STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	ľ	ILDING		COMPL	
		155593	B. WI			12/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	ł .			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER	FRANKLIN, IN 46131				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DESCRIPTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG E 0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
⊏ 0000							
Bldg							
g ·	An Emergency Prep	paredness Survey was	E 00	000	The submission of this plan of	f	
	conducted by the Indiana Department of Health in				correction does not indicate a		
	accordance with 42	CFR 483.73.			admission by the Indiana Mas	onic	
					Home, Inc (the "facility") that t	he	
	Survey Date: 12/19/	/22			findings and allegation contain		
		0.1.00			herein are an accurate and tru		
	Facility Number: 0				representation of the quality o		
	Provider Number:				care and services provided to		
	AIM Number: 200090430				residents of the Indiana Maso		
	At this Emergency	Preparedness survey, Indiana			Home, Inc. This facility recogr its obligation to provide legally		
		alth Center was found not in			medically necessary care and		
		nergency Preparedness			services to its residents in an		
	_	Sedicare and Medicaid			economic and efficient manne	ir	
	-	lers and Suppliers, 42 CFR			The facility hereby maintains i		
	483.73.	11			in substantial compliance with		
					requirements of participation t		
	The facility has 167	certified beds. At the time of			comprehensive health care		
	the survey, the cens	us was 141.			facilities. To this end, the plan	of	
					correction shall serve as the		
	Quality Review con	npleted on 12/22/22			credible allegation of complian	nce	
					with all State and Federal		
	•	42 CFR, Subpart 483.73 is NOT			requirements governing the		
	MET as evidenced	by:			management of this facility. It		
					thus submitted as a matter of		
					stature only.		
E 0004	403.748(a), 416.5	4(a), 418,113(a).					
SS=F	` , .	5(a), 483.475(a), 483.73(a),					
Bldg	484.102(a), 485.6						
	485.727(a), 485.9						
	491.12(a), 494.62	(a)					
	Develop EP Plan,	Review and Update					
	Annually						
		6.54(a), §418.113(a),					
	- , , -	0.84(a), §482.15(a),					
	§483.73(a), §483.	475(a), §484.102(a),					

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

TITLE (X6) DATE

William Pierce Administrator 01/06/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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 (X1) PROVIDER/SUPPLIER/SUPP		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 12/19/2022			ETED		
	PROVIDER OR SUPPLIER			800 FRI	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY	<u> </u>	
INDIANA	T WASONIC HOME	HEALIN CENTER			LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU	§485.68(a), §485.	625(a), §485.727(a), 6.360(a), §491.12(a),		IAU			DATE
	Federal, State and preparedness req must develop esta comprehensive er program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness plan and updated at leamust do all of the * [For hospitals at §485.625(a):] Emergency Planust develop and main preparedness req CAH] must develoc comprehensive er program that mee section, utilizing a * [For LTC Facilitie Emergency Planust develop and main preparedness planus and updated at least * [For ESRD Facil Emergency Planust develop and main preparedness planus the section of	an. The [facility] must tain an emergency In that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable id local emergency uirements. The [hospital or iop and maintain a imergency preparedness ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must					
	program that mee section, utilizing a * [For LTC Facilitic Emergency Plan. develop and main preparedness plar and updated at least * [For ESRD Facil Emergency Plan. develop and main program of the section of the sect	ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. ities at §494.62(a):]					

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593 A. BUILDING B. WING		onstruction	COMPLETED 12/19/2022				
	PROVIDER OR SUPPLIER			800 FR	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY (LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and updated at lea						
	failed to maintain an plan that was review annually in accorda This deficient pract Findings include: Based on review of Response Policy & documentation date Administrator and t Operations (DPO) of a.m. to 1:00 p.m. or complete emergenc reviewed by the fact twelve month period The aforementioned reviewed on 03/10/2 most recent twelve interview at the tim Administrator stated most recent review program documentation provided a "Manual "12/19/21" for emerdocumentation at the at 3:30 p.m. on 12/1 This finding was reviewed.	the Facility Director of Plant during record review from 9:40 in 12/19/22, documentation for a sy preparedness program ility within the most recent d was not available for review. It plan was dated as being 21 which was not within the month period. Based on the of record review, the digital of the of emergency preparedness atton. The Administrator I Reviewed" sheet dated regency preparedness program the end of the tour of the facility	E 0	004	1) No specific residents we found to be affected by the alled deficient practice. 2) All residents have potent to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual revattestation form; however, the had been reviewed, and update multiple times within 2022. The facility provided to the IDOH L surveyor a comprehensive emergency preparedness plan was tested in live exercises du 2022 that included: District 5 Health Care Coalition Infection Disease Med Surge (May 12, 2022), Active Threat (July 21,2 conducted on campus by Vant Point Consulting, District 5 He Care Coalition tornado disasteresulting in med surge (Decen 8, 2022). Additionally, the facil has continuously updated the Emergency Preparedness Pla because of the COVID-19 pandemic that impacted emerginfectious diseases and communications. Records spet to COVID-19 pandemic policie were not requested by surveyout were available for review. Evidence of the facility participation and plan testing in the surveyor and plan testing in the facility participation and plan testing in the facility par	eged tial view plan ted e SC n that uring tage alth er nber lity n ging ecific	01/06/2023

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/19/2022	
	ROVIDER OR SUPPLIER			800 FR	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY ILIN, IN 46131		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	emergency exercises in 2022 provided to the LSC surveyor during the survey. The emergency preparedness was reviewed by the Director of Clinical Services and Medical Director with facility Administration documented on the Manual Review attestation (ATTACHMA dated 12/19/2022). 4) All Emergency Preparedness policies and assessments will continue to be updated and amended as need to follow changing CDC, CMS IDOH guidance. A performance improvement plan (ATTACHMB) was developed to ensure get forward that the emergency preparedness plan is reviewed and documentation will be available to validate the EPP review. Facility administrator whave responsibility to update a provide the Emergency Preparedness Plan at least annually for Clinical, operation and Medical Director review. Changes to this plan will be reviewed in monthly QAPI meetings next scheduled for 1/26/2023 (ATTACHMENT C agenda 1/26/23). To determin any employee training or systetesting that may be needed fo updated and revised Emergency Preparedness policies for the calendar year. Routine employeraining will continue to be ongoing. Evidence of routine services and survey and the provide continue to be ongoing. Evidence of routine services and survey and the provide continue to be ongoing. Evidence of routine services and survey and the provide continue to be ongoing. Evidence of routine services and survey and the provide continue to be ongoing. Evidence of routine services and survey and the provide continue to be ongoing.	was s plan of ator, MENT be eded, s, and ce MENT poing d, will and nal, QAPI e em or ncy 2023 yee	DATE

