PRINTED: 10/02/2018

	T OF HEALTH AND HU R MEDICARE & MEDIC					OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441		JILDING	ONSTRUCTION	COMPL	3) DATE SURVEY COMPLETED 09/11/2018	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg	conducted by the In Health in accordan	paredness Survey was andiana State Department of the with 42 CFR 483.73.	E 00	000				
	Survey Date: 09/1 Facility Number: 0 Provider Number: 100	000338 155441						
	Nursing and Rehab substantial complia Preparedness Requ	Prearedness survey, Corydon bilitation Center was found in since with Emergency irements for Medicare and ting Providers and Suppliers, 42						
	The facility has 38 the survey, the cen	certified beds. At the time of sus was 27.						
	Quality Review co	mpleted on 09/17/18 - DA						
	The requirement at MET as evidenced	42 CFR, Subpart 483.73 is NOT by:						
E 0023 SS=C Bldg								
-	failed to ensure em and procedures inc documentation that information, protect	view and interview, the facility ergency preparedness policies lude a system of medical preserves resident ets confidentiality of resident excurse and maintains the	E 00)23	E 023 Policies and Procedures Medical Documentation o What corrective action (s) where the second is to have been second in the		10/11/2018	

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

availability of records in accordance with 42 CFR

occupants.

483.73(b)(4). This deficient practice could affect all

TITLE

to affected by the deficient

affected by the deficient practice;

o All Residents have the chance

(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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 91EZ21 Facility ID: 000338 If continuation sheet Page 1 of 33

PRINTED: 10/02/2018

	T OF HEALTH AND HU R MEDICARE & MEDIC					MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE C A. BUILDING B. WING			PLETED
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	315 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB RD DON, IN 47112		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	Findings include:			practice.		
	Based on record reand the Maintenand a.m., a policies and system of medical cresident informatio resident informatio the availability of review. Based on in review then again a Administrator and confirmed the facil medical documentar	Based on record review with the Administrator and the Maintenance Director on 09/11/18 at 10:20 a.m., a policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review. Based on interview at the time of record review then again at the exit conference, the Administrator and the Maintenance Director confirmed the facility does have a system of medical documentation but no policy and procedure was available for review.		o How other residents hav potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; All residents have the potential be affected by the practice of All residents have the potential be affected by the practice of The plan will be updated 10/11/2018 to address media documentation that preserve protect patient information aconfidentiality.	he be ve nitial to otential ce I by lical es and	
				o What measures will be in place or what systemic chat will be made to ensure that deficient practice does not do Emergency preparedness training will be provided for least annually on 10/10/2010 o Documentation will be maintained of all emergency preparedness training. Initial emergency preparedness to will be provided during generorientation, and volunteer orientation, when applicable o Facility staff will participal community-based exercise least annually if accessible.	nges the occur; ss staff at 8. y al raining eral e. ate in a at	

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 2 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/11/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	315 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB RD DON, IN 47112	
(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
				o How the corrective action(swill be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place o QA program will be put into place ED/or designee will review Emergency preparedness prowith QAPI team annually to ensure compliance. o By what date the systemic changes will be complete o 10/11/2018 o Facility requests desk reviewing the control of the con	e r, o iew ogram
E 0024 SS=C Bldg	failed to ensure eme and procedures incl an emergency or oth strategies, including integration of State care professionals to an emergency in act 483.73(b)(6). This coccupants. Findings include: Based on record rev Administrator and to 09/11/18 at 10:21 a included the use of	riew and interview, the facility ergency preparedness policies ude the use of volunteers in her emergency staffing at the process and role for or Federally designated health to address surge needs during cordance with 42 CFR deficient practice could affect all view and interview with the he Maintenance Director on m., a policy and procedure that volunteers in an emergency or affing strategies, including the	E 0024	E 024 Policies/Procedures – Volunteers and Staffing o What corrective action (s) be accomplished for those residents found to have been affected by the deficient pract o All residents have the pote to be affected o The plan will be updated b 10/11/2018 to include to interrogation of state and feder health care professional to address surge needs. o How other residents having potential to be affected by the	ice; ential y eral g the
		integration of State or		same deficient practice will be	

