STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386			A. BU	A. BUILDING COMPI		(X3) DATE : COMPL 11/28/	ETED
	PROVIDER OR SUPPLIER	1		520 W I	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST		
LAUREL	S OF DEKALB			BUILE	R, IN 46721		
(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 E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000	="" p=""> The Laurels of Dek wishes to have this submitted of correction stand as our writt allegation of compliance.	plan	
	of Dekalb was foun Emergency Prepare Medicare and Medi and Suppliers, 42 C	00574 155386 266430 Preparedness survey, Laurels d not in compliance with dness Requirements for caid Participating Providers FR 483.73. The facility has a had a census of 78 at the time			Preparation and/or execution of this plan does not constitute admission to, nor agreement weither the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepand/or executed to ensure continuing compliance with regulatory requirements. Our of compliance is January 3,20 = "" p = "" > The Laurels of DeKa requesting a desk review in liest a facility revisit.	with, ne ons pared date 23. lb is	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §47 §483.475(d)(2), §47 §485.625(d)(2), §47 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
LABORATOR	L LY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	I IGNATURI	3	I TITLE		(X6) DATE

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

(X6) DATE

Emily Nelson Administrator 12/22/2022

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

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155386	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2022	
	PROVIDER OR SUPPLIEI	2		520 W L	DDRESS, CITY, STATE, ZIP COD LIBERTY ST R, IN 46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	(2) Testing. The [text]	facility] must conduct he emergency plan ility] must do all of the					
	community-based (A) When a commot accessible, confunctional exercise (B) If the [faction natural or man-materization of the elist exempt from endominity-based functional exercise actual event. (ii) Conduct an additional exercise (iii) Conduct an additional exercise (iii) of this section in include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitation discussion using a clinically-relevant set of problem star messages, or preto challenge an eliii) Analyze the [facility's] emetals.	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed.					
	*[For Hospices at (2) Testing for ho	spices that provide care in					

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Event ID:

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	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 155386	UILDING	nstruction 	COMPI 11/28	LETED
	F PROVIDER OR SUPPLIEI		520 W L	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST R, IN 46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	conduct exercises plan at least annument the following: (i) Participate in a community based (A) When a community based functional of the emergency exempt from engages and community facility-based functional exercise of the emergency exempt from engages and community facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise functional exercise (B) A mock disast (C) A tabletop exempt from engages functional exercise functional exercise functional exercise functional exercise functional exercise functional exercise to discussion using a clinically-relevant set of problem star messages, or present to challenge an element of the exercises to test to per year. The hose (i) Participate in a that is community	nunity based exercise is not lect an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Idditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. Spices that provide inpatient to hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155386	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/28/2022	
	PROVIDER OR SUPPLIEI	₹		520 W L	DDRESS, CITY, STATE, ZIP COD IBERTY ST R, IN 46721		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE		TE	(X5) COMPLETION
	REGULATORY OF RE	RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Just an annual individual ctional exercise; or experiences a natural or gency that requires activation plan, the hospice is aging in its next required nity based or facility-based the following the onset of the dditional annual exercise but is not limited to the -scale exercise that is d or a facility based the; or tercise or workshop led by a udes a group discussion		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	TE	
	§482.15(d), CAHs (2) Testing. The [conduct exercises	441.184(d), Hospitals at s at §485.625(d):] PRTF, Hospital, CAH] must s to test the emergency ar. The [PRTF, Hospital,					
	CAH] must do the (i) Participate in a that is community (A) When a comn accessible, condu	e following: an annual full-scale exercise					

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Facility ID: 000574

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	IT OF DEFICIENCIES OF CORRECTION			CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/28/2022
	PROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST ER, IN 46721	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		Hospital, CAH] experiences			
		or man-made emergency			
		ation of the emergency			
		s exempt from engaging in			
		ull-scale community based ty-based functional exercise			
		ty-based idirctional exercise			
	_	an [additional] annual			
	` '	at may include, but is not			
	limited to the follo				
		scale exercise that is			
	community-based				
	-	tional exercise; or			
	•	ck disaster drill; or			
	(C) A tabletor	exercise or workshop that			
	is led by a facilitat	or and includes a group			
	discussion, using	a narrated,			
	clinically-relevant	emergency scenario, and a			
	set of problem sta	tements, directed			
	messages, or pre	pared questions designed			
	to challenge an er	mergency plan.			
	, ,	ne [facility's] response to			
		umentation of all drills,			
	•	s, and emergency events			
		cility's] emergency plan, as			
	needed.				
	*[For PACE at §46	60.84(d):]			
	-	ACE organization must			
	. , -	to test the emergency			
	plan at least annu				
	organization must	_			
		n annual full-scale exercise			
	that is community	-based; or			
	, ,	unity-based exercise is not			
		ct an annual individual,			
	facility-based fund				
	, ,	kperiences an actual natural			
		ergency that requires			
	activation of the e	mergency plan, the PACE			

