STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155254	B. WI	NG		09/17/	2024
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		5430 W			
APERIO	N CARE GREENFI	ELD			NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
E 0000							
Bldg							
2.29.	An Emergency Pre	paredness Survey was	E 00	000	PLAN OF CORRECTION ON		
		ndiana Department of Health in		,00	BEHALF OF APERION CARE		
	accordance with 42	-			GREENFIELD	'	
					"This plan of correction		
	Survey Date: 09/1	7/24			constitutes the facility's writted credible allegation of	ten	
	Facility Number: (000157			compliance. Preparation		
	Provider Number:				and/or execution of this Plan	of	
	AIM Number: 100				Correction does not constitu		
					admission or agreement by t		
	At this Emergency	Preparedness survey, Aperion			provider of the truth of the facts		
		was found not in compliance with alleged or the conclusion set					
		edness Requirements for			forth in the Statement of		
		icaid Participating Providers			Deficiencies. This plan of		
	and Suppliers, 42 C				correction is prepared and/o	r	
	**				executed solely because		
	The facility has 60	certified beds. At the time of			required by the provisions of	f	
	the survey, the cens	sus was 50.			the health and safety code		
					section 1280 and 42 CFR 483	·".	
	Quality Review con	mpleted on 09/18/24			Facility operators reserve		
					litigation rights of the truth o	f	
					the facts alleged or the		
					conclusion set forth in the		
					Statement of Deficiencies".		
E 0004		54(a), 418.113(a), 441.1					
SS=C		Review and Update					
Bldg	Annually						
		view and interview, the facility	E 00	004	What Corrective Action(s) Will	Ве	10/04/2024
		d update the Emergency			Accomplished For Those		
	-	(EPP) at least annually in			Residents Found To Have Bee	en	
		CFR 483.73(a). This deficient			Affected By The Deficient		
	practice could affect	et all occupants.			Practice:	41-1-	
	Dindin i 1 1				No residents were affected by	tnis	
	Findings include:				alleged deficient practice.		
	Based on records re	eview and interview with the			How Other Residents Having	The	

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

TITLE

(X6) DATE

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/17/2024
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
APERIOI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR Maintenance Direct 9:30 a.m. and 11:45 ownership lacked a be found to show th updated within the had a cover page withe most recent was administrator. Base records review, the updated to conform This finding was re Director at the time	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION FOR (MD) on 09/17/24 between For a.m., the EPP from the new cover page, and no date could the EPP was reviewed and last year. The facilities old EPP sith annual updates listed but the dated 02/03/23 by the old and on an interview during MD stated the EPP was being to the new ownership. Wiewed with the Maintenance of discovery and again during with the Maintenance Director	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Potential To Be Affected By T Same Deficient Practice Will I Identified And What Correctiv Action(s) Will Be Taken: All residents have the potentia be affected by this alleged deficient practice. The Emergency Preparedness Plan was reviewed and update What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En That The Deficient Practice D Not Recur: The maintenance Director wa in-serviced on the need to ens the Emergency Preparedness Plan is reviewed and updated annually. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Re The Maintenance Director/Designee will monito Emergency Preparedness Pla monthly ongoing to ensure the plan is reviewed and updated annually. Any negative finding be corrected immediately and forwarded to the Administrato report of progress will be forw to the QAPI committee month for a minimum of 6 months and 100% compliance and plan w adjusted accordingly. b="""> b="""> b="""> b="""> Providers PLAN OF CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION. Provide The American Should Be Taken: All residents Practice Will I Be Taken: All residents Practice Will Be Taken: All residents Practice Will Be Put In Place and update deficient Practice D Not Recur: The maintenance Director wa in-serviced on the need to ensure the Emergency Preparedness Plan is reviewed and updated annually. Any negative finding be corrected immediately and forwarded to the Administrator report of progress will be forw to the QAPI committee month for a minimum of 6 months and 100% compliance and plan w adjusted accordingly.	The Be e all to seed. Solution sure oes secure oes secure oes secure oes secure oes secure oes secure oes oes oes oes oes oes oes oes oes oe

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	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	A. BUILDING COMP B. WING 09/17		X3) DATE SURVEY COMPLETED 09/17/2024
	PROVIDER OR SUPPLIE		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ALGOLATION TO			="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> b=""> b=""> b=""> "" bb=""> "" bb="">	
				b=""> b="">	