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 3 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		155441	B. Wl	NG		09/11	/2018
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			OUNTRY CLUB RD		
CORYDO	ON NURSING AND	REHABILITATION CENTER			OON, IN 47112		
(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	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Federally designate	ed health care professionals to			identified and what corrective		
	address surge need	address surge needs during an emergency was			action(s) will be take;		
	not available for re	view.			o All residents and staff have	the	
					potential to affected.		
					o The plan will be updated by	y	
					10/11/2018 to include to		
					interrogation of state and fede	ral	1
					health care professional to		
					address surge needs.		
					o What measures will be into	0	
					place or what systemic change	es	
					will be made to ensure that the	е	
					deficient practice does not occ	cur;	
					o Emergency preparedness		
					training will be provided for sta	aff at	
					least annually on 10/10/2018.		
					Documentation will be mainta	ined	
					of all emergency preparednes	S	
					training.		
					o Initial emergency prepared	ness	
					training will be provided during		
					general orientation, and volun	-	
					orientation, when applicable.		
					o Emergency preparedness		
					facility exercises and/or drills v	will	
					be conducted based on the		
					emergency plan and risk		
					assessment.		
					o Facility staff will participate	in a	
					community-based exercise at		
					least annually if accessible		
					o Documentation of the training	ina	
					will be maintained in the emplo	•	
					file, within in-service binder an	•	
					in computer-based system.	• .	
					Joinpater Based System.		
					o How the corrective action(s	3)	
					will be monitored to ensure the	-	

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

deficient practice will not recur, i.e., what quality assurance

Page 4 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		(X3) DATE SURVEY COMPLETED				
		155441	B. WI	NG		09/11/2	2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 315 COUNTRY CLUB RD CORYDON, IN 47112				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
E 0026 SS=C Bldg	failed to ensure eme and procedures incl under a waiver decl accordance with sec provision of care an care site identified be officials in accordant This deficient practic Findings include: Based on record revaled the Maintenance a.m., a policy and p LTC facility under a Secretary, in accord Act was not availabe interview at the time the exit conference, Maintenance Direct	riew and interview, the facility ergency preparedness policies ude the role of the LTC facility ared by the Secretary, in etion 1135 of the Act, in the d treatment at an alternate by emergency management are with 42 CFR 483.73(b)(8). Find the could affect all occupants. The with the Administrator is a Director on 09/11/18 at 10:24 rocedure for the role of the area waiver declared by the ance with section 1135 of the le for review. Based on is of record review then again at the Administrator and the or confirmed he was unaware did that no policy and procedure view.	E 00	026	program will be put into place o QA program will be put into place ED/or designee will revie Emergency preparedness pro- with QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk revie lieu of revisit E 026 Roles Under a Waiver Declared by Secretary o What corrective action (s) to be accomplished for those residents found to have been affected by the deficient practic o All resident has the potenti- be affected by this practice. o The plan will be updated be 10/11/2018 to include emerge preparedness policies alternate care site and reviewed annual and updated. o How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All resident has the potenti- be affected by this practice. o The plan will be updated by The plan will be updated by	ew gram ew in will ice; al to by ency te elly	10/11/2018

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 5 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/11/2018
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	10/11/2018 to include emerge preparedness policies alternat care site and reviewed annual and updated. o What measures will be into place or what systemic change will be made to ensure that the deficient practice does not occoo Emergency preparedness training will be provided for staleast annually. o Documentation will be maintained of all emergency preparedness training. o Initial emergency prepared training will be provided during general orientation, and volunt orientation, when applicable. o Emergency preparedness facility exercises and/or drills when the emergency plan and risk assessment. o Facility staff will participate community-based exercise at least annually if accessible. o Documentation of the traini will be maintained in the employed.	ncy te lly es ecur; aff at ness dee teer will in a ing oyee
				file, within in-service binder and in computer-based system. o How the corrective action(swill be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place	s) e

