STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING -- B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE GREENFIELD	5430 W US 40 GREENFIELD, IN 46140

(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. Survey Date: 09/17/24 Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720 At this Emergency Preparedness survey, Aperion Care Greenfield was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 50. Quality Review completed on 09/18/24	E 0000	**PLAN OF CORRECTION ON BEHALF OF APERION CARE GREENFIELD** **"This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483". Facility operators reserve litigation rights of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies".**	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the	E 0004	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. How Other Residents Having The	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., the EPP from the new ownership lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. The facilities old EPP had a cover page with annual updates listed but the most recent was dated 02/03/23 by the old administrator. Based on an interview during records review, the MD stated the EPP was being updated to conform to the new ownership. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken: All residents have the potential to be affected by this alleged deficient practice. The Emergency Preparedness Plan was reviewed and updated. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance Director was in-serviced on the need to ensure the Emergency Preparedness Plan is reviewed and updated annually. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly. **b="">**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach,	E 0006	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:	10/04/2024

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	155254	A. BUILDING -- B. WING	09/17/2024

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	including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. The documentation provided was blank and used as an example only. Based on interview at the time of record review, the MD stated a risk assessment utilizing an all-hazards approach could not be found. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The Emergency Preparedness Plan was updated to include a documented, facility and community-based risk assessment to include missing resident and strategies for addressing events identified in the risk assessment. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director was in-serviced over the requirements to ensure that the emergency preparedness plan includes facility and community-based risk assessments, that include missing residents and strategies for addressing events identified in the risk assessment. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance	

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			Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly. **b="">** ="" b="">** ** ="" b="">** ** ="" b="">** ** ="" b="">** ** ="" b="">** **b="">** ="" b="">** ** ="" b="">** **span="">** ="" span="">** ** ="" ball="">** ** ="" span="">** ** ="" span="">** ** ="" bthe="">** **span="">** ="" span="">** ** ="" span="">**	
E 0009 SS=C Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(Local, State, Tribal Collaboration Process Based on record review and interview, the facility	E 0009		10/04/2024

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	failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., the EOP from the new ownership had a template for emergency contact info but the documentation was blank and the relevant information not included. No additional documentation could be located ensuring the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The provided documentation listed contacts in Illinois. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		**b="">** **b="">** ="" b="">** ="" b="">** What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The Emergency Preparedness Plan was updated to include a process for cooperation and collaboration with local, tribal, regional, state and federal officials. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director was in-serviced over the requirements to ensure that the emergency preparedness plan includes a process for cooperation and collaboration with local, tribal, regional, state and federal officials.	

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			How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., the EPP from the new ownership lacked a cover page, and no date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year. The facilities old EPP had a cover page with annual updates listed but the most recent was dated 02/03/23 by the old administrator. Based on an interview during records review, the	E 0013	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The Emergency Preparedness Plan policies and procedures were reviewed and updated.	10/04/2024

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	MD stated the EPP was being updated to conform to the new ownership. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance director was in-serviced on the requirement for the Emergency Preparedness plan policies and procedures need for annual update. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly. **span="">** ="" span="">** ="" ball="">** ="" span="">** ="" span="">** ="" bthe="">** span="">** ="" span="">** ="" span="">** b="">**	

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E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., the EPP from the new ownership lacked a cover page, and no date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. The facilities old EPP had a cover page with annual updates listed but the most recent was dated 02/03/23 by the old administrator. Based on an interview during records review, the MD stated the EPP was being updated to conform to the new ownership. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.	E 0029	=”” span=””> What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The emergency preparedness plan was reviewed and updated to include a communication plan. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance Director was in-serviced on the need to ensure the Emergency Preparedness Plan is reviewed and updated annually. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance	10/04/2024