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Event ID:

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Facility ID: 001133

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155593	A. BU B. W.	JILDING ING		COMPL 12/19/	
				_	ADDDECC CITY CTATE ZID COD	.2, .0,	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER	_	FRANKLIN, IN 46131			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0006 SS=F Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a 483.475(a)(1)-(2), 485.625(a 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2) §481.113(a)(1)-(2) §483.73(a)(1)-(2) §485.625(a)(1)-(2) §485.625(a)(1)-(2) §491.12(a)(1)-(2), (a) Emergency Pl develop and main preparedness plan and updated at lea must do the follow (1) Be based on a facility-based and assessment, utiliz approach.*	416.54(a)(1)-(2), 418.113(a) 0(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) 0(1)-(2), 485.68(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment 0, §416.54(a)(1)-(2), §482.15(a)(1)-(2), §482.15(a)(1)-(2), §485.68(a)(1)-(2), 0, §485.68(a)(1)-(2), 0, §485.727(a)(1)-(2), 0, §486.360(a)(1)-(2), 1, §494.62(a)(1)-(2) an. The [facility] must tain an emergency on that must be reviewed, ast every 2 years. The plantaing:] Ind include a documented, community-based risk		TAG		у	DATE
		§418.113(a):] Emergency must develop and					

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Event ID:

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Facility ID: 001133

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155593	A. BUILDING B. WING		COMPLETED 12/19/2022
		100000			12/13/2022
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD	
INDIANA	MASONIC HOME	HEALTH CENTER		(LIN, IN 46131	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCT!	DATE
		gency preparedness plan wed, and updated at least			
		e plan must do the			
	following:	o pian maot ao aio			
	_	ind include a documented,			
	facility-based and	community-based risk			
	assessment, utiliz	ing an all-hazards			
	approach.				
	` '	gies for addressing			
		s identified by the risk ding the management of			
		•			
the consequences of power failures, natural disasters, and other emergencies that would					
affect the hospice's ability to provide care.					
	'	, ,			
	*[For LTC facilities	s at §483.73(a):]			
		The LTC facility must			
	•	tain an emergency			
		n that must be reviewed,			
	do the following:	ast annually. The plan must			
	_	nd include a documented,			
	, ,	community-based risk			
		ing an all-hazards			
		ng missing residents.			
	· · ·	gies for addressing			
	emergency events	s identified by the risk			
	assessment.				
	*IFor ICE/IIDs at 8	§483.475(a):] Emergency			
	_	must develop and maintain			
		eparedness plan that must			
		updated at least every 2			
	years. The plan m	ust do the following:			
	(1) Be based on a	nd include a documented,			
	' '	community-based risk			
	_	ing an all-hazards			
	approach, includir	ng missing clients.			
	(2) Include strated	ies for addressing			

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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		COMPI	LETED
		155593	B. WI	NG		12/19	/2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY		
INIDIANA	MASONIC HOME	HEALTH CENTER			(LIN, IN 46131		
INDIANA	I MASONIC HOME	HEALTH CENTER		FRAINN	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	emergency events identified by the risk						
	assessment.						
		view and interview, the facility	E 00	006	No specific residents we	re	01/06/2023
		n emergency preparedness			found to be affected by the alle	eged	
	plan that was (1) based on and includes a				deficient practice.		
		y-based and community-based			2) All residents have poten	tial	
		lizing an all-hazards approach			to be affected by the alleged		
		d within the most recent twelve			deficient practice but were not		
	-	2) included strategies for			affected.		
		ncy events identified by the			3) The facility only failed to		
	risk assessment in accordance with 42 CFR				update the Emergency		
483.73(a) (1) and 42 CFR 483.73(a) (2). This			Preparedness Plan annual				
deficient practice could affect all occupants.			attestation form; however,				
					facility did have a documented		
	Findings include:				facility and community-based	risk	
				assessment plan. The facility			
		"Emergency Preparedness and			provided to the IDOH LSC sur	veyor	
		Procedures Manual"			a comprehensive emergency		
		ed 03/10/21 with the			preparedness plan that did inc	lude	
		the Facility Director of Plant			a Hazard Vulnerability		
		during record review from 9:40			Assessment that was tested in		
	_	n 12/19/22, a documented			live exercises during 2022. Th	е	
		community-based risk			functional exercises included:		
		ed by the facility within the			District 5 Health Care Coalition		
		month period was not			Infection Disease Med Surge	(May	
		v. Based on interview at the			12, 2022), Active Threat (July		
		ew, the Administrator stated			21,2022) conducted on campu	-	
		ate of the most recent review of			Vantage Point Consulting that		
		dness program documentation.			included 2 hours of staff training		
		provided a "Manual			District 5 Health Care Coalition	· -	
		ated "12/19/21" for emergency			tornado disaster resulting in m	ied	
		am documentation at the end			surge (December 8, 2022).		
	of the four of the fa	cility at 3:30 p.m. on 12/19/21.			Additionally, the facility has		
	This finding	viewed with the Advisit interest			continuously updated the	_	
		viewed with the Administrator			Emergency Preparedness Pla	n	
	and the DPO during	g the exit conference.			because of the COVI-19	ilita i	
					pandemic. Evidence of the fac	-	
					participation and plan testing i		
					emergency exercises in 2022	was	
					provided to the LSC surveyor		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155593 B. WING		(X3) DATE SURVEY COMPLETED 12/19/2022				
	ROVIDER OR SUPPLIE	R HEALTH CENTER	800 FR	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY (LIN, IN 46131		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON D BE OPRIATE	(X5) COMPLETION DATE
				during the survey. The er preparedness plan was re by the Director of Clinical and Medical Director with Administrator, documente Manual Review attestation (ATTACHMENT A, dated 12/19/2022). 4) All Emergency Preparedness policies and assessments which included Hazard Vulnerability Assewill continue to be updated amended as needed, to for changing CDC, CMS, and guidance. A performance improvement plan (ATTACB) was developed to ensure forward that the emergency preparedness plan is review and documentation will be available to validate the Ereview. Facility administration have responsibility to update the Emergency Preparedness Plan which the Hazard and Vulnerabity Assessment at least annual Clinical, operational, and Indicated the Indicated for 1/26/2023 2 (ATTACHMENT C QAPI at 1/26/23). Routine employed training will continue to be ongoing. Evidence of rout training to emergency preparedness for 2022 was provided to the LSC survey and the ISC survey	eviewed Services facility d on the n d des the essment, d and bllow d IDOH CHMENT are going cy ewed, ester includes lity ally for Medical Changes ed in ext 2023 agenda ee eine staff	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		lì í	UILDING	INSTRUCTION	COMPL 12/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(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)	ΓΕ	(X5) COMPLETION DATE
E 0013 SS=F Bldg	484.102(b), 485.6: 485.727(b), 485.9: 491.12(b), 494.62(c) Development of Eligham States of Eligham St	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 1.84(b), §482.15(b), 475(b), §484.102(b), 525(b), §485.727(b), 5.360(b), §491.12(b), 5.360(b), 5.360(b			the time of survey.		
	ESRD Facilities:	S. I.S. I.S. I. P. G. L. H. L.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 12/19/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 800 FREEMASON PARKWAY FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	(X5) E COMPLETION DATE	
	procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication placetion. The policiaddress manager nonmedical emergilimited to: Fire; equilimited and update to:	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be atted at least every 2 years.	E 0013	1) No specific residents v	were 01/06/2023	
	failed to review and preparedness polici policies and proced diseases (EID). Th	l update its emergency es and procedures to include ures for emerging infectious e policies and procedures must dated at least annually in	E 0013	 No specific residents of found to be affected by the adeficient practice. All residents have pote to be affected by the alleged deficient practice but were not appear to be affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the specific part of the practice but were not affected by the practice but	alleged ential	