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

o QA program will be put into

Page 6 of 33

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/02/2018 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			ON	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u></u>	COMPI		
		155441	B. WING		09/11	/2018	
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP COD			
				COUNTRY CLUB RD			
CORYDO	ON NURSING AND	REHABILITATION CENTER	CO	RYDON, IN 47112			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPE	LD BE ROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION				DATE	
				place ED/or designee will			
				Emergency preparedness			
				with QAPI team annually ensure compliance.	10		
				ensure compliance.			
				o By what date the syste	emic		
				changes will be complete	d		
				o 10/11/2018			
				o Facility requests desk			
				lieu of revisit			
E 0032							
SS=C							
Bldg							
J	Based on record re	view and interview, the facility	E 0032	E 032 Primary/Alternate N	Means for	10/11/2018	
		e emergency preparedness		Communication			
	_	an includes (3) Primary and					
		r communicating with the		o What corrective action			
		facility's staff (ii) Federal, State,		be accomplished for thos			
		local emergency management ance with 42 CFR 483.73(c)(3).		residents found to have b			
	_	tice could affect all occupants.		affected by the deficient po o All resident has the po			
	This deficient prac	tice could affect all occupants.		be affected by this practic			
	Finding include:			o The plan will be updat			
				10/11/2018 to include			
	Based on record re	view with the Administrator		Communication plan, LTO	C staff,		
	and the Maintenan	ce Director on 09/11/18 at 10:27		federal, tribal, regional an			
		ey preparedness communication		emergency management	•		
		de a primary and an alternate					
		nication. Based on interview at					
		review then again at the exit		o How other residents h	-		
		Iministrator and the		potential to be affected by			
		etor confirmed the facility does		same deficient practice w			
	means for commun	plan for primary and alternative		identified and what correct action(s) will be taken;	шve		
	incans for commu	neation.		o All resident has the po	tential to		
				be affected by this practic			

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

Event ID:

91EZ21

Facility ID: 000338

o The plan will be updated by 10/11/2018 to include emergency

> If continuation sheet Page 7 of 33

PRINTED: 10/02/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE (A. BUILDING B. WING		
NAME OF	PROVIDER OR SUPPLIEI	R		TADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB RD	•
CORYD	ON NURSING AND	REHABILITATION CENTER	CORY	'DON, IN 47112	
(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 APPROPRIA DEFICIENCY) preparedness policies alterna	DATE
				care site and reviewed annua and updated.	
				o What measures will be into place or what systemic chang will be made to ensure that the deficient practice does not occor or Emergency preparedness training will be provided for steleast annually. o Documentation will be maintained of all emergency preparedness training. o Initial emergency prepared training will be provided during general orientation, and volumorientation, when applicable. o Emergency preparedness facility exercises and/or drills be conducted based on the emergency plan and risk assessment. o Facility staff will participate community-based exercise at least annually if accessible. o Documentation of the train will be maintained in the emplifile, within in-service binder an in computer-based system	ges ges ge cur; aff at dness g nteer s will e in a fing loyee
				o How the corrective action(will be monitored to ensure th deficient practice will not recu	ie

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

i.e., what quality assurance program will be put into place o QA program will be put into place ED/or designee will review

Page 8 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED 09/11/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	315	EET ADDRESS, CITY, STATE, ZIP COE 5 COUNTRY CLUB RD RYDON, IN 47112)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APP	CTION (X5) ULD BE PROPRIATE COMPLETION DATE
				Emergency preparednes with QAPI team annually ensure compliance.	. •
				o By what date the syst changes will be complete o 10/11/2018 o Facility requests desk lieu of revisit	ed
E 0033 SS=C Bldg	failed to ensure the communication plan sharing information for residents under the necessary, with other maintain the continuent the event of an evacuinformation as perm (1)(ii); (6) A means the general condition under the facility's (164.510(b)(4) in acc (4). This deficient procupants. Findings include: Based on record revaled the Maintenance a.m., the emergency	riew and interview, the facility emergency preparedness in includes (4) A method for and medical documentation the LTC facility's care, as exhealth care providers to aity of care; (5) A means, in auation, to release resident aitted under 45 CFR 164.510(b) of providing information about in and location of residents eare as permitted under 45 CFR cordance with 42 CFR 483.73(c) tractice could affect all	E 0033	E 033 Methods for Sharin Information o What corrective action be accomplished for those residents found to have the affected by the deficient of the All resident has the problem affected by this practice of the plan will be updated 10/11/2018 to include a resharing information and redocumentation with other healthcare providers. And provide general informating general condition and located the control of the providers utilize procare.	n (s) will se been practice; otential to ice. Ited by method of medical er Ind a way to icion about cation of
	method for sharing	information and medical esidents under the LTC		potential to be affected b	by the