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			Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
E 0030 SS=C Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., the provided EPP's communication plan was not current. The communication plan did not include an updated list of names and contact information for staff, and resident physicians. The provided documentation was a template and no current information was included with staff contacts or resident physicians. The Maintenance Director agreed that the EPP needed attention and that some of the	E 0030	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The emergency preparedness plan was updated to include contact information for staff and resident physicians. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure	10/04/2024

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	lists provided contained contact information from the state of Illinois. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		That The Deficient Practice Does Not Recur: The Maintenance Director was inserviced on the requirement to ensure the Emergency Preparedness plan has updated communication plan. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between	E 0036	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective	10/04/2024

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	9:30 a.m. and 11:45 a.m., the EPP from the new ownership lacked a cover page, and no date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. The facilities old EPP had a cover page with annual updates listed but the most recent was dated 02/03/23 by the old administrator. Based on an interview during records review, the MD stated the EPP was being updated to conform to the new ownership. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		Action(s) Will Be Taken: All residents have the potential to be affected by this alleged deficient practice. The Emergency Preparedness Plan was updated to include a training and testing program. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director was in-serviced over the requirements for testing and training program. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director will monitor the Emergency Preparedness Plan training and testing monthly to ensure the plan is reviewed and updated annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system	E 0041	What Corrective Action(s) Will Be Accomplished For Those	10/04/2024

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	155254	A. BUILDING -- B. WING	09/17/2024

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APERION CARE GREENFIELD	5430 W US 40 GREENFIELD, IN 46140

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	inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the MD stated he believed the test was done but the fuel quality testing for the diesel fired generator could not be located. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.		Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. A fuel quality test was performed on 9-19-24. Results obtained 9-26-24 Passed What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance Director was in-serviced on the requirements of annual fuel quality testing for the diesel generator. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director will monitor annual fuel testing monthly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be	

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			adjusted accordingly.	
K 0000 Bldg. 01	A Life Safety Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/17/24 Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720 At this Life Safety Code survey, Aperion Care Greenfield was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type II (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detection in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 50 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility had two detached storage buildings and a detached maintenance shop which were not sprinklered.	K 0000	**PLAN OF CORRECTION ON BEHALF OF APERION CARE GREENFIELD** **"This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483". Facility operators reserve litigation rights of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies".**	

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	Quality Review completed on 09/18/24			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Maintenance Director on 09/17/24 between 9:30 a.m. and 11:45 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided was conflicting because of the recent ownership change and the new company being based in Illinois. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)	K 0346	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The fire watch plan was updated to include notifying ISDH if the fire alarm system becomes out of service for 4 or more hours. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director was in serviced over the requirements to ensure that the fire plan must include notification to ISDH. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director/Designee	10/04/2024

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			will monitor the fire watch plan monthly to ensure that notification of ISDH is on the policy. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility.	K 0354	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The fire watch plan was updated to include notifying ISDH if the sprinkler system becomes out of service for 10 or more hours. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does	10/04/2024

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	Findings include: Based on records review and interview with the Maintenance Director on 09/17/24 between 9:30 a.m. and 11:45 a.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided was conflicting because of the recent ownership change and the new company being based in Illinois. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)		Not Recur: The Maintenance Director was in serviced over the requirements to ensure that the fire plan must include notification to ISDH. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director/Designee will monitor the fire watch plan monthly to ensure that notification of ISDH is on the policy. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 business office with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each	K 0361	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective	10/11/2024

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	space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 20 residents. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., the business office had a large pass-through window and the office was not protected by electrically supervised automatic smoke detection. The smoke detection in the office was battery operated single station smoke alarm. Based on interview at the time of observation, the MD agreed the window was greater than 20 square inches and the office did not contain electrically supervised automatic smoke detection. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)		Action(s) Will Be Taken: All residents have the potential to be affected by this alleged deficient practice. The sliding glass window will be replaced by standard wall by 10/11/24. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: Maintenance Director was in-serviced over areas open to corridors. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The maintenance director/designee will monitor monthly areas open to corridors to ensure requirements are meet. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 3 staff. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., the corridor door to the Employee Breakroom was broken near the bottom and was penetrated all the way through. The door was not solid core and would not resist the passage of smoke. The MD stated that a resident recently kicked the door causing it to break. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)	K 0363	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. A new door was ordered for the employee breakroom. Will be installed by 10/11/24 What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: Maintenance Director will be in-serviced over the requirements for corridor doors. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director/Designee will monitor 5 corridor doors daily on scheduled work days x 4 weeks, then weekly x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A	10/11/2024