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Event ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE (A. BUILDING B. WING	<u></u>) date survey completed 09/17/2024
	ROVIDER OR SUPPLIE		5430	r address, city, state, zip cod W US 40 NFIELD, IN 46140	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				="" b=""> b=""> b=""> b=""> b=""> =" b=""> b=""> b=""> =" b=""> =" b=""> b=""> =" b="">	
E 0006 SS=C Bldg	Based on record re failed to maintain a Plan (EPP) that wa documented, facilit	yiew and interview, the facility in Emergency Preparedness (1) based on and includes a cry-based and community-based ilizing 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SU COMPLET 09/17/20	TED
	PROVIDER OR SUPPLIEF		5430 V	ADDRESS, CITY, STATE, ZIP COD N US 40 NFIELD, IN 46140		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	strategies for addressidentified by the ris with 42 CFR 483.7.	esidents and (2) included ssing emergency events k assessment in accordance 3(a) (1) and 42 CFR 483.73(a) (2). ice could affect all occupants.		No residents were affected alleged deficient practice How Other Residents Ha	ving The	
	Findings include: Based on records re Maintenance Direct 9:30 a.m. and 11:45 be found regarding and community-bas all-hazards approac provided was blank Based on interview the MD stated a risl all-hazards approac This finding was re Director at the time	eview and interview with the tor (MD) on 09/17/24 between 5 a.m., no documentation could a documented facility-based sed risk assessment utilizing an h. The documentation and used as an example only. at the time of record review, as assessment utilizing an h could not be found. Eviewed with the Maintenance of discovery and again during with the Maintenance Director		Potential To Be Affected Same Deficient Practice Identified And What Corre Action(s) Will Be Taken: All residents have the pole be affected by this allege deficient practice. The Emergency Prepared Plan was updated to include understand to include many resident and strategies for addressing events identificially risk assessment. What Measures Will Be Felace and What Systemic Changes Will Be Made To That The Deficient Practic Not Recur: The Maintenance Director in-serviced over the requite to ensure that the emergence preparedness plan include and community-based risk assessments, that include missing residents and strength of the risk assessment.	By The Will Be ective tential to d dness ude a issing or fied in the Put Into c fo Ensure foe Does or was irements ency les facility sk e ategies	
				How The Corrective Actions Be Monitored To Ensure Deficient Practice Will Not The Maintenance	The	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPL 09/17/	ETED
	PROVIDER OR SUPPLIER		5430 W	ADDRESS, CITY, STATE, ZIP COD / US 40 NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
				Director/Designee will monito Emergency Preparedness Pla monthly ongoing to ensure th plan is reviewed and updated annually. Any negative finding be corrected immediately and forwarded to the Administrator report of progress will be forw to the QAPI committee month for a minimum of 6 months and 100% compliance and plan w adjusted accordingly. b=""> ="" span="">	r the an e gs will I or. A varded oly	
E 0009 SS=C Bldg	, , , ,	6.54(a)(4), 418.113(a)(al Collaboration Process				

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Event ID:

Based on record review and interview, the facility

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	TEMENT OF D	DEFICIENCIES RRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	î í	JILDING	NSTRUCTION	(X3) DATE COMPL 09/17/	ETED
		ER OR SUPPLIER			5430 W	ADDRESS, CITY, STATE, ZIP COD US 40 IFIELD, IN 46140		
(X4) PREF	TIX	(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
	inclucollar Feder to me disassed documents of the control of the c	anded a process of aboration with leveral emergency aintain an integrater or emergency amentation of the act such official actipation in collining efforts in a 73(a)(4). This capants. The don records represent and 11:45 ership had a tender but the docume of a man and 11:45 ership had a tender at the docume of a man and 11:45 ership had a tender and and analystate, or Faredness official grated response regency situation. The facility's ender and composition and consider and composition and comp	emergency preparedness plan for cooperation and ocal, tribal, regional, State, or preparedness officials' efforts grated response during a cy situation, including the LTC facility's efforts to also and, when applicable, of its aborative and cooperative accordance with 42 CFR deficient practice could affect all deficient practice could affect all deficient practice and the analysis of the process collaboration was blank and the anot included. No additional did be located ensuring the dness plan included a process collaboration with local, tribal, dederal emergency als' efforts to maintain and during a disaster or an including documentation of a fforts to contact such officials de, of its participation in properative planning efforts. The process are discovery and again during with the Maintenance Director			b=""> b=""> b=""> b=""> b=""> b="""> ="" b="""> ="" b="""> What Corrective Action(s) Will Accomplished For Those Residents Found To Have Ber Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By TI Same Deficient Practice Will Eldentified And What Corrective Action(s) Will Be Taken: All residents have the potential 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 office. What Measures Will Be Put In Place and What Systemic Changes Will Be Made To Entrat The Deficient Practice Do Not Recur: The Maintenance Director was in-serviced over the requirement to ensure that the emergency preparedness plan includes a process for cooperation and collaboration with local, tribal, regional, state and federal office.	this The ne Be it is to sure pes	

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	OF CORRECTION	IDENTIFICATION NUMBER 155254	A. BUILDING B. WING		COMPLETED 09/17/2024
	ROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0013 SS=C Bldg	Based on record rev failed to review and Preparedness Plan's at least annually in a 483.73(a). This defi occupants. Findings include: Based on records re Maintenance Direct 9:30 a.m. and 11:45 ownership lacked a be found to show th Procedures were rev last year. The facilit with annual updates was dated 02/03/23	4(b), 418.113(b), 441.1 P Policies and Procedures iew and interview, the facility update the Emergency (EPP) Policies and Procedures accordance with 42 CFR cient practice could affect all view and interview with the or (MD) on 09/17/24 between a.m., the EPP from the new cover page, and no date could e EPP's Policies and viewed and updated within the ies old EPP had a cover page listed but the most recent by the old administrator.	E 0013	How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Re The Maintenance Director/Designee will monito Emergency Preparedness Pla monthly ongoing to ensure the plan is reviewed and updated annually. Any negative finding be corrected immediately and forwarded to the Administrato report of progress will be forw to the QAPI committee month for a minimum of 6 months an 100% compliance and plan w adjusted accordingly. What Corrective Action(s) Will Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By T Same Deficient Practice Will I Identified And What Correctiv Action(s) Will Be Taken: All residents have the potentia be affected by this alleged deficient practice. The Emergency Preparednes Plan policies and procedures reviewed and undated	r the an e gs will r. A rarded ly ad/or ill be 10/04/2024 en rather the Be e e al to s