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Facility ID: 000574

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	1		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155386	B. WING			11/28/	/2022
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD	_	
		•			IBERTY ST		
LAUREL:	S OF DEKALB		_ B	BUTLEF	R, IN 46721		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	-	gaging in its next required					
		nity based or individual,					
		tional exercise following the					
	onset of the emer	-					
	, ,	n additional exercise every					
		he year the full-scale or					
		e under paragraph (d)(2)(i) onducted that may include,					
	but is not limited to	-					
		scale exercise that is					
		or individual, a facility					
	based functional e						
	(B) A mock disast						
	` '	ercise or workshop that is					
	. ,	and includes a group					
	discussion, using	- -					
	_	emergency scenario, and a					
	set of problem sta	-					
		pared questions designed					
	to challenge an er	·					
	(iii) Analyze the P	ACE's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the PACE's emero	gency plan, as needed.					
	*[For LTC Facilitie	es at 8483 73(d)·1					
	_	ty] must conduct exercises					
	· ' -	ency plan at least twice per					
	_	announced staff drills using					
	-	ocedures. The [LTC facility,					
	ICF/IID] must do t	= -					
	_	n annual full-scale exercise					
	that is community.						
		nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund						
	-	ility] facility experiences an					
		nan-made emergency that					
	requires activation	of the emergency plan, the					
		mpt from engaging its next					

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	OF CORRECTION	IDENTIFICATION NUMBER 155386	lì í	UILDING		COMPL 11/28	ETED
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD LIBERTY ST		
LAUREL	S OF DEKALB			1	R, IN 46721		
(X4) ID PREFIX	(EACH DEFICIEN	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	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Ile community-based or		TAG	DEFICIENCY)		DATE
	•	based functional exercise					
	1	et of the emergency event.					
	(ii) Conduct an ad	dditional annual exercise					
	· ·	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	based functional e	or an individual, facility					
	(B) A mock disas						
	1 ' '	ercise or workshop that is					
	led by a facilitator	· · · · · · · · · · · · · · · · · · ·					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er						
		LTC facility] facility's					
		maintain documentation of					
		exercises, and emergency					
	emergency plan,	e the [LTC facility] facility's					
	*[For ICF/IIDs at §	. , , =					
	l ' '	CF/IID must conduct					
		he emergency plan at least le ICF/IID must do the					
	following:	ic for /iib mast do the					
	_	n annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	1	ctional exercise; or.					
		experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required nity-based or individual,					
		ctional exercise following the					
	onset of the emer	•					
		J,					

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Event ID:

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Facility ID: 000574

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/28/2022		
	PROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COE LIBERTY ST ER, IN 46721	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION ROPRIATE
TAG	(ii) Conduct an ad that may include, following: (A) A second full-scommunity-based facility-based function (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an erection (iii) Analyze the IC maintain documer exercises, and error the ICF/IID's emel *[For HHAs at §48 (d)(2) Testing. The exercises to test to the exercises to test to the community-based (A) When a community-based (A) When a community-based (B) If the HH natural or man-material or man	etional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. EF/IID's response to and atation of all drills, tabletop mergency events, and revise regency plan, as needed. 84.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is ; or community-based exercise conduct an annual based functional exercise A experiences an actual ade emergency plan, the HHA is aging in its next required aity-based or individual, tional exercise following the	TAG	DEFICIENCY	DATE