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			report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 30 residents and staff. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., the following locations were missing ceiling	K 0372	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. The ceiling tiles will be replaced in the clean utility room, the corridor near the dining room, the corridor near the entrance to therapy, and the corridor near the administrators officeby 10/11/24. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance director was inserviced over the requirements	10/11/2024

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	tiles in the smoke barrier drop ceiling: 1) The Clean Utility Room. 2) the Corridor near the Dining Room. 3) The Corridor near the entrance to Therapy. 4) In the Corridor near the Administrators Office. The MD stated that a water leak had caused the facility to replace several smoke barrier ceiling tiles in the facility. The MD stated that the water leak was not recent having occurred back in the spring. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)		regarding smoke barriers. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director/Designee will monitor ceiling tiles daily on scheduled work days x 4 weeks, then weekly x 8 weeks negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric 1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the laundry room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 2 staff. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director	K 0511	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. An electrical junction box was placed in the laundry room. An outlet cover was replaced in the DON office 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 have the potential to be affected by this alleged	10/04/2024

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	(MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., an electrical junction box was missing in the laundry room above the washing machine which had been removed leaving exposed wire in metal conduit. Based on interview at the time of the observations, the Maintenance Director acknowledged the wires were exposed stating he would need to install a junction box to secure the wires. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure electrical outlets were protected in the DON office according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 3 staff. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., in the DON office, beneath the window Air Conditioner Unit, an outlet cover protecting the electrical outlet was missing. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)		deficient practice. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director was in-serviced over the regulation for utilities- gas and electric specifically pertaining to outlets. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor 5 outlets and junction boxes daily on scheduled work days x 4 weeks, then weekly x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	

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K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining resident rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect everyone in the facility. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Director (MD) on 09/17/24 between 11:45 a.m. and 1:15 p.m., resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director acknowledged that resident rooms were using the egress corridor as a return air system and the facility has sought a waiver in the past. No waiver for the upcoming year was available for review, the MD stated that due to the ownership change the facility had not applied for the waiver as of the date of this survey. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present.	K 0521	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. A Life safety code waiver has been requested as the zlleged noncompliance cannot be corrected without financial hardship on the facility and it does not pose a threat to the residents health and safety. 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 have the potential to be affected by this alleged deficient practice. What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Maintenance Director will be in-serviced over the requirements for return air systems and the life safety code waiver to be requested. How The Corrective Action(s) Will Be Monitored To Ensure The	10/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 01 B. WING	09/17/2024

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	3.1-19(b)		Deficient Practice Will Not Recur: Maintenance Director/Designee will monitor the life safety code waiver to ensure annual update occurs ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Maintenance Director (MD) on 09/17/24 between 9:30 a.m. and 11:45 a.m., no documentation of an annual fuel quality test for the diesel generator	K 0918	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: No residents were affected by this alleged deficient practice. 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 have the potential to be affected by this alleged deficient practice. A fuel quality test was performed on on 9-19-24. Results obtained 9-26-24 Passed	10/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 01 B. WING	09/17/2024

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	was available for review. Based on interview at the time of records review, the MD stated he believed the test was done but the fuel quality testing for the diesel fired generator could not be located. This finding was reviewed with the Maintenance Director at the time of discovery and again during the exit conference with the Maintenance Director present. 3.1-19(b)		What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The maintenance Director was in-serviced on the requirements of annual fuel quality testing for the diesel generator. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur: Maintenance Director will monitor annual fuel testing ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	