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING			LETED
		155254	B. W	NG		09/17/	/2024
NAME OF P	ROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
				5430 W			
APERION	N CARE GREENFIE	<u>-</u> LD		GREEN	IFIELD, IN 46140		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	to the new ownersh	was being updated to conform			What Measures Will Be Put In	to	
	to the new ownersh	ıp.			Place and What Systemic	lO .	
	This finding was re	viewed with the Maintenance			Changes Will Be Made To En	sure	
	_	of discovery and again during			That The Deficient Practice Do		
		with the Maintenance Director			Not Recur:		
	present.				The maintenance director was	;	
					in-serviced on the requiremen	t for	
					the Emergency Preparedness	plan	
					policies and procedures need	for	
					annual update.		
					How The Corrective Action(s)	\ \ /ill	
					Be Monitored To Ensure The	VVIII	
					Deficient Practice Will Not Red	cur.	
					The Maintenance	Jul .	
					Director/Designee will monitor	the	
					Emergency Preparedness Pla		
					monthly ongoing to ensure the	;	
					plan is reviewed and updated		
					annually. Any negative finding	s will	
					be corrected immediately and	_	
					forwarded to the Administrator		
					report of progress will be forward to the QAPI committee monthless.		
					for a minimum of 6 months an	•	
					100% compliance and plan wi	,	
					adjusted accordingly.	50	
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Event ID:

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

F OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	UILDING	ONSTRUCTION	(X3) DATE COMPL 09/17/	ETED
ROVIDER OR SUPPLIEF		5430 W	ADDRESS, CITY, STATE, ZIP COD US 40 IFIELD, IN 46140		
SUMMARY (EACH DEFICIEN	<u> </u>	STREET A	/ US 40	<u> </u>	(X5) COMPLETION DATE

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	CON	TE SURVEY MPLETED 17/2024
	ROVIDER OR SUPPLIER		5430 W	address, city, state, zif / US 40 NFIELD, IN 46140	P COD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				\ ="" span=""> ="" bthe=""> span=""> ="" span="">		

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155254 B. WING		onstruction 	COMPL 09/17/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0029 SS=C Bldg	403.748(c), 416.54 Development of C Based on record rev to review and updat Preparedness Plan's least annually in acc 483.73(a). This defi occupants. Findings include: Based on records re Maintenance Direct 9:30 a.m. and 11:45 ownership lacked a be found to show th was reviewed and u The facilities old EF annual updates liste dated 02/03/23 by the an interview during the EPP was being to ownership. This finding was rev Director at the time	4(c), 418.113(c), 441.1 ommunication Plan iew and interview, the failed	E 00		"" span=""> What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bee Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Totential To Be Affected By The Same Deficient Practice Will Beldentified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. The emergency preparedness was reviewed and updated to include a communication plan. What Measures Will Be Put Intellige Place and What Systemic Changes Will Be Made To Ensignative The Deficient Practice Down Recur: The maintenance Director was in-serviced on the need to ensithe Emergency Preparedness Plan is reviewed and updated annually.	this The ne ne the ne ne the n	10/04/2024
					How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Rec The Maintenance		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155254	B. WI	NG		09/17/2024
	PROVIDER OR SUPPLIE N CARE GREENFI			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 0030 SS=C Bldg	403.748(c)(1), 41 Names and Conta Based on record re failed to ensure the communication pla contact information Entities providing a Residents' physicia Volunteers in acco (1). This deficient poccupants. Findings include: Based on records re Maintenance Direct 9:30 a.m. and 11:4 communication pla communication pla list of names and ce resident physicians was a template and included with staff physicians. The Ma	6.54(c)(1), 418.113(c)(act Information view and interview, the facility emergency preparedness in includes (1) Names and for the following: (i) Staff (ii) services under arrangement (iii) ins (iv) Other LTC facilities (v) redance with 42 CFR 483.73(c) practice could affect all eview and interview with the tor (MD) on 09/17/24 between 5 a.m., the provided EPP's in was not current. The in did not include an updated contact information for staff, and in the provided documentation in ocurrent information was contacts or resident sintenance Director agreed that ention and that some of the	E 00	TAG	Director/Designee will monitor Emergency Preparedness Plate monthly ongoing to ensure the plan is reviewed and updated annually. Any negative finding will be corrected immediately forwarded to the Administrato report of progress will be forw to the QAPI committee month for a minimum of 6 months an 100% compliance and plan w adjusted accordingly. What Corrective Action(s) Will Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By T Same Deficient Practice Will I Identified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. The emergency preparedness was updated to include contain information for staff and reside physicians. What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En	r the an e gs and r. A rarded ally ad/or ill be 10/04/2024 een / this The she e e all to s plan ct ent ent