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 9 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/11/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	315 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB RD DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	facility's care, as ne providers to maintal Based on interview the Administrator at	cessary, with other health care in the continuity of care. at the time of record review, and the Maintenance Director or documentation was available		identified and what corrective action(s) will be taken; o All resident has the potent be affected by this practice o The plan will be updated of 10/11/2018 to include a meth sharing information and medi documentation with other healthcare providers. And a way provide general information and general condition and location residents. o o What measures will be interplace or what systemic change will be made to ensure that the deficient practice does not occorrect of the place of what systemic change will be made to ensure that the deficient practice does not occorrect of the place of what systemic change will be made to ensure that the deficient practice does not occorrect of the place	ial to n od of cal vay to bout n of des e cur; aff at dness g tteer will e in a ling loyee

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 10 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/11/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	315 C	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112	I
(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 0034 \$S=C Bldg	failed to ensure the communication plan providing informati occupancy, needs, a assistance, to the au the Incident Comma accordance with 42 deficient practice confinings include: Based on record rev	iew and interview, the facility emergency preparedness includes a means of on about the LTC facility's not its ability to provide thority having jurisdiction or and Center, or designee in CFR 483.73(c)(7). This hald affect all occupants.	E 0034	o How the corrective action(swill be monitored to ensure the deficient practice will not recurite., what quality assurance program will be put into place on QA program will be put into place ED/or designee will revise Emergency preparedness prowith QAPI team annually to ensure compliance. o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk revise lieu of revisit E 034 Information on Occupancy/Needs o What corrective action (s) be accomplished for those residents found to have been affected by the deficient praction All resident has the potentiate affected by this practice. o The plan will be updated be 10/11/2018 to include information about facility occupancy, need and ability to aid.	e e r, c c c c c c c c c c c c c c c c c c

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 11 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI 09/11	
	PROVIDER OR SUPPLIER DN NURSING AND	REHABILITATION CENTER	315 C	r address, city, state, zip co OUNTRY CLUB RD 'DON, IN 47112	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULLD BE PROPRIATE	(X5) COMPLETION DATE
	of providing inform occupancy, needs, a assistance, to the au the Incident Comm accordance with 42 available for review time of record review conference, the Admintenance Direct communication pla aforementioned occ	tion plan that included a means nation about the LTC facility's and its ability to provide atthority having jurisdiction or and Center, or designee in CFR 483.73(c)(7) was not w. Based on interview at the ew then again at the exit ministrator and the tor confirmed that the n did not include the supancy, needs, and ability to to the AHJ, IC, or designee.		o How other residents potential to be affected by same deficient practice or identified and what correaction(s) will be taken; o All resident has the pube affected by this pract on The plan will be updated 10/11/2018 to include in about facility occupancy and ability to aid. O What measures will be place or what systemic of will be made to ensure the deficient practice does not be consumentation will be made to ensure the deficient practice does not be consumentation will be maintained of all emergency prepared the residual prepared ness training. In the emergency prepared to the provided during of the provided during of the provided during of the conducted based on the emergency plan and risk assessment. O Facility staff will partice community-based exercite ast annually if accessing the provided in the file, within in-service binding computer-based systems.	by the will be ective botential to ice. ated by formation reds be into changes hat the not occur; lness for staff at 2018. Deency nitial as training general er able. Iness drills will the control occur, and	

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 12 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULT A. BUILD B. WING		(X3) DATE COMPL 09/11/	ETED
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	3	TREET ADDRESS, CITY, STATE, ZII 115 COUNTRY CLUB RD CORYDON, IN 47112	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE AG DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 0035 SS=C Bldg	failed to ensure the communication pla information from the facility has determined residents and their that accordance with 42 deficient practice of Findings include: Based on record revand the Maintenance	view and interview, the facility emergency preparedness in includes a method for sharing the emergency plan that the med is appropriate with families or representatives in CFR 483.73(c)(8). This could affect all occupants.	E 0035	o How the corrective will be monitored to deficient practice will i.e., what quality ass program will be put in o QA program will be place ED/or designed Emergency prepared with QAPI team annuel ensure compliance. o By what date the changes will be common 10/11/2018 o Facility requests of lieu of revisit E 035 LTC and ICF/IP Plan with Patients o What corrective a be accomplished for residents found to hat affected by the deficition of the deficition of the facility has a sharing information of the emergency plan with and their families or representatives. o We will discuss deplans	ensure the I not recur, surance into place be put into the will review diness program the ually to systemic spleted desk review in IID Sharing faction (s) will those	10/11/2018