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6UDX21 Facility ID: 001133

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/19/2022	
	ROVIDER OR SUPPLIER		800 FI	ADDRESS, CITY, STATE, ZIP COREEMASON PARKWAY KLIN, IN 46131	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION (X5) DULD BE PPROPRIATE COMPLETION DATE	Í
	accordance with 42 practice could affect	CFR 483.73(b). This deficient tall occupants.		affected. 3) The facility only faupdate the Emergency	illed to	
	Findings include:			Preparedness Plan ann attestation form. The fa	cility has a	
	Response Policy & documentation date Administrator and t Operations (DPO) of a.m. to 1:00 p.m. or preparedness policiwithin the most reconstravailable for review of record review of record review of record review of record review prepared preparedness program of the tour of the farms.	"Emergency Preparedness and Procedures Manual" d 03/10/21 with the he Facility Director of Plant during record review from 9:40 in 12/19/22, emergency es and procedures reviewed ent twelve month period was view. Based on interview at the ew, the Administrator stated atte of the most recent review of dness program documentation. provided a "Manual atted "12/19/21" for emergency am documentation at the end cility at 3:30 p.m. on 12/19/21. viewed with the Administrator is the exit conference.		documented Epidemic/I Preparation and Respowithin the Emergency Preparedness Plan that offered to the LSC surverview. A separate emergenedness supplement specific to Infectious Districts and COVID-19 was also although the LSC surverequest that material whave been provided Impupon specific request. It policies and procedures infectious diseases and had been reviewed by the leadership (Attachment review attestation form) IDOH health survey teat annual recertification suconducted on 11/15/202 found to be in substantic compliance. The plan were viewed by the IDOH I Preventionist on 4/21/20 found the plan to be in substantic compliance. Facility empreparedness plans were a live exercise during 20 functional exercise conducted to District 5 Health Care	Pandemic nse section I was eyor for ergency ent plan seases o available, eyor did not nich could mediately The facility of for COVID-19 he facility D, manual I, and the In in the Irvey 22 and was al vas also infection 022 who substantial ergency re tested in 022. The ducted by re Coalition	
				Infection Disease Med S May 12, 2022. Additional facility has continuously the Emergency Prepare	ally, the updated	

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	OF CORRECTION	IDENTIFICATION NUMBER 155593	A. BUILDING B. WING		COMPLETED 12/19/2022
	ROVIDER OR SUPPLIER		800 FR	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY (LIN, IN 46131	
(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)	DATE
				Plan because of the COVI-19 pandemic. Evidence of the far participation and plan testing emergency exercises in 2022 provided to the LSC surveyor during the survey. 4) All Emergency Preparedness policies and assessments which includes those related to emerging infectious diseases will contint to be updated and amended needed, to follow changing CCMS, and IDOH guidance. A performance improvement plant (ATTACHMENT B) was develous ensure going forward that the emergency preparedness plant reviewed, and documentation be available to validate the Eleannual review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plant which incompared the emerging infectious diseased teast annually for Clinical, operational, and Medical Directive in QAPI next scheduled 1/26/2023 2023 (ATTACHME QAPI agenda 1/26/23). Chant made to this plant will be review in monthly QAPI meetings to determine any employee train or system testing that may be needed. Routine employee train or system testing that may be needed. Routine employee train or system testing that may be needed. Routine employee train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routine employees train or system testing that may be needed. Routin	cility in 2 was nue as DC, an loped the n is n will PP ludes ases ector ed for ENT C ges ewed ning aining aining ing to 2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 12/19/2022			
	PROVIDER OR SUPPLIER		800 FF	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY KLIN, IN 46131	
(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)	(X5) COMPLETION DATE
E 0029 SS=F Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §485.68(c), §485.6 §485.920(c), §486: §494.62(c). (c) The [facility] mean emergency preplan that complies local laws and muat least every 2 years failed to develop an preparedness common with Federal, State, reviewed and updat accordance with 42 practice could affect Findings include: Based on review of Response Policy & documentation date Administrator and to Operations (DPO) of a.m. to 1:00 p.m. or complete emergency plan reviewed by the second of the complete emergen	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 1.84(c), §482.15(c), 475(c), §484.102(c), 525(c), §485.727(c), 1.360(c), §491.12(c), 1.360(c),	E 0029	1) No specific residents wer found to be affected by the alled deficient practice. 2) All residents have potent to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual reviattestation form. The facility did have a documented communication plan, identified the facility Emergency Preparedness Plan as Coordination with Local Emergency Responders and Resources, Key Contacts listed within Section 1: Introduction to	eged ial iew in