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	OF CORRECTION	IDENTIFICATION NUMBER 155386	l í	UILDING		COMPL 11/28	ETED
	PROVIDER OR SUPPLIER S OF DEKALB	e e		520 W L	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST R, IN 46721		
(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)	NTE.	(X5) COMPLETION DATE
	(A) A second community-based facility-based function (B) A mock di (C) A tabletor is led by a facilitat discussion, using clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the H maintain documer exercises, and em the HHA's emerged *[For OPOs at §48 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency problem statement prepared question emergency plan. It actual natural or no requires activation OPO is exempt from required testing exercises, and emintain documer exercises.	limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed oared questions designed mergency plan. HA's response to and ntation of all drills, tabletop nergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of tts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155386	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/28/2022	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB		520 \	ET ADDRESS, CITY, STATE, ZIP COD W LIBERTY ST LER, IN 46721			
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
	exercises to test to RNHCI must do the RNHCI must do the (i) Conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain documer exercises, and enter the RNHCI's emel Based on record restailed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community facility-based funct b. If the LTC facility or man-made emergof the emergency promengaging its not man community-based of the community-based full-scale functional the onset of the actual (ii) Conduct an addinclude, but is not least A second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude, but is not least of the second full-scale functional and dinclude and full-scale functional and dinclude and full-scale functional and dinclude and full-scale functional and full-scale full-scal	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility nercises to test the emergency er year, including drills using the emergency experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a er individual, facility-based I exercise for 1 year following table to the following:	E 0039	The facility will conduct a community-based exercise satisfy the regulation. The facility's Maintenance Director will ensure the facility based exercise held on an annual basis. Continued compliance will monitored by the Maintena Director. Variances will be corrected at the time of observation and trends will reported to the facility's monthly QA meeting. The Administrator is responsible for the continucompliance of the regulation /b>	be nce I be	

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functional exercise.
b. A mock disaster drill; or

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	OF CORRECTION	IDENTIFICATION NUMBER 155386	A. BUILDING B. WING		COMPLETED 11/28/2022
	PROVIDER OR SUPPLIER S OF DEKALB		520 W	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST :R, IN 46721	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0000	facilitator that inclusion and a set of problem messages, or preparchallenge an emerge (iii) Analyze the LT maintain documentate exercises, and emerged LTC facility's emerged accordance with 42 deficient practice coefficient practice coefficient practice coefficient practice and the Maintenance a.m., there was doct facility-based function but there was no doct facility's response we policies were effect additional annual exyear was not available interview at the time Maintenance Direct exercises were inconconducted.	des a group discussion, using y-relevant emergency scenario, in statements, directed ed questions designed to ency plan. It facility's response to and atton of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. The diew with the Administrator is a Director on 11/28/22 at 10:19 attentation of a individual in the last one for coordinate of the ency plan in the last one for review. Based on its of records review, the or stated the required in the last one for coordinate or have not been where the ency in the last one for the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been where the ency is a supplier or have not been the ency			
Bldg. 01	A Life Safety Code	Recertification and State	K 0000	="" p=""> The Laurels of De	eKalb
	Licensure Survey w	as conducted by the Indiana th in accordance with 42 CFR	12 0000	wishes to have this submitted of correction stand as our wr allegation of compliance.	d plan

