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	1747 N RURAL ST INDIANAPOLIS, 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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 10/04/2022				LETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG	§485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2), [(a) Emergency P develop and main preparedness plan and updated at lea 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 Hospices maintain an emerg 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.	and include a documented, community-based risk ring an all-hazards gies for addressing is identified by the risk response to the second of th		TAG	DEFICIENCY		DATE
	1	n that must be reviewed,					

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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 I RURAL ST JAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION			DATE	
	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				
	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 praction. The facility emergency preparedness plan has been updated to include a reevaluation and documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) inclustrategies for addressing emergency events identified by risk 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP! 10/04			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF disease (EID) threa Influenza, Ebola, Z	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION its. Examples of EIDs include ika Virus and others". This ould affect all occupants.	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) same deficient practice identified and what core 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. mented facility-based and isk assessment addressing a disease (EID) threats was not w. EID was not included in the lnerability Assessment (HVA)" and on interview at the time of Administrator agreed dness program documentation origing infectious diseases facility-based and isk assessment as mandated as Certification memo QSO:		This alleged deficiency potential to affect all Re The facility emergency preparedness plan has updated to include a re and documented, facilit and community-based assessment, utilizing a all-hazards approach, i missing residents and (strategies for addressir emergency events ider risk assessment - what measures winto place and what system changes will be made to that the deficient practic recur; The Administrator or decomplete a monthly revised assessment to ensith assessment reflect facilities current emergency how the corrective will be monitored to enside deficient practice will not i.e., what quality assurate program will be put into Results will be brought the Maintenance Direct designee for follow up a 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	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIE	R	<u> </u>	1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218		
(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)	IATE	(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 muss standby power sy emergency plans this section and ir procedures plans (i) and (ii) of this signal (ii) and (iii) of this signal (iii)	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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	i i		COMPI	(X3) DATE SURVEY COMPLETED 10/04/2022	
		155807	B. W.	ing		10/04	12022
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
RURAL HEALTH CARE CENTER				RURAL ST 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 B CROSS-REFERENCED TO THE APPROP	E	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), 8485,625(e)(3)					
	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel						
	•	mergency generators must					
	1	w it will keep emergency					
	I ' '	perational during the					
	emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]						
	(0)	(6)					
		corporated by reference in opproved for incorporation by					
		Director of the Office of the					
	1	n accordance with 5 U.S.C.					
		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					
	(NARA). For inform	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code					
	1	ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 02169	∌, www.nīpa.org,					
	1.617.770.3000.	th Cara Facilities Code					
		th Care Facilities Code, ed August 11, 2011.					
		im amendment (TIA) 12-2 to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155807	B. WI	ING		10/04/2	2022
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, 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 APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
	2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 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 ements 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 w from 9:20 a.m. to 11:55 a.m. y generator inspection r 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		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218					
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE			
140	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 strong a tour of the strong and the strong and the strong and the strong are the strong are the strong and the strong are the stron	checks & Testing" monthly checks & Testing" monthly entation for the facility's hergency generator for as also not available for review. At the time of record review, at 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.		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 more generator system documentation generator system designee will complete review x 6 months of the emergency prepared designee will complete review x 6 months of the emergency state. The Maintenance Directive will be monitored to ensure generator system. The Maintenance documentation in the generator will be put into the more generator will be put into the Maintenance Directive generator will be brought the Maintenance Directive designee for follow up a 6 months, or until 100%	cted by the e will be rective Thas the esidents. em onthly imentation forward and for the safety fe Safety fe Safety fe to be it monthly. Will be put estemic to ensure ce does not etor or a monthly fe facility fess risk that the facilities te. We action(s) sure the ot recur, ance of place; and it to QAPI by tor or and review x			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 10/04/2022					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE			
K 0000				compliance is achieved. by what date the system of the 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 0 Center was found in Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facility Type V (000) consts sprinklered. The fa with smoke detection areas open to the con battery operated sm resident sleeping ro	00388 155807 454140 Code survey, Rural Health Care ot in compliance with	K 0000					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		(X2) MULTIPLE CO A. BUILDING B. WING			
	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 wooden shed provided Quality Review compared to the stairways and Sm Stairways and Sm Stairways and Sm Stairways and Sm as exits are in account 18.2.2.3, 18.2.2.4. Based on observation failed to ensure 1 of were provided with states existing stairs handrail on one side could affect over 20 needing to exit the firm the stair of the side walk by the a handrail. The stain the concrete steps to former handrail had interview at the tim Maintenance Director.	dents have customary access all areas providing facility dered except one detached ling facility storage. Impleted on 10/11/22 Okeproof Enclosures 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 Is 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 In 10/04/22, three of the six steps of the six	K 0225		DATE 10/28/2022 with tes ed e build and e. s) e ice; s to ently ving the e
		viewed with the Business I the Maintenance Director erence.		This deficient practice could a over 20 residents, the facility received 3 bids to repair the handrail and is currently await	has