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	OF CORRECTION	IDENTIFICATION NUMBER 155593	A. BUILDING B. WING		COMP	LETED 0/2022
	PROVIDER OR SUPPLIER		800 FR	ADDRESS, CITY, STATE, ZIF REEMASON PARKWA' KLIN, IN 46131		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	review, the Administrate of the most recupreparedness prograte Administrator provisheet dated "12/19/2 preparedness prograte of the tour of the factor of th	nterview at the time of record strator stated 03/10/21 was the ent review of emergency and documentation. The ded a "Manual Reviewed" 21" for emergency and documentation at the end cility at 3:30 p.m. on 12/19/21. Eviewed with the Administrator of the exit conference.		the Emergency Mana Plan, and Section III: Preparedness Collab. These areas reflect the policies and proceduc communications, corecoordination of informin accordance with 4 483.73(c). The emerpreparedness plan with the Director of Clinand Medical Director Administrator, docum Manual Review attest (ATTACHMENT A data 12/19/2022). The further exercises the facility in for 2022 included: Health Care Coalition Disease Med Surge 2022), Active Threat conducted on campulation of staff training the Health Care Coalition disaster resulting in the Communication of the facility participating in emergency was provided to surveyor during the slive exercises allower review of the facility communication planted community procordination of service outside community procordination of service outside community procordination meetings the emergency manager the service of the policy than the procordination of service outside community procordination of service outside community procordination meetings the emergency manager the procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination meetings the emergency manager than the procordination of service outside community procordination meetings the emergency manager than the procordination of the pr	is Emergency poration. The facility press for intacts, and mation sharing 2 CFR gency was reviewed inical Services with facility mented on the station atted inctional participated District 5 in Infection (May 12, (July 21,2022) is by Vantage at included 2 g, District 5 in tornado med surge Evidence of ion and plan of exercises in ion the LSC is survey. These is and the ces with martners. In attends is Health Care in at allows	

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CENTERS FOR	MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/19/2022
	ROVIDER OR SUPPLIED	HEALTH CENTER	800 FI	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	ALGOLATORI O			networking and collaboration among health care providers (acute care, LTC, Home Health Health Departments (State and County), and emergency responders). 1) All Emergency Preparedness policies and assessments including those related to emergency preparedness plan communications, will continue be updated and amended as needed, to follow changing CL CMS, and IDOH guidance. A performance improvement pla (ATTACHMENT B) was devel to ensure going forward that the emergency preparedness plan reviewed, and documentation be available to validate the EF annual review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plan which inclused the communication plan, at leas annually for Clinical, operation and Medical Director review in QAPI next scheduled for 1/26/20232023 (ATTACHMEN QAPI agenda 1/26/23). Charmade to this plan will be revie in monthly QAPI meetings to determine any employee train or system testing that may be needed for updated and revise Emergency Preparedness	th, and E to DC, an loped he n is will PP dudes ast nal, n NT C nges wed ing
			1	policies. Routine employee	

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training will continue to be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/19/2022	
	PROVIDER OR SUPPLIER		-	800 FRI	ADDRESS, CITY, STATE, ZIP C EEMASON PARKWAY LIN, IN 46131	COD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
140	REGULATORY	ESC IDENTIF FING INFORMATION		TAG	ongoing. Evidence of r training to emergency preparedness for 2022 provided to the LSC su the time of survey.	2 was	DAIL
E 0036 SS=F Bldg	484.102(d), 485.6: 485.727(d), 485.9: 491.12(d), 494.62: EP Training and T §403.748(d), §416: §441.184(d), §460: §485.68(d), §485.6: §485.920(d), §486: §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625: 485.727, CMHCs §486.360, and RH Training and testir develop and maint preparedness train that is based on the in paragraph (a) of assessment at paragraph (b) of this section, policies at (b) of this section, plan at paragraph training and testing reviewed and updates.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) resting 5.54(d), §418.113(d), 2.54(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 2.360(d), §491.12(d), 2.360(d), §491.12(d), 3.360(d), 3.360					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		A. BUILDING B. WING		COMPLETED 12/19/2022	
	PROVIDER OR SUPPLIER		800 F	CADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and maintain an e training and testin the emergency pla of this section, risk (a)(1) of this section at paragraph (b) of communication pla section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/II requirements for eat §483.470(i). *[For ESRD Facility Training, testing, and itesting, and patient orients on the emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at paragraph (a)(1) of this section. The train continuation the communication the communication the section. The train the communication the section. The train the communication the communication the section. The train the communication the section. The train the communication the section.	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based aplan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155593		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPL 12/19/	ETED	
	F PROVIDER OR SUPPLIEI			800 FR	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY (LIN, IN 46131		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	Based on record record failed to develop ar preparedness training was reviewed and the accordance with 42 practice could affect. Based on review of Response Policy & documentation date Administrator and to Operations (DPO) a.m. to 1:00 p.m. of emergency prepare program documentate the most recent twee interview at the time Administrator state most recent review program documentation at the at 3:30 p.m. on 12/	Procedures Manual" and 03/10/21 with the the Facility Director of Plant during record review from 9:40 an 12/19/22, the facility's dness training and testing ation was not reviewed within alve month period. Based on the of record review, the d 03/10/21 was the date of the of emergency preparedness ation. The Administrator l Reviewed" sheet dated regency preparedness program the end of the tour of the facility	E 00	TAG 036	1) No specific residents we found to be affected by the alledeficient practice. 2) All residents have potento be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual restattestation form; however, the has been reviewed, and updamultiple times within 2022. The facility did provide to the IDOHLSC surveyor a comprehensive emergency preparedness plan was tested in live exercises du 2022 that included: District 5 Health Care Coalition Infection Disease Med Surge (May 12, 2022), Active Threat (July 21, conducted on campus by Van Point Consulting, District 5 He Care Coalition tornado disasteresulting in med surge (Decenta, 2022). Additionally, the facil has continuously updated the Emergency Preparedness Platecause of the COVI-19 pandemic. Evidence of the facil participation and plan testing it emergency exercises in 2022 provided to the LSC surveyor during the survey. The emergency preparedness plan was review by the Director of Clinical Servand Medical Director with facil Administrator, documented on Manual Review attestation (ATTACHMENT A dated	re eged tial tial tial tial tial tial tial tial	01/06/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 12/19/2022	
	ROVIDER OR SUPPLIER		800 FR	EEMASON PARKWAY (LIN, IN 46131		
(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)	TE	(X5) COMPLETION DATE
				12/19/2022). All Emergency Preparedness policies and assessments will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDC guidance. Facility administrate will monitor and provide the Emergency Preparedness Pla least annually for Clinical, operational, and Medical Directive in QAPI next scheduled 1/26/20232023 (ATTACHMEN QAPI agenda 1/26/23). Change to this plan will be reviewed in monthly QAPI meetings to determine any employee train or system testing that may be needed for updated and revised Emergency Preparedness policies. Routine employee training will continue to be ongoing. Evidence of routine straining to emergency preparedness for 2022 was provided to the LSC surveyor the time of survey.	OH or n at ctor d for IT C ges ing	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan s this section and in	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1)				