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Event ID:

 $82EG21 \qquad {\tt Facility\ ID:} \quad 000157$

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMP		COMPLETED 09/17/2024		
	ROVIDER OR SUPPLIER		5430 W	ADDRESS, CITY, STATE, ZIP COD / US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE	
	the state of Illinois. This finding was rev Director at the time	viewed with the Maintenance of discovery and again during with the Maintenance Director		That The Deficient Practice Do Not Recur: The Maintenance Director was inserviced on the requirement ensure the Emergency Preparedness plan has update communication plan. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Rec The Maintenance Director/Designee will monitor Emergency Preparedness Pla monthly ongoing to ensure the plan is reviewed and updated annually. Any negative finding be corrected immediately and forwarded to the Administrator report of progress will be forwated to the QAPI committee monthly for a minimum of 6 months and 100% compliance and plan will adjusted accordingly.	to ed Will cur: the n s s will r. A arded ly d/or
E 0036 SS=C Bldg	403.748(d), 416.54 EP Training and T	4(d), 418.113(d), 441.1 esting			
	failed reviewed and Preparedness Plan's Plan at least annuall 483.73(a). This defi- occupants. Findings include:	iew and interview, the facility updated the Emergency (EPP) Training and Testing y in accordance with 42 CFR cient practice could affect all view and interview with the or (MD) on 09/17/24 between	E 0036	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bed Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By TI Same Deficient Practice Will Eldentified And What Corrective	this The he

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		A. BUILDING B. WING	onstruction 	COMPLETED 09/17/2024	
	ROVIDER OR SUPPLIER		5430 W	ADDRESS, CITY, STATE, ZIP COD / US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0041	ownership lacked a be found to show th Plan was reviewed a year. The facilities of annual updates listed dated 02/03/23 by the an interview during the EPP was being to ownership. This finding was reviewed the exit conference of present.	a.m., the EPP from the new cover page, and no date could e EPP's Training and Testing and updated within the last old EPP had a cover page with d but the most recent was ne old administrator. Based on records review, the MD stated updated to conform to the new viewed with the Maintenance of discovery and again during with the Maintenance Director		Action(s) Will Be Taken: All residents have the potential 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 In Place and What Systemic Changes Will Be Made To En That The Deficient Practice Do Not Recur: The Maintenance Director was in-serviced over the requirement for testing and training program. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Recure The Deficient Practice Deficient Pra	s a decoration of the control of the
SS=F Bldg	Hospital CAH and	LTC Emergency Power iew and interview, the facility	E 0041	What Corrective Action(s) Will	I Be 10/04/2024
		the emergency power system	E 0041	Accomplished For Those	10/04/2024