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 13 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/11/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	315 C	TADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB RD 'DON, IN 47112	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	information from the facility has determine residents and their f	le a method for sharing the emergency plan that the the ned is appropriate with the amilies or representatives in		o We will discuss and go ove all new admissions	
	interview at the tim Administrator and t	CFR 483.73(c)(8). Based on e of record review, the he Maintenance Director ocumentation or plan has been		o How other residents havin potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the pote to be affected by this finding. o The facility has a method f sharing information from emergency plan with resident and their families or representatives. o We will discuss during Car Plans o We will discuss and go over all new admissions	ential for s
				o What measures will be into place or what systemic chang will be made to ensure that the deficient practice does not occor on The policy will be located in Emergency Preparedness program binder under communication plan. O How the corrective action (will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place on The policy is in the Emerge Preparedness program binde under communication plan.	ese cur n the

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDIN	LE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		155441	B. WING		09/11/2018
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	31	EET ADDRESS, CITY, STATE, ZIP COD 5 COUNTRY CLUB RD PRYDON, IN 47112	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION LD BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAC	G DEFICIENCY)	DATE
				o ED/or designee will rev Emergency preparedness with QAPI team annually ensure compliance.	s program
				o By what date the syste changes will be completed	
				o 10/11/2018 o Facility requests desk lieu of revisit	review in
K 0000					
Bldg. 01	Licensure Survey w State Department of CFR 483.90(a). Survey Date: 09/11 Facility Number: 0 Provider Number: 100 At this Life Safety of and Rehabilitation of compliance with Re Medicare/Medicaid Life Safety from Fi	00338 155441	K 0000		
	Life Safety Code (I Health Care Occupa This one story facil Type II (111) const sprinklered. The fa	ity was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors			

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 15 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	UILDING	nstruction 01	(X3) DATE COMPL 09/11/	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	315 CO	DDRESS, CITY, STATE, ZIP COD UNTRY CLUB RD ON, IN 47112		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	and spaces open to operated smoke alar rooms. The facility census of 27 at the table All areas where resi were sprinklered an services were sprinklered for facility Quality Review con	idents have customary access d all areas providing facility klered, except two detached	TAG			DATE
K 0222 SS=F Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lockinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special locks afety needs of the the Clinical or Security are being met. In a special lock are being met.	king arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ded by staff at all times; or e means available to the				

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet Page 16 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155441	B. W	NG		09/11/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			UNTRY CLUB RD		
CORYDO	ON NURSING AND	REHABILITATION CENTER			OON, IN 47112		
			1				
(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 APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	of power to the device; the					
	• •	ed by a supervised					
		r system and the locked					
		by a complete smoke					
	-	(or is constantly monitored					
		ation within the locked					
		he sprinkler and detection					
	*	ged to unlock the doors					
	upon activation.	2.2.5.2 TIA 12.4					
	18.2.2.2.5.2, 19.2. DELAYED-EGRES						
	ARRANGEMENTS						
		elayed-egress locking					
		in accordance with					
	7.2.1.6.1 shall be						
		g low and ordinary hazard					
		gs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2.						
	ACCESS-CONTR						
	LOCKING ARRAN						
		Egress Door assemblies					
		ance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2.	2.4					
	ELEVATOR LOBE						
	LOCKING ARRAN	IGEMENTS					
	Elevator lobby exi	t access door locking in					
	accordance with 7	2.1.6.3 shall be permitted					
	on door assemblie	es in buildings protected					
	throughout by an a	approved, supervised					
	automatic fire dete	ection system and an					
	approved, supervi	sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2.						
		on, record review, and	K 0	222	K 222 Egress Doors		10/11/2018
		ty failed to ensure the facility					
	failed to ensure 3 of	3 exits	\perp		o What corrective action (s) v	VIII	

