted. viewed with the Business the Maintenance Director					
	during the exit confe 3.1-19(b)						
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mone Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainten energy power soun accordance with N circuit breakers are program for period components is est manufacturer requi- of maintenance are	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer rmed in accordance with le inspected weekly, lad 30 minutes 12 times a lintervals, and exercised hiths for 4 continuous hours. lider load conditions include					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/04/2022	
	ROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD I RURAL ST NAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	l l	
TAG	and circuits are mand separate from Minimizing the pose emergency power consideration for responsible for resp	(NFPA 99), NFPA 110, 0 (NFPA 70) riew, observation and ty failed to document or weekly inspections for 14 ecent 52 week period and monthly load testing for 1 ecent 12 month period to meet NFPA 110, 2010 Edition, the ency and Standby Powers 0, Standard for Emergency and tems, 2010 Edition, Section regency Power Supply System 1 appurtenant components, reekly and exercised monthly. Es spark-ignited generator sets t least once a month with the 1 for 30 minutes or until the nd the oil pressure have 10, Section 8.3.4 states a f EPSS inspections, tests, n, and repairs shall be lily available. This deficient t all residents, staff and "Weekly Generator System documentation with the he Maintenance Director w from 9:20 a.m. to 11:55 a.m.	K 0918	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; - Weekly Generator System & Testing emergency general load testing and monthly general load documentation has been completed and will continue to maintained to ensure compliant 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; - This deficient practice could affect all residents, staff visitors in the facility. None we affected. The maintenance di or designee will complete a weekly generator system & testing emergency generator test audit and monthly general load testing audit to ensure compliance. What measures will be put integlace and what systemic chair	ents by the stem tor erator o be once. ne ere ere de fand ere rector load ator	
	documentation after	y generator inspection 06/20/22 was not available for based on review of "Monthly"		will be made to ensure that the deficient practice does not reconstruction		

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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. B	a. building <u>01</u>		COMPLETED	
		155807	B. W	B. WING		10/04/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			RURAL ST		
RURAL F	HEALTH CARE CEN	NTER			IAPOLIS, IN 46218		
	Т				·		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
	· ·	Checks & Testing" monthly			- Maintenance director h		
	_	entation for the facility's			been in-serviced on 12-14-18	on	
	_	ergency generator for			weekly generator system &		
	_	s also not available for review.			testing emergency generator I	oad	
		at the time of record review,			testing documentation.		
	the Administrator and the Maintenance Director agreed weekly and monthly load testing documentation for the aforementioned periods in				Maintenance director in service		
					on 12-19-18 on monthly general load documentation. The	alUI	
					maintenance director or desig	nee	
	2022 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, the facility has one natural gas fired emergency generator located outside the				will complete a weekly genera		
					system & testing emergency	ioi	
					generator load test audit and		
					monthly generator load testing	1	
	building near the smoking shed.				audit to ensure compliance.	1	
		saction of the sactio			How the corrective action(s) w	ill be	
	This finding was re	viewed with the Business			monitored to ensure the defici		
	1	I the Maintenance Director			practice will not recur, i.e., who		
	during the exit conf				quality assurance program wil		
					put into place; and		
	3.1-19(b)						
					- Results will be brought	to	
					QA by maintenance director for		
					follow up and review for 6mon	ths,	
					or until 100% compliance is		
					achieved.		
					By what date the systemic		
					changes for each deficiency w	/ill	
					be completed.		
					10/00/00		
					- 10/28/22		
K 0923	NFPA 101						
SS=E		Cylinder and Container					
Bldg. 01	Storag	Cymruer and Container					
Diag. 01	ı •	Cylinder and Container					
	Storage						
	_	qual to 3,000 cubic feet					
		are designed, constructed,					
		accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST IAPOLIS, IN 46218	
	1			I	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
	`		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	Directive.	DATE
	>300 but <3,000 d				
	_	are outdoors in an n an enclosed interior			
		mited- combustible			
		door (or gates outdoors)			
		ed. Oxidizing gases are not			
		ables, and are separated			
		s by 20 feet (5 feet if			
		closed in a cabinet of			
		onstruction having a			
		re protection rating.			