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254		UILDING	NSTRUCTION	(X3) DATE S COMPLI 09/17/2	ETED
	PROVIDER OR SUPPLIER N CARE GREENFIE		•	5430 W	ADDRESS, CITY, STATE, ZIP COD / US 40 IFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	found in the Health 110, and Life Safet	and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could			Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice.		
	Maintenance Direct 9:30 a.m. and 11:45 annual fuel quality was available for re time of records revi the test was done by the diesel fired gene This finding was re Director at the time	eview and interview with the for (MD) on 09/17/24 between 6 a.m., no documentation of an test for the diesel generator view. Based on interview at the ew, the MD stated he believed at the fuel quality testing for erator could not be located. Viewed with the Maintenance of discovery and again during with the Maintenance Director			How Other Residents Having Potential To Be Affected By T Same Deficient Practice Will E Identified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. A fuel quality test was perform on 9-19-24. Results obtained 9-26-24 Passed What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En That The Deficient Practice De Not Recur:	he Be e all to ned to	
					The maintenance Director was in-serviced on the requirement annual fuel quality testing for the diesel generator. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Remaintenance Director will mor annual fuel testing monthly ongoing. Any negative finding be corrected immediately and forwarded to the Administrator report of progress will be forw to the QAPI committee month for a minimum of 6 months an 100% compliance and plan will	ts of the Will cur: hitor s will r. A arded ly d/or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			(X3) DATE SURVEY	
THILD TETHIN	or condition	155254		B. WING 09/17/2024		
				CTREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER				/ US 40	
APERION	N CARE GREENFIE	ELD		GREENFIELD, IN 46140		
(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)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	adjusted accordingly.	DATE
					adjusted accordingly.	
K 0000						
DId= 04						
Bldg. 01	A Life Safety Recer	tification and State Licensure	K 0	000	PLAN OF CORRECTION ON	
	_	ted by the Indiana Department	KU	000	BEHALF OF APERION CARE	<u>.</u>
	-	ance with 42 CFR 483.90(a).			GREENFIELD	
					"This plan of correction	
	Survey Date: 09/17	7/24			constitutes the facility's writ	ten
	Facility Number: 0	00157			credible allegation of compliance. Preparation	
	Provider Number:				and/or execution of this Plan of	
	AIM Number: 100274720				Correction does not constitu	
					admission or agreement by t	
	At this Life Safety (Code survey, Aperion Care			provider of the truth of the fa	
	Greenfield was four	nd not in compliance with			alleged or the conclusion se	
	Requirements for Pa	articipation in			forth in the Statement of	
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			Deficiencies. This plan of	
	-	re and the 2012 edition of the			correction is prepared and/o	r
		etion Association (NFPA) 101,			executed solely because	
		SC), Chapter 19, Existing			required by the provisions of	f
	Health Care Occupa	ancies and 410 IAC 16.2.			the health and safety code	
	This one story facil	ity was determined to be of			section 1280 and 42 CFR 483	<i>b</i> ".
	_	ruction and fully sprinkled. The			Facility operators reserve litigation rights of the truth of	٠,
		arm system with smoke			the facts alleged or the	"
		ridors, spaces open to the			conclusion set forth in the	
		ry-operated smoke detection			Statement of Deficiencies".	
	· ·	ing rooms. The facility has a			Statement of Beneficious :	
	-	and a census of 50 at the time				
	of this visit.					
	All areas where the	residents have customary				
		ered and all areas providing				
	_	re sprinklered. The facility had				
	-	e buildings and a detached				
	_	which were not sprinklered.				
	•	-				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE CO A. BUILDING B. WING	<u> </u>		
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD V US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION puleted on 09/18/24	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0346 SS=C Bldg. 01	Quality Review con NFPA 101 Fire Alarm System Based on record revialled to provide a conform the protection of procedures to be fol alarm system has to four hours or more accordance with LS deficient practice afform the protect of the provided was conflicted the provided was conflicted of the provided was conflicte	npleted on 09/18/24 n - Out of Service riew and interview, the facility complete 1 of 1 written policy fresidents indicating lowed in the event the fire be placed out of service for in a twenty four hour period in C, Section 9.6.1.6. This	K 0346	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bee Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By The Same Deficient Practice Will Bee Identified And What Corrective Action(s) Will Bee Taken: All residents have the potential be affected by this alleged deficient practice. The fire watch plan was update include notifying ISDH if the fire alarm system becomes out of service for 4 or more hours. What Measures Will Been Put Interplace and What Systemic Changes Will Been Made To Ensight The Deficient Practice Down Not Recur: The Maintenance Director was serviced over the requirements ensure that the fire plan must include notification to ISDH. How The Corrective Action(s) Been Monitored To Ensure The Deficient Practice Will Not Recompany Director/Designer	Be 10/04/2024 en this The ne de
				Maintenance Director/Designe	