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2022	
	PROVIDER OR SUPPLIER S OF DEKALB		520 W	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST ER, IN 46721	
(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 APPROPR	
TAG	Survey Date: 11/28 Facility Number: 0 Provider Number: 100 At this Life Safety 0 was found not in co for Participation in Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility one of the facility has a find detection in the correction of the resident rooms. 101 and had a census survey. All areas where resident were sprinklered. The garage providing factorage of beds, main that was not sprinklered. Quality Review consumptions.	200574 155386 266430 Code survey, Laurels of Dekalb mpliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC) g Health Care Occupancies and ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors, areas open to the y operated smoke detectors in The facility has a capacity of as of 78 at the time of this dents have customary access the facility had a detached cility services including tresses and snow blowers ered.	TAG	Preparation and/or executior this plan does not constitute admission to, nor agreement either the existence of or the scope and severity of any of cited deficiencies, or conclus set forth in the statement of deficiencies. This plan is pre and/or executed to ensure continuing compliance with regulatory requirements. Ou of compliance is January 3,2 ="" p="">The Laurels of DeK requesting a desk review in la facility revisit.	t with, the sions epared or date 2023. falb is
K 0271 SS=E Bldg. 01	7.7, provides a level the provisions of 7				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/28/2022 155386 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 520 W LIBERTY ST LAURELS OF DEKALB **BUTLER. IN 46721** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 01/03/2023 Based on observation and interview, the facility K 0271 The walking surface at the 200 failed to ensure 1 of 7 exit discharge were hall exit to be made level for provided with an unobstructed level walking an unobstructed walking surface in accordance with NFPA 101 (2012 surface in accordance to the edition) section 7.7. This deficient practice could regulation. Based on facility fire affect 20 residents that would use the 200 hall exit. exit plan residents on 200 hall have potential to be affected. All Findings include: remaining exits reviewed; no other areas were found to be in violation Based on observations with the Maintenance of the regulation.Continued Director on 11/28/22 at 12:50 p.m., the first eight compliance of the regulation will feet of the 200-hall exit assault walkway way had be monitored by the Maintenance dips in the walkway and a one-inch lip that stuck Director though the Preventative up between the concrete and asphalt. This Maintenance Program. All condition did not provide a level walking surface. variances will be corrected at the Based on interview at the time of observation, the time of observation and trends will Maintenance Director agreed the walkway did not be reported to the facility's provide an unobstructed level walking surface. monthly QA Committee, monthly for 3 months. The Administrator is This finding was reviewed with the Administrator responsible for compliance with and Maintenance Director during the exit this regulation. conference. 3.1-19(b)K 0321 **NFPA 101** SS=E Hazardous Areas - Enclosure Bldg. 01 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the

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approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting

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CENTERS FOR	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386 NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2022	
			STREET ADDRESS, CITY, STATE, ZIP COD 520 W LIBERTY ST BUTLER, IN 46721			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	partitions and door Doors shall be se automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel b. Laundries (largent composed in the	Automatic Sprinkler N/A I-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops booms (exceeding 64 In Rooms Illons) orage Rooms/Spaces eet) Iclassified as Severe	K 0321	="" b="">="" b="" maintenance="" director="" completed="" repairs="" to=" 2"="" diameter="" holes="" in="" ceilings="" of="" hall,=' filled="" with="" material=""	01/03/2023	
	Findings include:			capable="" resisting="" transfer="" smoke="" maintain="" fire=""		
	Director on 11/28/2 room on the service	ons with the Maintenance 22 at 1:10 p.m., in the mechanical be hall (which contained a fuel ter) had a two-inch hole in the		resistance="" rating="" ceiling="" barrier. <="">="" b="">="" b="">="" b="">Maintenance Director		

ceiling. Also, the soiled utility room on the service hall had a two-inch hole in the ceiling. Based on

interview at the time of the observations, the

completed repairs to the 2"