		Il to 300 cubic feet			
		compartment, individual			
	cylinders available	e for immediate use in			
	patient care areas	with an aggregate volume			
	of less than or equ	ual to 300 cubic feet are not			
	required to be sto	red in an enclosure.			
	Cylinders must be	handled with precautions			
	as specified in 11.	6.2.			
		ign readable from 5 feet is			
	_	ate of a cylinder storage			
		ign includes the wording as			
		FION: OXIDIZING GAS(ES)			
	STORED WITHIN				
		d so cylinders are used in			
		y are received from the			
		ylinders are segregated			
		. When facility employs gral pressure gauge, a			
		grai pressure gauge, a e considered empty is			
	•	ty cylinders are marked to			
		Cylinders stored in the open			
	are protected from				
		.3.3, 11.3.4, 11.6.5 (NFPA			
	99)				
		on and interview, the facility	K 0923	What corrective action(s) will	be 10/28/2022
		inimum distance of at least five		accomplished for those reside	
	feet separated comb	oustible materials from oxygen		found to have been affected b	
	_	n 1 of 1 oxygen storage areas.		deficient practice;	
	NFPA 99, Section 1	11.3.2.3 requires oxidizing gases			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155807	B. W	ING		10/04/20	22
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			RURAL ST		
RURAL H	HEALTH CARE CE	NTER			IAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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	TE C	OMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	such as oxygen shall	ll be separated from			- The 'E' type oxygen		
	combustibles by on	e of the following:			cylinder was immediately pick	ed	
	(1) a minimum distance of 20 feet.(2) a minimum distance of 5 feet if the required				up off of the floor and supporte	ed in	
					a proper cylinder cart.		
	-	protected by an automatic					
		accordance with NFPA 13,			How other residents having th	е	
		stallation of Sprinkler Systems.			potential to be affected by the		
	* /	et of noncombustible			same deficient practice will be		
		a minimum fire protection			identified and what corrective		
	rating of ½ hour.				action(s) will be taken;		
	This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the						
					- This alleged deficient		
oxygen storage and transfilling room by the main					practice could affect over 20 s	taff	
entrance to the facility.				and visitors in the vicinity of th	е		
					nurse's station. No staff or		
	Findings include:				residents were affected. The		
					maintenance director complete	ed	
		ons with the Maintenance			an audit of properly secured		
	_	our of the facility from 11:55			cylinders of nonflammable gas	sses	
	_	10/04/22, stacked cardboard			with no others found.		
		p against one liquid oxygen					
	-	the oxygen storage and					
		the main entrance to the			What measures will be put into		
	-	six 'E' type oxygen cylinders			place and what systemic chan	-	
		gen storage container were			will be made to ensure that the		
		Based on interview at the time			deficient practice does not rec	ur;	
		the Maintenance Director					
	_	age in the room was less than			- The maintenance direct	tor	
		quid oxygen container in the			or designee will complete a		
	room.				weekly audit of properly secur		
		t distant			cylinders of nonflammable gas	sses.	
	-	viewed with the Business					
	-	I the Maintenance Director			How the corrective action(s) w		
	during the exit conf	erence.			monitored to ensure the defici		
	2.1.10(1)				practice will not recur, i.e., who		
	3.1-19(b)				quality assurance program wil	ı pe	
					put into place; and		
					Describe will be but to		
					- Results will be brought		
			1		QA by maintenance director for	or	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN (IT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER HEALTH CARE CEN		r í	ILDING NG STREET A 1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218	(X3) DATE (COMPL 10/04/	ETED
(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
					follow up and review for 6mon or until 100% compliance is achieved. By what date the systemic		
					changes for each deficiency w be completed. - 10/28/22	iii	

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