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MADILAN	or condition	155254	B. WI		<u>01</u>	09/17/	
NAME OF P	ROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE GREENFIE	ELD	GREENFIELD, IN 46140				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY 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 OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
K 0354 SS=C Bldg. 01	failed to provide 1 of the event the autom placed out-of-service 24-hour period in a 9.7.5. LSC 9.7.6 reconstruction procedures comply the Standard for the Maintenance of Wasystems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained patrol the affected a extinguishers and the fire department consider. During the should not only be sure that the other following such as eg	view and interview, the facility of 1 correct written policies in natic sprinkler system has to be see for 10 hours or more in a secondance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, and the Inspection, Testing and ster-Based Fire Protection 5, 15.5.2 requires nine impairment coordinator shall (b) states a fire watch should ersonnel who continuously area. Ready access to fire the ability to promptly notify are important items to be patrol of the area, the person clooking for fire, but making the protection features of the ress routes and alarm systems	K 0	354	will monitor the fire watch plar monthly to ensure that notificated of ISDH is on the policy. Any negative findings will be corresimmediately and forwarded to Administrator. A report of progwill be forwarded to the QAPI committee monthly for a minimof 6 months and/or 100% compliance and plan will be adjusted accordingly. What Corrective Action(s) Will Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By The Same Deficient Practice Will Eldentified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. The fire watch plan was updatinclude notifying ISDH if the sprinkler system becomes out service for 10 or more hours.	tion cted the gress mum I Be en this The he Be el al to ted to	10/04/2024
		nctioning properly. This buld affect all occupants in the			What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En That The Deficient Practice D	sure	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED 09/17/2024	
		155254	B. WI	NG		09/17/	2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140			
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	Maintenance Direct a.m. and 11:45 a.m. include contacting t of Health via the IS https://gateway.isdh or by the secondary Gateway is nonopel Incident Reporting incidents@isdh.in.g the record review, t acknowledged the f provided was conflit ownership change a based in Illinois. This finding was re Director at the time	eview and interview with the for on 09/17/24 between 9:30, the fire watch plan failed to the Indiana State Department DH Gateway link at a.in.gov as the primary method method when the ISDH rational by completing the form and e-mailing it to gov. Based on interview during the Maintenance Director fire watch documentation acting because of the recent and the new company being the wiewed with the Maintenance of discovery and again during with the Maintenance Director			Not Recur: The Maintenance Director was serviced over the requirement ensure that the fire plan must include notification to ISDH. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Rec Maintenance Director/Designe will monitor the fire watch plan monthly to ensure that notifica of ISDH is on the policy. Any negative findings will be correctimmediately and forwarded to Administrator. A report of progwill be forwarded to the QAPI committee monthly for a minim of 6 months and/or 100% compliance and plan will be adjusted accordingly.	Will cur: ee intion cted the gress	
K 0361 SS=E Bldg. 01	failed to ensure 1 of pass-through windo inches met the requ corridor. LSC 19.3. than patient sleeping hazardous areas sha unlimited in area, properties which the smoke compartmen electrically supervise.	Open to Corridor on and interview, the facility f 1 business office with a w greater than 20 square irements of spaces open to the 6.1(7) states that spaces other g rooms, treatment rooms, and all be open to the corridor and rovided: (a) The space and space opens onto in the same t are protected by an sed automatic smoke detection the with 19.3.4, and (b) Each	K 0.	361	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bed Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By TI Same Deficient Practice Will Eldentified And What Corrective	en this The he 3e	10/11/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/17/2024	
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD W US 40 NFIELD, IN 46140	
APERIO (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF space is protected b (c) The space does required exits. LCS openings, such as m pass-through window windows, and cashi shall be permitted to or doors without sp both of the followin (1) The aggregate a not exceed 20 inche (2) The openings ar distance from the fl This deficient pract 20 residents. Findings include: Based on an observ tour of the facility v (MD) on 09/17/24 b	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION y an automatic sprinklers, and not to obstruct access to 3 19.3.6.5.1 states miscellaneous nail slots, pharmacy ws, laboratory pass-through er pass-through windows, to be installed in vision panels ecial protection, provided that ng criteria are met: rea of openings per room does es squared (0.015 m2). The installed at or below half the coor to the room ceiling. The initial could affect staff and up to attion and interview during a with the Maintenance Director between 11:45 a.m. and 1:15	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) Action(s) Will Be Taken: All residents have the potent be affected by this alleged deficient practice. The sliding glass window wil replaced by standard wall by 10/11/24. What Measures Will Be Put Place and What Systemic Changes Will Be Made To E That The Deficient Practice Not Recur: Maintenance Director was in-serviced over areas open corridors. How The Corrective Action(s Be Monitored To Ensure The Deficient Practice Will Not R The maintenance	itial to I be Into Insure Does to S) Will eeecur:
K 0363 SS=E	window and the off electrically supervise The smoke detection operated single state interview at the time agreed the window inches and the office supervised automat This finding was re Director at the time	ffice had a large pass-through fice was not protected by sed automatic smoke detection. In in the office was battery from smoke alarm. Based on the of observation, the MD was greater than 20 square the did not contain electrically fice smoke detection. In the office was battery from the MD was greater than 20 square th		director/designee will monitor monthly areas open to corrice ensure requirements are metaly and any negative findings will be corrected immediately and forwarded to the Administrate report of progress will be for to the QAPI committee montfor a minimum of 6 months at 100% compliance and plantal adjusted accordingly.	lors to et. or. A warded chly und/or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/17/2024	
	PROVIDER OR SUPPLIER		5430 V	ADDRESS, CITY, STATE, ZIP COD N US 40 NFIELD, IN 46140	
(X4) ID PREFIX TAG Bldg. 01	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure 1 of resist the passage of practice could affect. Findings include: Based on an observatour of the facility w (MD) on 09/17/24 to p.m., the corridor downs broken near the all the way through and would not resist. MD stated that a rescausing it to break. This finding was red Director at the time	on and interview, the facility flover 30 corridor doors would flower 30 corridor doors would flower 30 staff. attion and interview during a with the Maintenance Director between 11:45 a.m. and 1:15 boor to the Employee Breakroom be bottom and was penetrated The door was not solid core at the passage of smoke. The sident recently kicked the door wiewed with the Maintenance of discovery and again during with the Maintenance Director	K 0363	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By T Same Deficient Practice Will Eldentified And What Corrective Action(s) Will Be Taken: All residents have the potential 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 In Place and What Systemic Changes Will Be Made To En That The Deficient Practice Down Not Recur: Maintenance Director will be in-serviced over the requirement for corridor doors. How The Corrective Action(s) Be Monitored To Ensure The Deficient Practice Will Not Remaintenance Director/Designed will monitor 5 corridor doors door scheduled work days x 4 weeks, then weekly x 8 weeks Any negative findings will be corrected immediately and forwarded to the Administrato	en The he Be e al to ne withis Will cur: ee aily s.