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§483.73(e), §485.625(e)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/19/2022	
	F PROVIDER OR SUPPLIEI			800 FRI	NDDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	(e) Emergency ar The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 Emergency generator must be the location requirements TIA and TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built of structure or buildi 482.15(e)(2), §48 Emergency generator the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §48 Emergency generator the eminspection, testing requirements four Facilities Code, N Code.	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) rator location. The is located in accordance with rements found in the Health ide (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must inergency power system g, and [maintenance] ind in the Health Care in FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs ig that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the		TAG	DEFICIENCY)		DATE
	§483.73(g), and 0 The standards inc	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	A. B	IULTIPLE CO UILDING 'ING	NSTRUCTION	COMI	E SURVEY PLETED 9/2022
	PROVIDER OR SUPPLIED	HEALTH CENTER		800 FRE	DDRESS, CITY, STATE, ZIP CO EEMASON PARKWAY LIN, IN 46131	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reference by the I	Director of the Office of the					
	Federal Register	in accordance with 5 U.S.C.					
	552(a) and 1 CFF	R part 51. You may obtain					
		the sources listed below.					
	You may inspect	a copy at the CMS					
	Information Reso	urce Center, 7500 Security					
		ore, MD or at the National					
	Archives and Records Administration						
		mation on the availability of					
	this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code _of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are						
	1 .	eference, CMS will publish a					
		Federal Register to					
	announce the cha	_					
	' '	Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 0216	9, www.nipa.org,					
	1.617.770.3000.	Ith Care Facilities Code,					
	. ,	ed August 11, 2011.					
		rim amendment (TIA) 12-2 to					
	NFPA 99, issued	` ,	1				
		FPA 99, issued August 9,					
	2012.	1 7 00, Issued August 9,					
	-	FPA 99, issued March 7,					
	2013.						
		FPA 99, issued August 1,					
	2013.						
		FPA 99, issued March 3,					
	2014.	,					
	-	ife Safety Code, 2012					
	edition, issued Au						
	l '	NFPA 101, issued August					
	11, 2011.	, 3					
		FPA 101, issued October					
	30, 2012.	•					
		PA 101, issued October					

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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	<u></u>	COMPI	LETED
		155593	B. W	ING		12/19	/2022
				CENTER	A DODDEGG CHTM CTATE THE COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
INIDIANIA	MACONIO LIOME	LIEALTH OFNITED			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	(LIN, IN 46131		
(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
	22, 2013.						
	(xi) TIA 12-4 to NI	FPA 101, issued October					
	22, 2013.						
	(xiii) NFPA 110, S	tandard for Emergency and					
	Standby Power S	ystems, 2010 edition,					
	including TIAs to	chapter 7, issued August 6,					
	2009						
		view, observation and	E 00	041	No specific residents we	ere	01/06/2023
		ty failed to implement the			found to be affected by the all	eged	
		ystem inspection, testing and			deficient practice.		
	_	ements found in the Health			2) All residents have poten	tial	
	Care Facilities Code, NFPA 110, and Life Safety				to be affected by the alleged		
	Code in accordance with 42 CFR 483.73(e)(2).				deficient practice but were not		
	This deficient practice could affect all residents,				affected.		
	staff and visitors.				Facility maintenance		
					department has implemented	а	
	Findings include:				new weekly generator and		
					annunciator panel inspection		
		review with the Administrator			checklist for documenting wee	-	
	1	ector of Plant Operations			emergency generator inspecti		
	, ,	m. to 1:00 p.m. on 12/19/22,			Zone 1 &2 (ATTACHMENT E)		
		generator inspection			remote emergency stop buttor		
		the most recent 52 week period			generators 1 & 2 are now labe		
		or review. Based on interview			(ATTACHMENT F) to indicate		
		d review, the DPO stated the			"Emergency Stop". The gener		
	1	ergency generators and stated			fuel supply sample was collec		
	1	e staff perform visual			for analysis on 12/29/2022 by		
	_	of the two emergency			outside contractor Premier En		
		ekly basis but agreed weekly			(ATTACHMENT G), test analy	/SIS	
	_	ntation was not available for			is expected to be returned on		
					1/13/2023. The 36-month	ır	1
		the DPO during a tour of the .m. to 3:30 p.m. on 12/19/22, the			emergency generator four-hou continuous operational test wa		1
		ergency generators for the			continuous operational test was	33	1
		side the building each had an			(ATTACHMENT H) with no		1
	· ·	ndicating the generator was			performance issues identified.		
	rated at 300 kW.	indicating the generator was			The Facility Director of F		
	Taicu ai 300 KW.				Operations has responsibility		
	h Based on observe	ations with the Administrator			coordinating and scheduling	IOI	1
		ector of Plant Operations			required generator inspections		
	and the Facility Dil	color of Frank Operations			Liedaniea Aerieraroi ilizhecrious	>,	1