diameter holes in the ceiling of the

soiled utility room and mechanical

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155386	B. WI	B. WING 11/28/2022			2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			LIBERTY ST		
LAURELS OF DEKALB			BUTLE	R, IN 46721			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ctor agreed both rooms had an			room on service hall, filled with	า	
	unsealed penetration	on in the ceiling.			material capable of resisting th		
					transfer of smoke to maintain		
	This finding was re	eviewed with the Administrator			resistance rating of the ceiling		
	and Maintenance I	Director during the exit			smoke barrier. No residents w	ere	
	conference.				affected by the alleged deficie	nt	
					practice.		
	3.1-19(b)				="" b="">="" b="">h	_	
					other ceilings were found to		
					in violation of this regulation	١.	
					=""" b="""> =""">Continued		
					compliance with the regulation		
					be completed by the maintena		
					director through daily rounds a	and	
					the preventative maintenance		
					program. Variances will be corrected at the time of		
					observation and trends will be		
					reported to the facility's QA		
					meeting, monthly for 3 months		
					="" b="">The administrator i		
					responsible for continued		
					compliance of the regulation		
					="" b="">Date of compliance		
					1/3/2023		
					="" b="">		
					="" bdate="">		
K 0341	NFPA 101						
SS=C	Fire Alarm Syste	m - Installation					
Bldg. 01	Fire Alarm Syste						
	· ·	em is installed with systems					
		approved for the purpose in					
		NFPA 70, National Electric					
	Code, and NFPA	72, National Fire Alarm					
	Code to provide	effective warning of fire in any					
	I *	ig. In areas not continuously					
	occupied, detecti	on is installed at each fire					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	01	COMPLETED 11/28/2022	
155386		<u> </u>					
	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP COD 520 W LIBERTY ST BUTLER, IN 46721				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	alarm control unit. detection is also ir appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1, Based on observation failed to ensure 1 of continuously in property. NFPA 72, National 2010 Edition, Section defects and malfund deficient practice condition and visitors. Findings include: Based on observation panel with the Main at 12:44 p.m., the time alarm control panel a.m. when checked interview at the time Administrator and the agreed the fire alarm time and will need to the supervision of the supervis	In new occupancy, installed at notification ower extenders, and in transmitting equipment. Wiring or other is are monitored for 1, 9.6, 9.6.1.8 On and interview, the facility if 1 fire alarm systems was per operating condition. Fire Alarm and Signaling Code, on 14.2.1.2.2 states system extions shall be corrected. This bould affect all residents, staff on of the fire alarm control intenance Director on 11/28/22 one on the display of the fire indicated the time to be 11:44 at 12:44 p.m. Based on the of observation, the he Maintenance Director in control panel had the wrong	K 0		A visual inspection of the firalarm system was completed 11/28/2022 and time changed reflect current time. No residents were affected by the alleged deficient practice. All residents have the potent to be affected. The facility's TELS system houndated the visual inspection of fire panel to include this regulation. The Maintenance Director is aware of the characteristic to TELS. Continued compliance will be monitored by the Maintenance birector. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA meeting, month for 3 months. The Administrator is responsible for the continue compliance of the regulation	d to	01/03/2023
	3.1-19(b)				="" b="">		
K 0355 SS=E Bldg. 01							

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386		onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/28/2022	
	PROVIDER OR SUPPLIER S OF DEKALB	520 W	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST FR, IN 46721		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the therapy gym was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 8 residents in therapy.	K 0355	Maintenance Director install the fire extinguisher at corre height, not more than five fe above the floor. No residents were affected by the alleged deficient practice. No other fire extinguishers were found to be in violation the regulation.	ect et s	
	Based on observations with the Maintenance Director on 11/28/22 at 11:55 a.m., the portable fire extinguisher located in therapy was mounted on the wall with the top of the extinguisher 5 feet 3 inches above the floor. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was mounted with the top of the extinguisher greater than five feet above the floor. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Continued compliance with the regulation will be completed by the Maintenan Director through daily round and the Preventative Maintenance Program. Variances will be corrected at the time of observation and trends will be reported to the facility's QA meeting, month for 3 months. The Administrator is responsible for compliance	at e	
			the regulation.		
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155386		(X2) MULT A. BUILD B. WING		NSTRUCTION 01		SURVEY LETED 1/2022	
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 520 W LIBERTY ST BUTLER, IN 46721				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors were not being used as a portion of the return air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A 2012 Edition 4.3.12.1.1 Egress corridors in nursing homes and long term care facilities, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining arrears. This deficient practice affects the 100, 200, 300 and 400 halls therefore affecting all residents.		K 0521		The facility respectfully rewaiver of K521. The life swaiver request will be recthe state of Indiana by 12	afety eived by	01/03/2023
	Director on 11/28/2 p.m., all resident ro 400 halls were usin return air system. B time of observation Maintenance Direct exhausted into the c	ons with the Maintenance 22 between 11:30 a.m. to 1:00 oms on the 100, 200, 300 and g the egress corridor as a cased on an interview at the tor confirmed the return air was corridor for all resident rooms.					
K 0712 SS=F Bldg. 01	alarm signal and s	the transmission of a fire simulation of emergency fire ills are held at expected					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155386	B. W	B. WING 11/28/2		/2022	
NAME OF E	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
		·			LIBERTY ST		
LAUREL	S OF DEKALB			BUTLE	R, IN 46721		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	BEHELIKETY		DATE
	I	mes under varying st quarterly on each shift.					
		ar with procedures and is					
		re part of established					
		rills are conducted between					
	9:00 PM and 6:00	AM, a coded					
	announcement ma	ay be used instead of					
	audible alarms.						
	19.7.1.4 through 1						
		view and interview, the facility	K 0	712	Maintenance Director has be	-	01/03/2023
		re drills or documented on each shift for 2 of 4			in serviced on requirements for		
	_	1.6 states drills shall be			fire drills per guidelines. No residents were affected by the		
	_	on each shift to familiarize			alleged deficient practice.	ie	
		nurses, interns, maintenance			All residents have the potential to be affected. Maintenance Director has been in serviced		
		inistrative staff) with the					
		ncy action required under					
	varied conditions.	QSO-20-31 1135 temporary			on requirements for fire drill	s	
	waiver states in lieu	ı of a physical fire drill, a			per NFPA 101 fire drill		
		ation training program related			guidelines.		
	_	lan, which considers current			Administrator or designee to		
		is acceptable. The training will			review fire drill documentation	on	
		including existing, new or			monthly as part of the QA		
		es, on their current duties, life nd the fire protection devices			meeting to ensure compliant	ce	
	1 .	ea (ended 06/07/22). This			with requirements. The QA committee will moni	tor	
	I -	ffects all staff and patients.			monthly for 3 months.		
	practice at	Panello.			/b>		
	Findings include:						
		t tala states					
		view with the Administrator					
		irector on 11/28/22 at 10:45					
		d shift drill for the first quarter					
	fire drill for the third shift drill for the first quarter in 2022. Based on interview at the time of record						
		nance Director agreed the third					
		st quarter in 2022 was not					
	conducted.	•					
	This finding was re	viewed with the Administrator					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155386	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2022
	PROVIDER OR SUPPLIER S OF DEKALB	520 W	ADDRESS, CITY, STATE, ZIP COD LIBERTY ST R, IN 46721	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and Maintenance Director during the exit conference. 3.1-19(b)			
	3.1-51(c)			
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 5 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the 300-hall. Findings include: Based on observations with the Maintenance Director on 11/28/22 at 11:50 a.m., there was a soiled linen/trash barrel greater than 32-gallon outside of the soiled utility room on the 300-hall.	K 0754	On 11/28/2022 Maintenance Director removed 32-gallon barrel from hallway and place in soiled utility room. No residents were affected by the alleged deficient practice. Based on facility fire exit place residents on 300 hall have potential to be affected. All remaining corridors reviewed no other areas were found to be in violation of the	ne n d;