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155254	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/17/2024	
	PROVIDER OR SUPPLIE		5430 \	FADDRESS, CITY, STATE, ZIP COD W US 40 ENFIELD, IN 46140		
(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)	(X5) COMPLETION DATE	
				report of progress will be forward to the QAPI committee monthle for a minimum of 6 months an 100% compliance and plan will adjusted accordingly.	ly d/or	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Bu Barrie	ilding Spaces - Smoke				
Blug. 01	Based on observatifailed to ensure the passage of wire and smoke barriers wall the smoke resistant Section 19.3.7.5 re constructed in account and shall have a mirrating. LSC Section to be continuous froutside wall, from smoke barrier to a combination thereof for cables, cable travents, wires, and si electrical, mechanic communications sy floor, or floor/ceiling smoke barrier, or the roof/ceiling of the protected by a sy restricting the movember of the smoke services and single protected by a sy restricting the movember of the smoke services and single protected by a sy restricting the movember of the smoke services and single protected by a sy restricting the movember of the smoke services and services and services and services and services and services are services and services are services and serv	on and interview, the facility epenetrations caused by the d/or conduit through 1 of 2 ls were protected to maintain the of each smoke barrier. LSC quires smoke barriers to be ordance with LSC Section 8.5 inimum ½ hour fire resistive in 8.5.2.1 requires smoke barriers on an outside wall to an a floor to a floor, or from a smoke barrier, or by use of a off. 8.5.6.2 requires penetrations and any and externs that pass through a wall, and assembly constructed as a annough the ceiling membrane of a smoke barrier assembly, shall system or material capable of ement of smoke. This deficient ct 30 residents and staff.	K 0372	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Ber Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having Potential To Be Affected By Ti Same Deficient Practice Will Eldentified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. The ceiling will be replaced in the clean ut room, the corridor near the dir room, the corridor near the entrance to therapy, and the corridor near the administrator officeby 10/11/24.	this The he see all to tiles tility hing	
	Findings include:	and the same of th		What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En	sure	
	tour of the facility (MD) on 09/17/24	vation and interview during a with the Maintenance Director between 11:45 a.m. and 1:15 glocations were missing ceiling		That The Deficient Practice Do Not Recur: The maintenance director was inserviced over the requireme	3	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	1 1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> B. WING		COMPLETED 09/17/2024			
155254		B. W.			09/17/	ZUZ 4		
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD				STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
ı					, · · · · · · · · · · · · · · · · · · ·		(VE)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TO THE APPROPRIATE NCY) DATE		
TAG	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.			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.		Will cur: ee on ss, /e the	DATE	
K 0511 SS=E	NFPA 101 Utilities - Gas and	Electric						
Bldg. 01	ensure 1 of 1 electrical laundry room were a condition. LSC 19. with Section 9.1. Lauring and equipment National Electrical Carticle 314.28(3) (caprovided with cover suitable for the condition metal covers shall caprovided affect 2 staff. Findings include: Based on an observation of 19.00 per suitable for the condition of 250 per suitable for	ation, the facility failed to cal junction boxes in the maintained in a safe operating 5.1.1 requires utilities comply SC 9.1.2 requires electrical ent to comply with NFPA 70, Code. NFPA 70, 2011 Edition, constates junction boxes shall be ess compatible with the box and ditions of use. Where used, comply with the grounding 0.110. This deficient practice	K 0	511	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bed Affected By The Deficient Practice: No residents were affected by alleged deficient practice. An electrical junction box was pla in the laundry room. An outlet cover was replaced in the DOI office How Other Residents Having Potential To Be Affected By TI Same Deficient Practice Will Eldentified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged	en this ced N The ne se	10/04/2024	

STATEMENT OF DEFICIENCIES X13		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155254		B. WING 09/17/2024			/2024		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		5430 W			
APERION	N CARE GREENFIE	ELD			IFIELD, IN 46140		
			1		· 		075)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		between 11:45 a.m. and 1:15		IAU	deficient practice.		DATE
	` /	unction box was missing in the			delicient practice.		
		e the washing machine which			 What Measures Will Be Put In	to	
		eaving exposed wire in metal			Place and What Systemic		
		nterview at the time of the			Changes Will Be Made To En	sure	
		aintenance Director			That The Deficient Practice Do		
	· ·	vires were exposed stating he			Not Recur:		
		ll a junction box to secure the			The Maintenance Director was	S	
	wires.				in-serviced over the regulation	n for	
					utilities- gas and electric		
	This finding was re	viewed with the Maintenance			specifically pertaining to outlet	is.	
	Director at the time	of discovery and again during					
	the exit conference with the Maintenance Director				How The Corrective Action(s)	Will	
	present.				Be Monitored To Ensure The		
					Deficient Practice Will Not Red	cur:	
	2. Based on observation and interview, the facility				The Maintenance		
	failed to ensure electrical outlets were protected in				Director/Designee will monitor		
	the DON office according to 19.5.1. NFPA 70, 2011				outlets and junction boxes dai	ly	
		6.6, Receptacle Faceplates			on scheduled work days x 4		
		nires receptacle faceplates shall			weeks, then weekly x 8 weeks	3.	
		completely cover the opening			Any negative findings will be		
	and seat against the mounting surface. This			corrected immediately and forwarded to the Administrator. A			
	deficient practice could affect 3 staff.						
	Findings include:				report of progress will be forward		
	r manigs metade.				to the QAPI committee monthl for a minimum of 6 months an		
	Based on an observ	ation and interview during a			100% compliance and plan wi		
	Based on an observation and interview during a tour of the facility with the Maintenance Director				adjusted accordingly.	50	
	(MD) on 09/17/24 between 11:45 a.m. and 1:15				asjacioa accordingly.		
	` '	ffice, beneath the window Air					
	*	n outlet cover protecting the					
	electrical outlet was						
		2					
	This finding was re	viewed with the Maintenance					
	Director at the time	of discovery and again during					
	the exit conference with the Maintenance Director present.						
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155254		(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2024					
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140					
(X4) ID PREFIX TAG K 0521	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
SS=F	NFPA 101 HVAC							
Bldg. 01	Based on observation failed to ensure egree a portion of a return resident rooms. LSC conditioning, heatin related equipment to with NFPA 90A, the of Air Conditioning NFPA 90A, Section corridors in nursing shall not be used as or exhaust air syster unless otherwise per 4.3.12.1.3.4. This does everyone in the facility w (MD) on 09/17/24 bp.m., resident rooms corridor as a return sinterview at the time Maintenance Direct rooms were using the air system and the facility air system and the facility wownership change the waiver as of the This finding was rev Director at the time the exit conference of the system and the facility was reversely as the system and the facility was reversely the waiver as of the the waiver as of the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the time the exit conference of the system and the s	g, ventilating ductwork and be installed in accordance e Standard for the Installation and Ventilating Systems. 14.3.12.1.1 states egress and long term care facilities a portion of a supply, return, in serving adjoining areas rmitted by 4.3.12.1.3.1 through efficient practice could affect lity. 14.5 a.m. and 1:15 a.m. and 1:15 as were using the egress air system. Based on the of the observations, the or acknowledged that resident the egress corridor as a return accility has sought a waiver in for the upcoming year was and the facility had not applied for	K 0521	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. A L safety code waiver has been requested as the zlleged noncompliance cannot be corrected without financial hardship on the facility and it not pose a threat to the reside health and safety. How Other Residents Having Potential To Be Affected By T Same Deficient Practice Will I Identified And What Correctiv Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. What Measures Will Be Put In Place and What Systemic Changes Will Be Made To En That The Deficient Practice D Not Recur: The Maintenance Director will in-serviced over the requirem for return air systems and the safety code waiver to be requested.	this does ents The he be ents It is a sure does ents I be ents ents I be ents ents			
present.			How The Corrective Action(s) Be Monitored To Ensure The) VVIII				