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155593	B. W	ING		12/19/	2022
NAME OF E	PROVIDER OR SUPPLIER	· }		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	LIN, IN 46131		
(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		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		r of the facility from 1:00 p.m. to			system service when needed,		
	3:30 p.m. on 12/19/22, the two diesel fired				record keeping that supports t		
	emergency generators for the facility located				inspections and system service	es	
	outside the building each had an affixed nameplate indicating the generator was rated at				completed.		
	300 kW. A remote emergency stop button was						
	located on the exterior of the weather proof shell						
	for each the two emergency generators but each						
	remote emergency stop button was not labeled.						
	Based on interview at the time of the						
	observations, the DPO agreed the remote manual						
	stop stations were not labeled.						
	-						
	c. Based on record review with the Administrator						
	and the Facility Dir	ector of Plant Operations					
	(DPO) from 9:40 a.	m. to 1:00 p.m. on 12/19/22,					
	documentation of a	n annual fuel quality test for					
	-	esel fired emergency					
	_	available for review. Based on					
		e of record review, the DPO					
		as two diesel fired emergency					
		ed documentation of an					
		test for the diesel fired					
		ors was not available for					
	review.						
	d. Based on record	review with the Administrator					
		ector of Plant Operations					
		m. to 1:00 p.m. on 12/19/22,					
		riod emergency generator					
		on for four continuous hours					
		diesel fired emergency					
		available for review. Based on					
		e of record review, the DPO					
		as two diesel fired emergency					
		ed documentation of					
		esting for four hours within					
	the most recent thre	ee year period was not					
		. Based on observations with					
	the Administrator a	nd the DPO during a tour of					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155593	B. WI	NG		12/19/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 800 FREEMASON PARKWAY FRANKLIN, IN 46131				
					T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION 0 p.m. to 3:30 p.m. on 12/19/22,		TAG	DEFICIENCE!		DATE
	the facility has two generators located of Manufacturer's nam generator stated the kW.	diesel fired emergency outside the building. eplate rating for each generator was rated at 300					
	conference.						
K 0000							
Bldg. 04							
	Licensure Survey w Department of Heal 483.90(a). Survey Date: 12/19 Facility Number: 0 Provider Number: 2000 At this Life Safety 0 Home Health Cente with Requirements Medicare/Medicaid Life Safety from Fit National Fire Protec Life Safety Code (L using Chapter 18, N and 410 IAC 16.2. This two story facilit Type II (111) constructed the story of the atticy non-combustible or	01133 155593 090430 Code survey, Indiana Masonic r was found not in compliance	K 00	000	The submission of this plan of correction does not indicate at admission by the Indiana Mas Home, Inc (the "facility") that the findings and allegation contains herein are an accurate and true representation of the quality of care and services provided to residents of the Indiana Mason Home, Inc. This facility recognits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility hereby maintains in substantial compliance with requirements of participation for comprehensive health care facilities. To this end, the plan correction shall serve as the credible allegation of compliar with all State and Federal requirements governing the management of this facility. It thus submitted as a matter of stature only.	n onic he ned ue f the nic nizes and the or of nce	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155593	B. WI	NG		12/19/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER			LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ridors and in all areas open to					
		icility has smoke detectors					
	hard wired to the fire alarm system in all resident						
		e facility has a capacity of 167					
	and had a census of	141 at the time of this visit.					
		dents have customary access					
	-	d all areas providing facility					
	services were sprink	clered.					
	Quality Review con	npleted on 12/22/22					
K 0353	NFPA 101						
SS=F	Sprinkler System -	- Maintenance and Testing					
Bldg. 04							
	Automatic sprinkle	er and standpipe systems					
	are inspected, test	ted, and maintained in					
	accordance with N	IFPA 25, Standard for the					
	Inspection, Testing	g, and Maintaining of					
	Water-based Fire	Protection Systems.					
	Records of system	n design, maintenance,					
	inspection and tes	ting are maintained in a					
	secure location an	id readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAR	RKS information on					
	-	non-required or partial					
	automatic sprinkle	r system.					
	9.7.5, 9.7.7, 9.7.8,	and NFPA 25					
		riew, observation and	K 0.	353	 No specific residents we 		01/06/2023
		ty failed to document sprinkler			found to be affected by the alle	∍ged	
		in accordance with NFPA 25.			deficient practice.		
		for the Inspection, Testing,			All residents have potent	ial	
		Water-Based Fire Protection			to be affected by the alleged		
		ion, Section 5.2.4.1 states			deficient practice but were not		
	gauges on wet pipe	sprinkler systems shall be			affected.		