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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 N 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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
	3.1-19(b)			the repair. what measures will be into place and what systemic changes will be made to ensith the deficient practice do recur; The Maintenance Director or designee will complete a movisual check x 6 months to ethe handrail is in proper contand working properly. how the corrective act will be monitored to ensure the deficient practice will not recipie., what quality assurance program will be put into place Results will be brought to Quantity to the Maintenance Director or designee for follow up and reference is achieved. by what date the system changes for each deficiency be completed.	c sure sure sees not or onthly ensure dition stion(s) the sur, see; and API by eview 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 those residents found to have been 	se

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155807	B. W	ING		10/04	2022
						<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					RURAL ST		
RURAL	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. L	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		
	railings, or projectir	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	ing	
		ice could affect over 20			the potential to be affected by	_	
	residents, staff and visitors if needing to use the				same deficient practice will be		
	exit by Room 26.				identified and what corrective		
	one of Room 20.				action(s) will be taken;		
	Findings include:				This deficient practice could a	ffect	
	8				over 20 residents, staff and vis		
	Based on observations with the Maintenance				if needing to use the exit by R		
	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	Dido	
	•	ling with a drop off from the			currently awaiting the repair.		
		the grass below and also had			· what measures will be p	out	
		ot provided with a curb, wall			into place and what systemic	, u.	
	-	np. Both the landing and the			changes will be made to ensu	re	
		vare affixed to the concrete			that the deficient practice does		
	-	insert the posts for where a			recur;	71100	
		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 dilid	
	and arep our and rer	······································			· how the corrective actio	n(s)	
	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 conf				i.e., what quality assurance	,	
	during the east com	erence.			program will be put into place;	and	
	3.1-19(b)				Results will be brought to QAF		
	3.1 17(0)				the Maintenance Director or	1 Dy	
					designee for follow up and rev	iew y	
					6 months, or until 100%	ICW A	
					compliance is achieved.		
					-	nic	
					by what date the system		
					changes for each deficiency w	TIII	
					be completed.		
			I		10/28/22		I

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

Event ID:

6U5L21

Facility ID: 000388

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		(X2) MULTIPLE CO A. BUILDING 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	NFPA 101		TAG		DATE
SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour ed automatically in .9.	K 0291	What corrective action(s) will	be 10/28/2022
	interview; the facilitesting 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 of 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. Findings include: Based on review of Light Test Log for (with the Administra Director during records).	ag shall be conducted monthly, 3 weeks and a maximum of 5 5, for not less than 30 5, therwise permitted by shall be permitted to be 6 days with the approval of the 6 isdiction. 6 ag shall be conducted annually 1/2 hours if the emergency 6 attery powered. 6 lighting equipment shall be 7 the tests required by 6 of visual inspections and tests 6 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 rounding will be conducted by maintenance director/designeensure that all battery-operate Emergency Lights and Month Exit and Emergency Light Chare functional and working properly.	ents by the the and Light as y of e the the the the the the the

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

Event ID:

6U5L21

Facility ID: 000388

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER 155807 NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER INDIANAPOLIS, IN 46218 EXCALD BUSHMARY STATEMENT OF DEFICIENCE (ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION testing documentation for August 2022 and September 2022 for the ten battery operated lights was not available for review. In addition, annual 90-minute functional testing documentation for august 2022 and salso not available for review. Based on interview at the time of record review, the Administrator agreed monthly and annual functional testing documentation for all ten battery operated lights for twice. Based on observations with the Maintenance Director during a tour of the facility of the formation of the facility of the facility of the facility and annual functional testing documentation for all ten battery operated lights for twice. Based on observations with the Maintenance Director during a tour of the facility of the facility and the battery operated light located in the corridor outside Room 21. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility finited to ensure 2 of 10 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.92.6 states battery operated emergency operated emergency pleths battery operated emergency pleths shall use only reliable types of rechargeable batteries.	CTATEMENT OF DEFICIENCIES Y1) DROVIDED/CHIDH IED/CLIA			_		325 1.0. 0.00 30
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Taylor T			1	STREET	ADDRESS CITY STATE 7ID COD	
RURAL HEALTH CARE CENTER INDIANAPOLIS, IN 46218	NAME OF P	ROVIDER OR SUPPLIER	₹			
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states battery operated emergency lights shall use		emergency lighting	systems was maintained in			
		accordance with LS	SC Section 7.9. LSC 7.9.2.6			
		states battery opera	ted emergency lights shall use			
only remaine types of rechargeable batteries						
provided with suitable facilities for maintaining			_			
them in properly charged condition. Batteries		_				
used in such lights or units shall be approved for			-			
their intended use and shall comply with NFPA 70						
National Electric Code. This deficient practice						
could affect all residents, staff and visitors.			-			