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

Event ID: 91EZ21

Facility ID: 000338

If continuation sheet Page 17 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155441	B. W	ING		09/11/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	L		315 CO	OUNTRY CLUB RD		
CORYDO	ON NURSING AND	REHABILITATION CENTER		CORYE	OON, IN 47112		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG			DATE
		or locking devices that did not wledge to open. LSC 19.2.1			be accomplished for those residents found to have been		
		e, passageway, corridor, exit			affected by the deficient practi	co:	
		tion, and access shall be in			o All exit doors have been po		
	_	apter 7, unless otherwise			with an exit code that does no		
		through 19.2.11. LSC 7.2.1.5.3			require a key, tool or special		
		shall not require the use of a			knowledge to operate on		
		al knowledge or effort for			10/1/2018.		
		egress side. This deficient			16/ 1/2010.		
	practice could affec	-					
	*	•			o How other residents having	the	
	Findings include:				potential to be affected by the		
					same deficient practice will be		
	Based on observation	on with the Maintenance			identified and what corrective		
	Director on 09/11/1	8 between 10:40 a.m. and 11:52			action(s) will be taken;		
	a.m., all exit doors	were held in the locked position			o Facility maintenance direct	or	
	_	d down device. Furthermore,			has meet with Corporate Facil	ity	
	I	quipped with an electronic			Director to ensure all fire door	rs	
		n that allowed staff to open			are in compliance with the		
		rs with a combination. A sign			applicable National Fire		
		ed the code required was the			Protection Association's (NFP	A)	
		e facility's phone number.			Code. Any doors that are		
		ew at the time of each			non-compliant with standards	will	
	observation, the Ma				be reported to Facility		
	_	ast four digits of the facility's			ED/designee and be		
	*	special knowledge that alert nts and visitors may not have			replaced/repaired immediately	' .	
	or know.	its and visitors may not have					
	OI KIIUW.				o What measures will be into	,	
	3.1-19(b)				place or what systemic change		
	3.1 17(0)				will be made to ensure that the		
					deficient practice does not occ		
						,	
					o Education given to all		
					employees to report directly to)	
					Facility ED/designee if any		
					deficiencies of Doors are notice	ed	
					on 10/2/2018 also facility		
					maintenance director has add	ed	
					door code postings to daily		

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441		JILDING	ONSTRUCTION <u>01</u>	(X3) DATE COMPL 09/11 /	ETED
	ROVIDER OR SUPPLIER ON NURSING AND	REHABILITATION CENTER		315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					mechanical check 10/2/2018 f continued compliance assurar		
					o How the corrective action(s will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place o Facility Manager/designee report monthly x 6 month to th Administrator. Also monitoring reviewed monthly by the QAP team to ensure compliance. By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk revieilieu of revisit	will e is	
K 0223 SS=E Bldg. 01	enclosure, or horizor hazardous area and kept in the cloopen by a release 7.2.1.8.2 that autodoors throughout entire facility upon * Required manua * Local smoke det smoke passing the required smoke det * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2.2.	osing Devices assageway, stairway zontal exit, smoke barrier, a enclosure are self-closing bed position, unless held device complying with bematically closes all such the smoke compartment or	V	223	K223 Doors with Self-Closing		10/11/2018

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

Event ID:

91EZ21 Facility ID: 000338 If continuation sheet Page 19 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155441	B. W	'ING		09/11/	2018
NA 75 05 5	DOLUBED OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	ROVIDER OR SUPPLIER	t .			OUNTRY CLUB RD		
	ON NURSING AND	REHABILITATION CENTER		CORYE	OON, IN 47112		
(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	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		f 1 Maintenance office corridor			Devices		
	_	open by a release device			- \A/I4	:11	
		C 7.2.1.8.2 that automatically			o What corrective action (s)	WIII	
		pon activation of the fire deficient practice could affect			be accomplished for those		
	staff and at least 10	-			residents found to have been	00:	
	starr and at least 10	residents.			affected by the deficient practi o On 9/11/2018, The	Ce,	
	Findings include:				Maintenance Director remove	d the	
	1 manigo merade.				device from door and provided		
	Based on observation	on with the Maintenance			education to staff. On 9/19/20		
	Director on 09/11/1				Maintenance Director provided		
		corridor door was held open			in-service to staff on the		
		vall. The Maintenance Office			importance of not propping op	en	
	was open to the Lau	ındry Room. The Laundry			self-closing doors.		
	room contained fue	l-fired dryers. Based on			o 9/11/2018 Sign was placed	lon	
	interview at the tim	e of observation, the			back of door advising "Do not	prop	
	Maintenance Direct	or confirmed the hold open			doors".		
	device does not rele	ease with the fire alarm.					
	2.1.10(1)						
	3.1-19(b)				o How other residents having		
					potential to be affected by the		
					same deficient practice will be identified and what corrective		
					action(s) will be taken;		
					o Residents currently living in	n the	
					facility, visitors and staff have		
					potential to be affected by this		
					alleged deficient practice.		
					o On 9/19/2018 Maintenance	į	
					Director provided in-service to		
					on the importance of not prop		
					open self-closing doors.		
					o 9/11/2018 Sign was placed	l on	
					back of door advising "Do not		
					doors		
					o What measures will be into		
					place or what systemic change		
					will be made to ensure that the		
	1		1		l		l