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155386		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W LIBERTY ST BUTLER, IN 46721				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Based on interview Maintenance Direct greater than 32-gall the 300 hall. This finding was re	at the time of observation, the or agreed the barrel was on and was left unattended in viewed with the Administrator irector during the exit		regulation. Staff, including maintenance director, will be in serviced of compliance with K754. Continued compliance of the regulation will be monitored the Maintenance Director though the Preventative Maintenance Program. All variances will be corrected at the time of observation and trends will be reported to the facility's monthly QA Committee, monthly for 3 months. The Administrator is responsible for compliance with this regulation.	e on e by		
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas w do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation interview; the facility portable space heater resident care areas a		K 0781	On 11/28/2022 Maintenance Director removed portable space heater from the therap gym. No residents were affected by the alleged	01/03/2023 Dy		

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	ETED
		155386	B. WING 11/28/2022			2022	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP COD 520 W LIBERTY ST BUTLER, IN 46721				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	residents, using the	therapy gym.			deficient practice.		
					No other areas were found to)	
	Findings include:				be in violation of the		
					regulation.		
		ons during a tour of the facility					
		ce Director on 11/28/22 at			On 11/29/2022 the		
		ble space heater was			Administrator in-serviced the	_	
		n the therapy gym. Based on			Rehab Director on the policy		
		15 p.m., the Space Heater		including items that are not			
		heaters are not allowed in the nterview at the time of the			allowed in the facility.		
	1	aintenance Director agreed a			Continued compuliance of the	_	
		a resident care area, removed			Continued compliance of th regulation will be monitored		
	_	d stated space heaters are not			the Maintenance Director	БУ	
	allowed in the facili	-			though the Preventative		
	anowed in the facin	ity.			Maintenance Program. All		
	This finding was re	viewed with the Administrator			variances will be corrected a	t	
		irector during the exit			the time of observation and		
	conference.	5			trends will be reported to the)	
					facility's monthly QA		
	3.1-19(b)				Committee, monthly for 3		
					months.		
					The Administrator is responsible for compliance with this regulation.		
					/b>		

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