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	l í	ILDING	ONSTRUCTION 01	(X3) DATE COMPL 10/04/	LETED
	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI 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 butto battery operated lig outside Room 16 ar interview at the tim Maintenance Direct two battery powere each failed to illum button was pushed.	viewed with the Business I the Maintenance Director					
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMAF Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NI should be included 1. Based on record interview; the facili documentation for to of all battery operat rooms was complet	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 0.	300	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Preventative maintenance of battery-operated smoke alarr	ents by the f 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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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155807	B. W	ING	_	10/04/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			RURAL ST		
RURAL H	HEALTH CARE CEN	NTER			IAPOLIS, IN 46218		
(X4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>	1	(Y5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1/10		Fire Alarm and Signaling Code,	+	1710	code recertification has been		DATE
		Maintenance and Tests states			maintained for the safety of all		
	· · · · · · · · · · · · · · · · · · ·	nent shall be maintained and			residents and will continue to		
	tested in accordance with the manufacturer's				maintain and tested in accorda		
	published instructions and per the requirements				with the manufacturer's publis		
	-	PA 72, 14.2.1.1.1 Inspection,			instructions and per the	iiou	
	_	nance programs shall satisfy			requirements of chapter 14		
	_	this Code and conform to the			134dillomonto di dilaptor 14		
	•	eturer's published instructions.			How other residents having th	e	
	This deficient practice could affect all residents,				potential to be affected by the		
	staff, and visitors.				same deficient practice will be		
	starr, and visitors.				identified and what corrective		
	Findings include: Based on review of "Weekly Smoke Detector				action(s) will be taken;		
					detern(e) will be taken,		
					- This deficiency has the		
	Check" documentat	ion dated 02/04/22 with the			potential to affect all residents	. No	
	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	е	
	on 10/04/22, residen	nt room battery operated smoke			maintenance director/designe	e to	
	detector preventive	maintenance documentation			ensure that all documentation	for	
	for the four month p	period of January 2022 through			the preventative maintenance	of all	
		er 08/22/22 was not available			battery-operated smoke alarm		
		on interview at the time of			resident rooms is complete an	ıd up	
	· ·	Administrator agreed testing			to date.		
		pattery operated smoke			What measures will be put into		
		prementioned periods in 2022			place and what systemic chan	-	
		or review. In addition, annual			will be made to ensure that the		
		ning documentation for the			deficient practice does not rec	ur;	
		month period was also not					
		7. Based on observations with			- Weekly review will be		
		rector during a tour of the			conducted by the maintenance		
	•	a.m. to 1:20 p.m. on 10/04/22,			director/designee to ensure th		
		imentation affixed to the Kidde			documentation for the prevent	ative	
	Model i9010 battery operated smoke alarm				maintenance of all		
		ing in resident sleeping Room			battery-operated smoke alarm		
		leeping Room 12 stated to test			resident rooms is complete an	ia up	
	-	and to clean the device			to date.		
	annually.				How the corrective action(s) w		
	TEL : C' 1:	: 1 :4 4 P :			monitored to ensure the defici		
	This finding was re	viewed with the Business			practice will not recur, i.e., who	at	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155807	B. W	NG		10/04/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIEF	2			RURAL ST		
RURAL H	IEALTH CARE CEI	NTER			APOLIS, IN 46218		
(X4) ID	SUMMARY	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	erence.			put into place; and		
	3.1-19(b)				Results will be brought to QA I	-	
	2 Dagad on absorption	ation and interview, the facility			maintenance director for follow	•	
	2. Based on observation and interview, the facility failed to replace 2 of over 20 battery operated				and review for 6months, or uni		
	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 date the systemic		
	recommended by the manufacturer's published				changes for each deficiency w	ill	
	instructions, single- and multiple-station smoke				be completed.		
	alarms shall be replaced when they fail to respond						
	to operability tests but shall not remain in service				- 10/28/22		
	-	s from the date of manufacture.					
	_	ice could affect over 10					
	residents, staff and	visitors.					
	Findings include:						
	Based on observation	ons with the Maintenance					
	Director during a to	our of the facility from 11:55					
	_	n 10/04/22, manufacturer's					
		xed to the Kidde Model i9010					
		oke alarm installed on the					
	_	leeping Room 10 stated the					
		red 02/17/12. An installation					
		as written on the back of each					
		rer's documentation affixed to					
		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						
	•						
			1				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155807	B. W	ING		10/04/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			RURAL ST		
RIIRAI L	HEALTH CARE CEI	NTER			NAPOLIS, IN 46218		
NONALI		WILK		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N OF CORRECTION (X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Business					
	_	d the Maintenance Director					
	during the exit conf	Perence.					
	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					
	-	notification is provided automatically in					
	accordance with 9.6.3 by audible and visual						
	signals. In critical care areas, visual alarms are						
		alarm system transmits					
		tically to notify emergency					
	forces in the even						
		.1, 19.3.4.3.2, 9.6.4,					
	9.7.1.1(1)	on and interview, the facility	17.0	2.42	la at a a una ativa a ati an	(a)	11/00/2022
		f 1 fire alarm systems was	K 0	343	· what corrective action		11/08/2022
		dance with LSC 19.3.4.3.2			will be accomplished for thoresidents found to have been		
		Notification and LSC 9.6.1.3.				1	
		es fire department notification			affected by the deficient practice;		
		ed 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		
		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		
	Based on observation	ons with the Maintenance			status has been investigated a		