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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 <u>04</u> COMPLETED			ETED	
		155593	B. W	ING		12/19/	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
INIDIANIA		LIEAL TH OFNITED			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	LIN, IN 46131		
(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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.L	DATE
	inspected monthly t	to ensure that they are in good			3) Facility maintenance		
	condition and that normal water supply pressure				department has implemented	а	
		. Section 5.1.2 states valves			new Monthly Sprinkler System		
	-	connections shall be			inspection form that includes a		
	_	nd maintained in accordance			monthly inspection of the sprir		
	-	ection 13.3.2.1 states all valves			gauge, sprinkler system contro		
	-	veekly. Section 13.3.2.1 states			valve, and the fire department		
	_	locks or supervised in			connection. A copy of the wee		
		plicable NFPA standards shall			one January 2023 completed		
		nspected monthly. Section			inspection form for Zone 1&2 a	are	
	4.3.1 states records shall be made for all				included as :(ATTACHMENT I		
	inspections, tests, and maintenance of the system				The inspection will be complet	,	
	and its components and shall be made available to				by the Plant Operations Direct		
	the authority having jurisdiction upon request.				or his qualified designee week		
	This deficient practice could affect all residents				The Facility Director of F	-	
	and staff in the facil				Operations has responsibility f		
	una stari in the faci				completing or coordinating and		
	Findings include:				scheduling required sprinkler	4	
	i mamgs meraac.				system inspections, system		
	Based on review of	the sprinkler system			service when needed, and rec	ord	
		or's "Sprinkler Inspection			keeping that supports the sprir		
	-	entation dated 10/25/22 with			inspections and system service		
		nd the Facility Director of			completed.	03	
		OPO) from 9:40 a.m. to 1:00 p.m.			5)		
		ly sprinkler gauge and sprinkler			3)		
		e and fire department					
	•	on documentation for eleven					
	•	recent twelve month period					
		or review. Based on interview					
		d review, the DPO stated the					
		spection contractor only					
		lity written documentation of					
	-	nspections done on an annual					
	*	ne during the most recent					
	_	d on 10/25/22. The DPO stated					
	_	orms quarterly inspections but					
	does not provide to						
		ne date and the results of					
	_	The DPO also stated facility					
	maintenance staff p	erforms weekly visual					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	l í	JILDING	nstruction <u>04</u>	(X3) DATE : COMPL 12/19/	ETED
	ROVIDER OR SUPPLIER			800 FRI	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY LIN, IN 46131		
(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)	TE	(X5) COMPLETION DATE
K 0754 SS=E Bldg. 04	control valves but as documentation was Based on observation and the Facility Directory (DPO) during a tour 3:30 p.m. on 12/19/2 wet sprinkler system inspection contractor the sprinkler system inspections were contracted to be capacited linen and 10 Soiled Linen and 11 Soiled Linen and 12 Soiled Linen and 13 Soiled Linen or trass shall not exceed 3 average density of room or space shall use a special system in the system in the special	Frash Containers Frash Container Frash Container capacity. The Fractional Container capacity in a container capacity in a container Frash Container capacity in a container capacity in a container Frash Container capacity. The Fractional Container capacity in a container capacit					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>04</u>		COMPLETED	
		155593	B. WI	NG		12/19/	2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	(LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	18.7.5.7, 19.7.5.7						
		on and interview, the facility	K 0	754	No specific residents we		01/06/2023
		bile soiled linen or trash			found to be affected by the all	eged	
	-	al container capacity of greater			deficient practice.		
		red in 3 of over 10 corridors			2) All residents have poten	tıal	
		om protected as a hazardous			to be affected by the alleged		
		ded. This deficient practice			deficient practice but were not		
	could affect over 20	residents, staff and visitors.			affected.		
	E' 1' ' 1 1				3) The nursing department		
	Findings include:				removed the soiled linen and t	rasn	
	Dagad on abassur-4	one with the Administrator			receptacles from the service	. in	
	Based on observations with the Administrator				hallway and have placed them	ı ın	
	and the Facility Director of Plant Operations (DPO) during a tour of the facility from 1:00 p.m. to				the soiled utility room. The		
		22, two unattended 32 gallon			receptacles will be used in the hallway only when attended a		
	-	cles and one unattended 32			providing patient care. Once	iiu	
	-	ion receptacle each partially			patient care has been complete	tod	
	-	nen or trash were stored next to			the receptacles will be returne		
		corridor outside Room 1351.			the soiled utility room for stora		
		2 gallon soiled linen			The nursing department mana	-	
		unattended 32 gallon trash			and administrator will visually	igolo	
	-	e each partially filled with			verify the receptacles are		
		were also stored next to one			compliant where properly store	ed in	
		dor outside Room 1335. Four			the soiled utility room when no		
		on soiled linen receptacles and			use during routine daily walkir		
		gallon trash collection			rounds. Non-nursing manager	•	
		tially filled with soiled linen or			inform nursing department		
		ed next to one another in the			managers if they observed the)	
	corridor outside Ro	om 2135. The receptacles were			receptacles stored outside the		
	not stored in a roon	n protected as a hazardous area			soiled utility room to allow		
	when not attended.	Based on interview at the			immediate intervention.		
		tions, the DPO agreed the					
	receptacles were no	t stored in a room protected as					
	a hazardous area wl	hen unattended.					
	This find:	rei arro d resida da a Adunto interesta o					
		viewed with the Administrator					
	and the DPO during	g the exit conference.					
	3.1-19(b)						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 04	(X3) DATE S COMPL 12/19/	ETED
	PROVIDER OR SUPPLIER		800 FF	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY KLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE
K 0918	NFPA 101					
SS=F	-	s - Essential Electric Syste				
Bldg. 04		s - Essential Electric				
3 -	System Maintenar					
	I -	other alternate power				
	_	iated equipment is capable				
		ce within 10 seconds. If the				
		n is not met during the				
		ocess shall be provided to				
		his capability for the life				
		branches. Maintenance				
	and testing of the	generator and transfer				
	switches are perfo	ormed in accordance with				
	NFPA 110.					
	Generator sets are	e inspected weekly,				
	exercised under lo	oad 30 minutes 12 times a				
	year in 20-40 day	intervals, and exercised				
	once every 36 mo	nths for 4 continuous hours.				
	Scheduled test un	der load conditions include				
	a complete simula	ited cold start and				
	automatic or man	ual transfer of all EES				
	loads, and are cor	nducted by competent				
	personnel. Mainte	nance and testing of stored				
	energy power sou	rces (Type 3 EES) are in				
		NFPA 111. Main and feeder				
		e inspected annually, and a				
	program for period	dically exercising the				
		tablished according to				
	·	uirements. Written records				
		nd testing are maintained				
		ble. EES electrical panels				
		arked, readily identifiable,				
		n normal power circuits.				
		ssibility of damage of the				
		source is a design				
	consideration for r					
		(NFPA 99), NFPA 110,				
	NFPA 111, 700.10		IZ 0010	A) Na amouté a contra de		01/06/2022
		review, observation and ty failed to ensure a written	K 0918	No specific residents found to be affected by the		01/06/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU		(2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>04</u>			COMPLETED	
		155593	B. W	ING		12/19/		
				_				
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
					EEMASON PARKWAY			
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	LIN, IN 46131			
(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 CROSS-REFERENCED TO THE APPRO		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	record of weekly in	spections for the facility's two			deficient practice.			