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155254	A. BUILDING B. WING		COMPLETED 09/17/2024		
NAME OF PROVIDER OR SUPPLIER APERION CARE GREENFIELD			STREET ADDRESS, CITY, STATE, ZIP COD 5430 W US 40 GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	3.1-19(b) NFPA 101 Electrical Systems Based on record rev failed to ensure an a performed for 1 of 1 generator. NFPA 99: 2012 Edition Section (Essential Electrical be inspected and tes Section 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power Syst NFPA 110, Section shall be performed a approved by ASTM practice could affect. Findings include: Based on records records records records.	iew and interview, the facility nnual fuel quality test was facility's diesel-powered 9, Health Care Facilities Code, in 6.5.4.1.1.2 states Type 2 EES System) generator sets shall ted in accordance with Section 6.4.4.1.1.3 states e performed in accordance indard for Emergency and ems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests standards. This deficient	K 0		Deficient Practice Will Not Recompliance Director/Designe will monitor the life safety code waiver to ensure annual update occurs ongoing. Any negative findings will be corrected immediately and forwarded to Administrator. A report of progwill be forwarded to the QAPI committee monthly for a minimor of 6 months and/or 100% compliance and plan will be adjusted accordingly. What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bee Affected By The Deficient Practice: No residents were affected by alleged deficient practice. How Other Residents Having To Potential To Be Affected By The Same Deficient Practice Will B Identified And What Corrective Action(s) Will Be Taken: All residents have the potential be affected by this alleged deficient practice. A fuel quality test was perform on on 9-19-24. Results obtaine 9-26-24 Passed	Eur: e e the ress num Be this The ne e e thought in the ne e this I to	DATE 10/04/2024
		a.m., no documentation of an est for the diesel generator					

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CT ATEN TO	T OF DEFICIENCIES	MI) BROWNED (CHIRDI IED (CLI)	III TIDI E CC	NCTRICTION	(V2) DATE	CLIDATEN		
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPL		
155254		B. W	ING		09/17	/2024		
NAME OF T	DOLUDED OD GLESS ST			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIEF	£		5430 W	/ US 40			
APERION CARE GREENFIELD			GREENFIELD, IN 46140					
(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 APPROPRIATE DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE	
	was available for review. Based on interview at the				What Measures Will Be Put Into			
		ew, the MD stated he believed			Place and What Systemic			
	the test was done by	ut the fuel quality testing for			Changes Will Be Made To En			
	the diesel fired generator could not be located.			That The Deficient Practice Do				
					Not Recur:			
	This finding was reviewed with the Maintenance			The maintenance Director was				
	Director at the time of discovery and again during			in-serviced on the requirements of				
	the exit conference with the Maintenance Director			annual fuel quality testing for the				
	present.				diesel generator.			
	3.1-19(b)				How The Corrective Action(s)	Will		
					Be Monitored To Ensure The			
					Deficient Practice Will Not Re	cur:		
					Maintenance Director will mor	nitor		
					annual fuel testing ongoing. A	ny		
					negative findings will be corre	cted		
					immediately and forwarded to	the		
					Administrator. A report of prog			
					will be forwarded to the QAPI	-		
					committee monthly for a minir			
					of 6 months and/or 100%			
					compliance and plan will be			
					adjusted accordingly.			
					,			
			1				I	

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