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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 NAPOLIS, 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 Disource of the trouble was not sure if it was line. At 1:00 p.m. of facility, the Mainter 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 extendity 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 b	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. hirector stated he believed the he was a phone line issue but has both phone lines or just one hance Director contacted the harm monitoring company, hut the system on test in order harm system to see if the he sed on interview with the he eptionist at 1:00 p.m., the fire hot sent a signal to the hor activated a manual fire hit door to the outside of the hor activated all horn/strobes in he head all doors which were he h	1747 N	RURAL ST	ade ted nat n o e ity out by w up ntil l. ble on he ted
	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		•	1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, 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	TE	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 typ						
	throughout by an approved automatic sprinkler system in accordance with NFPA						
	•	ne Installation of Sprinkler					
	Systems.	'					
	In Type I and II construction, alternative						
	protection measures are permitted to be						
	•	inkler protection in specific					
	areas where state or local regulations prohibit						
	sprinklers.						
	In hospitals, sprink	ders are not required in					
	clothes closets of	patient sleeping rooms					
	where the area of	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		
	-	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	
		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;		
	18 inches below the sprinkler deflector or in a				This deficient practice could at		
	-	re than 18 inches below the			over 20 residents, staff and vis	itors	
		hat prevent the spray pattern			in the vicinity of the oxygen		
	trom tully 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	PROVIDER'S 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 ensurthat the deficient practice docrecur; 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 activities will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be brought to QA the Maintenance Director or designee for follow up and reform the following and the	ity. onger age put ure es not ekly torage re that on(s) ne ur, e; and PI by view x
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		changes for each deficiency to be completed. 10/28/22	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(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 door closed with a second to comply the door closed with a second the door closed with a s	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, and sings, 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 practi The corridor door of room 12 l	ce;			

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		JILDING	01	COMPL 10/04/	ETED	
NAME OF F	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)	Έ	(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 afforwer 20 residents, staff and visin the vicinity of the resident sleeping Room 12. The corridodoor of room 12 has been repaired. what measures will be pinto 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 with maintain resistance of passages 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 to maintenance director for follow and review for 6 months, or untanges for each deficiency with the completed.	fect sitors or ut e not be vill e of n(s) r up il	

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, 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 havit 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 printo 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 proper wired and grounded. how the corrective action 	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 CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eplacement receptacles as (D). counding. The equipment or contacts of receptacles and dil be grounded by connection counding conductor of the er erceptacle 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 cuits, see 250.130. ice could affect 2 residents, resident sleeping Room 18. Ons with the Maintenance our 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 evice showed the ctrical receptacles needed viewed with the Business	1747 N	RURAL ST	ne ur, e; and by w up ntil d.			
during the exit conf 3.1-19(b)	I the Maintenance Director Perence.						