	emergency generators was maintained for 52				2) All residents have poten	tial		
	weeks of the most recent 52 week period. NFPA				to be affected by the alleged			
	99, 6.4.4.1.3 requires onsite generators shall be				deficient practice but were not			
	maintained in accordance with NFPA 110,				affected.			
	Standard for Emerg	ency and Standby Power			3) Facility maintenance			
	-	0, 8.4.1 requires an Emergency			department has implemented	а		
	-	em (EPSS) including all			new weekly generator and			
	* * * *	nents, shall be inspected			annunciator panel inspection			
	weekly and exercised monthly. NFPA 99, 6.4.4.2				checklist for documenting wee	klv		
	requires a written record of inspection,				emergency generator inspection	•		
	performance, exercising period, and repairs for the				for documenting weekly			
	generator to be regularly maintained and available				emergency generator inspection	ons		
	for inspection by the authority having				Zone 1 &2 (ATTACHMENT E)			
	jurisdiction. This deficient practice could affect all				remote emergency stop buttor			
	residents, staff and	-			generators 1 & 2 are now labe			
	,				(ATTACHMENT F) to indicate			
	Findings include:				"Emergency Stop". The general			
	8				fuel supply sample was collect			
	Based on record rev	view with the Administrator			for analysis on 12/29/2022 by			
		ector of Plant Operations			outside contractor Premier En			
	·	m. to 1:00 p.m. on 12/19/22,			(ATTACHMENT G). The 36-m			
		generator inspection			emergency generator four-hou			
		the most recent 52 week period			continuous operational test wa			
		or review. Based on interview			completed on 1/3/2023			
	at the time of record	d review, the DPO stated the			(ATTACHMENT H) with no			
		ergency generators and stated			performance issues identified.			
	-	e staff perform visual			4) The Facility Director of F			
	•	n of the two emergency			Operations has responsibility t			
		ekly basis but agreed weekly			coordinating and scheduling	0.		
		ntation was not available for			required generator inspections	S .		
	_	bservations with the			system service when needed,			
		the DPO during a tour of the			record keeping that supports t			
		.m. to 3:30 p.m. on 12/19/22, the			inspections and system service			
		ergency generators for the			completed.			
		side the building each had an						
	•	ndicating the generator was						
	rated at 300 kW.	manada de generator was						
	Tates at 500 KW.							
	This finding was re	viewed with the Administrator						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593	lì í	UILDING	nstruction <u>04</u>	(X3) DATE COMPI 12/19	LETED
NAME OF I	PROVIDER OR SUPPLIEI	R	•		DDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY	•	
INDIANA	MASONIC HOME	HEALTH CENTER			LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and the DPO during	g the exit conference.					
	3.1-19(b)						
	2 Based on observ	ation and interview, the facility					
		f 2 remote manual stops for					
		ors for the facility were labeled					
		NFPA 99. NFPA 99, Health					
		le, 2012 Edition, Section 15.5.1.3					
	" " " "	enerators and standby power					
		ired for compliance with this					
	code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for						
		andby Power Systems. NFPA					
		5.6.5.6 states all installations manual stop station of a type					
		ent or unintentional operation					
	_	room housing the prime					
		stalled, or elsewhere on the					
		prime mover is located outside					
	the building. The r	remote manual stop station					
	shall be labeled. The	his deficient practice could					
	affect all residents,	staff and visitors.					
	Findings include:						
	Based on observation	ons with the Administrator					
		rector of Plant Operations					
	` ′	er of the facility from 1:00 p.m. to					
	_	/22, the two diesel fired					
		ors for the facility located					
	1	g each had an affixed					
		ng the generator was rated at emergency stop button was					
		rior of the weather proof shell					
		nergency generators but each					
		stop button was not labeled.					
	Based on interview	-					
		PO agreed the remote manual					
	stop stations were r						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155593		UILDING	nstruction <u>04</u>	(X3) DATE COMPL 12/19/	ETED
	ROVIDER OR SUPPLIER		•	800 FRE	DDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY LIN, IN 46131		
(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)	TE	(X5) COMPLETION DATE
	_	viewed with the Administrator g the exit conference.					
	facility failed to ensume was performed for the generator. NFPA 9 2012 Edition, Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. In maintenance shall be with NFPA 110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect visitors. Findings include: Based on record revalunt the Facility Diraction (DPO) from 9:40 a. documentation of an the facility's two disagreem and the facility has generators and agreem annual fuel quality to the section of the section of the facility has generators and agreem annual fuel quality to the section of the section of the section of the facility has generators and agreem annual fuel quality to the section of the section	review and interview, the sure an annual fuel quality test the facility's diesel-powered 9, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests at least annually using tests at standards. This deficient at all residents, staff and view with the Administrator ector of Plant Operations m. to 1:00 p.m. on 12/19/22, an annual fuel quality test for esel fired emergency available for review. Based on e of record review, the DPO as two diesel fired emergency ed documentation of an test for the diesel fired ors was not available for					
	review. This finding was re	viewed with the Administrator g the exit conference.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>0</u>	4	COMPLETED 12/19/2022	
		155593	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP COD		
INDIANA	MASONIC HOME	HEALTH CENTER			IASON PARKWAY IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	3.1-19(b)						
	4 D44						
		review, observation and ty failed to document 36 month					
		generator testing for 2 of 2					
		ors in accordance with NFPA					
	" " "	NFPA 99, Health Care Facilities					
		, Section 6.4.1.1.6.1 states Type					
		tial electrical system power	1				
	` ′	ll be classified as Type 10,					
	_	enerator sets per NFPA 110.					
	NFPA 110, the Standard for Emergency and						
		stems, 2010 Edition, Section					
		EPSS shall be tested at least					
	1	66 months. Section 8.4.9.1					
		S shall be tested continuously					
		ts assigned class (See Section 2 states where the assigned					
	1	4 hours, it shall be permitted					
	I -	t after 4 continuous hours.					
		es the minimum load for this					
		ed in 8.4.9.5.1, 8.4.9.5.2, or					
		3.4.9.5.3 states for spark-ignited					
		be the available EPSS load.					
	_	ice could affect all residents,					
	staff and visitors.	,					
	Findings include:						
	Based on record rev	view with the Administrator					
	and the Facility Dir	ector of Plant Operations	1				
	(DPO) from 9:40 a.	m. to 1:00 p.m. on 12/19/22,	1				
	thirty-six month per	riod emergency generator					
	testing documentati	on for four continuous hours	1				
	for the facility's two	diesel fired emergency	1				
		available for review. Based on	1				
		e of record review, the DPO	1				
	stated the facility ha	as two diesel fired emergency	1				
	generator and agree	ed documentation of	1				I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	ULTIPLE CO JILDING	onstruction <u>04</u>	(X3) DATE COMPI	
		155593	B. W	ING		12/19	/2022
NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME HEALTH CENTER			800 FR	ADDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY (LIN, IN 46131			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		esting for four hours within					
		e year period was not					
		Based on observations with					
		nd the DPO during a tour of					
	the facility from 1:0	00 p.m. to 3:30 p.m. on 12/19/22,					
	the facility has two	diesel fired emergency					
	generators located of	outside the building.					
	Manufacturer's nam	eplate rating for each					
	generator stated the	generator was rated at 300					
	kW.						
	This finding was rev	viewed with the Administrator					
	and the DPO during	the exit conference.					
	3.1-19(b)						

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