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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 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are persent informed with and a copy of the with telephone open plan addresses the of staff per 18/19. Of the fire safety persent informed with telephone open plan addresses the of staff per 18/19. Of the fire safety persent information in the fire safety persent in the safety pers	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: falarm to fire department the call to fire department me call to fire department me can building for	K 0711	What corrective action(s) will be accomplished for those resider 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	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	A. BUILDING <u>01</u> COM			ETED
		155807	B. WING 10/04/2022			/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		TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	(b) The health care	occupancy fire safety plan and			place and what systemic chan	aes	
	training program ad	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		
	Findings include:				or evacuation.		
	1 manigo menado						
	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			_		
	*	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		, ,	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPL B. WING 10/04,			ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	alarm signal and seconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills arroutine. Where draware that drills arroutine. 19.70. PM and 6:00 announcement materials and independent of the facility failed to door staff training documprocedures on the seand on the third shift section 19.7.1.6 requarterly on each shad visitors. Findings include: Based on review of Drill/Report" document during record review on 10/04/22, document drill or staff training procedures in the seand during, document staff training documents staff training documents.	9.7.1.7 review and interview, the rument quarterly fire drills or rentation on fire drill recond shift for 1 of 4 quarters fit for 2 of 4 quarters. LSC quires drills to be conducted rift under varied conditions. In the conduct of t	K 0712	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 adocumentation 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 schedule, and documentation	nts y the and the nd e	10/28/2022

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	IT 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 P	ROVIDER OR SUPPLIER	. !		ET ADDRESS, CITY, STATE, ZIP COD	-	
				N RURAL ST		
RURALF	HEALTH CARE CEN	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 APPROPE DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
	·	per) 2021 and in the third st, September) 2022 was also		activation of the fire alarm sy	l l	
		view. Based on interview at the		will be monitored monthly by 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	I	
		the aforementioned shifts and		will be made to ensure that t	-	
	quarters was not av			deficient practice does not re		
	This finding was reviewed with the Business			acinotesti practico acco tico.	,	
				- Maintenance director	has	
Office Manager and the Maintenance Director				been in-serviced on fire-drill		
	during the exit conference.			schedule and documentation	n of	
				activation of the fire alarm sy	/stem	
	3.1-19(b)			for fire drills conducted betw	I	
				6:00am and 9:00pm. Audit o		
		review and interview, the		drills compliance to schedule		
	-	equately document quarterly		documentation of activation	of the	
	fire drills conducted			fire alarm system will be		
	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		-	20.1	
		ficient practice affects all		How the corrective action(s)	I	
	residents, staff and	VISITORS.		monitored to ensure the defi		
	Findings include:			practice will not recur, i.e., w	I	
	i maniga menude.			quality assurance program v put into place; and	VIII DC	
	Based on review of	"Chosen Healthcare Fire		put into piace, and		
	Drill/Report" docum			- Results will be brough	nt to	
	•	he Maintenance Director		QA by maintenance director	I	
		w from 9:20 a.m. to 11:55 a.m.		follow up and review for 6mg	I	
		nentation for the first shift fire		or until 100% compliance is	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		12/06/21 and on 04/08/22 did		achieved.		
		e of day the drill was				
		entation for the second shift		By what date the systemic		
	fire drill conducted	on 02/09/22 also did not		changes for each deficiency	will	
	include the time of	day the drill was conducted.		be completed.		
		at the time of record review,		·		
	the Administrator st	tated the facility operates three		- 10/28/22		
		greed documentation for the		1		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	l í	JILDING	nstruction 01	(X3) DATE COMPL 10/04/	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
RURAL H	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	viewed with the Business					
	Office Manager and during the exit confe	the Maintenance Director erence.					
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterior 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 mor 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-	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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	T 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	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		
TAG	and circuits are mand separate from Minimizing the pose emergency power consideration for responsible for the facility of the most of the most of the requirements of Standard for Emergency Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Epsolution of the most of Standard for Emergency Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Power Systems. NFPA 11 Standby Epsolution of the most of the requirements of Standard for Emergency Systems. NFPA 11 Standby Power Systems. NFPA 1	(NFPA 99), NFPA 110,	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 integrated place and what systemic chair will be made to ensure that the	ents by the stem tor erator n o be ince. ne e e d f and ere rector load ator	
		06/20/22 was not available for based on review of "Monthly		deficient practice does not rec		

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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	ING		10/04/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				RURAL ST		
RURAL H	HEALTH CARE CEN	NTER			IAPOLIS, IN 46218		
	Г		1		, - 		OV.5
(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 entation for the facility's			- Maintenance director h		
	_	entation for the facility's hergency generator for			been in-serviced on 12-14-18	on	
	_	s also not available for review.			weekly generator system & testing emergency generator I	and	
	Based on interview at the time of record review, the Administrator and the Maintenance Director agreed weekly and monthly load testing				testing documentation.	oau	
					Maintenance director in service	-ad	
					on 12-19-18 on monthly gener		
	1 -	he aforementioned periods in			load documentation. The	atoi	
		ble for review. Based on			maintenance director or desig	nee	
		ne Maintenance Director			will complete a weekly genera		
		facility from 11:55 a.m. to 1:20			system & testing emergency		
	_	ne facility has one natural gas			generator load test audit and		
	fired emergency generator located outside the building near the smoking shed.				monthly generator load testing	1	
					audit to ensure compliance.	,	
	_	_			How the corrective action(s) w	ill be	
	This finding was re-	viewed with the Business			monitored to ensure the defici		
	Office Manager and	the Maintenance Director			practice will not recur, i.e., who	at	
	during the exit conf	erence.			quality assurance program wil	l be	
					put into place; and		
	3.1-19(b)						
					 Results will be brought 		
					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	/III	
					be completed.		
					10/00/00		
					- 10/28/22		
K 0923	NFPA 101						
SS=E		Cylinder and Container					
Bldg. 01	Storag	Symmon and Container					
g. 0 i	ı •	Cylinder and Container					
	Storage	cysor and container					
	_	qual to 3,000 cubic feet					
		are designed, constructed,					
		accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						

	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
	ROVIDER OR SUPPLIER		1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST IAPOLIS, IN 46218	
TOTOLI				1.4. 0210, 11. 10210	
(X4) ID		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 OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	>300 but <3,000 c	cubic feet			
	Storage locations	are outdoors in an			
		n an enclosed interior			
	space of non- or li	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			
	· ·	e for immediate use in			
	-	with an aggregate volume			
		ual to 300 cubic feet are not			
	-	red in an enclosure.			
		handled with precautions			
	as specified in 11.				
		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 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)	.0.0, 11.0.4, 11.0.0 (NFFA			
		on and interview, the facility	K 0923	What corrective action(s) will	be 10/28/2022
		inimum distance of at least five	K 0323	accomplished for those reside	
		oustible materials from oxygen		found to have been affected b	
	_	n 1 of 1 oxygen storage areas.		deficient practice;	/y 1110
		11.3.2.3 requires oxidizing gases		denoient practice,	
	, 50000011	1.5.2.5 requires origining gases			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	COMPLETED	
		155807	B. W	ING		10/04/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	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	COMPLETION
TAG	REGULATORY OF	R 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.				up off of the floor and support	ed in
	(2) a minimum dista	ance of 5 feet if the required			a proper cylinder cart.	
	storage location is protected by an automatic					
		accordance with NFPA 13,			How other residents having th	е
	Standard for the Installation 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;	
		ice could affect over 20				
	· ·	visitors in the vicinity of the			 This alleged deficient 	
oxygen storage and transfilling room by the main entrance to the facility.				practice could affect over 20 s	taff	
				and visitors in the vicinity of th	e	
					nurse's station. No staff or	
	Findings include:				residents were affected. The	
					maintenance director complet	ed
		ons with the Maintenance			an audit of properly secured	
	_	our of the facility from 11:55			cylinders of nonflammable gas	sses
	_	n 10/04/22, stacked cardboard			with no others found.	
		ip 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 char	-
		gen storage container were			will be made to ensure that the	
		Based on interview at the time			deficient practice does not rec	eur;
		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	
		· · · · · · · · · · · · · · · · · · ·			cylinders of nonflammable gas	sses.
	-	viewed with the Business				
	-	d 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., wh	
	3.1-19(b)				quality assurance program wil	ı De
					put into place; and	
					Describe will be be 10	4-
					- 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

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

NAME OF P	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1747 N RURAL ST INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID				(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 APPROPRIAT DEFICIENCY) follow up and review for 6mont or until 100% compliance is achieved.		(X5) COMPLETION DATE
					By what date the systemic changes for each deficiency w be completed. - 10/28/22	ill	

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