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

Event ID:

91EZ21

Facility ID: 000338

If con

If continuation sheet Page 20 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	UILDING	ONSTRUCTION 01	(X3) DATE S	ETED
		155441	B. W	_		09/11/	2018
	PROVIDER OR SUPPLIER ON NURSING AND	REHABILITATION CENTER		315 CO	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	deficient practice does not occ		DATE
					o Maintenance Director will ensure doors to rooms equipp are closed and not propped op In addition, inspected weekly t verified by the Executive Direct Any concerns will be addressed immediately.	oen. then ctor.	
					o How the corrective action(s will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place o Maintenance Director will review with ED monthly during QAPI Meeting. If 100% thresh is not achieved, an action plant be developed.	e -, J old	
					By what date the systemic changes will be completed		
					o 10/11/2018 o Facility requests desk revie lieu of revisit	ew in	
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that provided K-tags, binformation, along	KS section any LSC					

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 21 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE : COMPL 09/11/	ETED
	PROVIDER OR SUPPLIEF ON NURSING AND	REHABILITATION CENTER	315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Should be include Based on record rev failed to ensure doc preventative mainte smoke alarms in res compartments was states to ensure ope shall have an inspec program. NFPA 72 equipment shall be accordance with ma instructions and per 14. This deficient p occupants. Findings include: Based on record rev	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION d on Form CMS-2567. View and interview, the facility rementation for the remance of battery operated sident rooms in 2 of 2 smoke complete. NFPA 72 14.2.1.1.1 reations integrity, the system retion, testing, and maintenance 29.10 states fire-warning maintained and tested in remuracturer's published requirements of Chapter reactice could affect all review with the Maintenance 8 between 9:04 a.m. and 9:49	ID PREFIX TAG K 0300	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) K 300 Protection — Other o What corrective action (s) to be accomplished for those residents found to have been affected by the deficient pract o All smoke detectors were identified and all batteries wer replaced in the smoke detecton 10/2/2018. o How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o On 10/2/2018 all batteries be replaced in the smoke detectors.	will ice; re ors g the	(X5) COMPLETION DATE 10/11/2018
	smoke alarm batter since July 2017. No regarding the smok recommendations. I of record review, the confirmed smoke a	nentation failed to indicate y replacement was performed o documentation was available e alarm manufacturer's Based on interview at the time ne Maintenance Director larm battery replacement has ed for at least a year.		o What measures will be into place or what systemic chang will be made to ensure that the deficient practice does not occor on the measures put into place and a systemic change made ensure the deficient practice of reoccur: On 10/2/2018 monitors are cording when smoke determines are changed was add to the TELS. o Maintenance Director was educated by ED regarding and change of batteries (or as per manufacturer suggestion on 10/2/2018.	es e cur; ce to not oring ector ded	

10/02/2018 PRINTED:

DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOF	RM APPROVED
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>01</u>		COMPL	
		155441	B. WING			09/11/	2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	318	EET ADDRESS, CITY, ST COUNTRY CLUB RYDON, IN 47112	*		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		IVE ACTION SHOULD BE CED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAC	DE	EFICIENCY)		DATE
				o How the co	orrective action(s	s)	
				will be monito	red to ensure the	9	
				deficient pract	tice will not recur	,	
				i.e., what qual	lity assurance		
				program will b	e put into place		
				o To ensure	the deficient prac	ctice	
					cur, the monitoring	ng	
				system establ	ished is to:		
				Administrator	/ Designee will		

monitor for compliance. Any issues will be addressed

		immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine what continued auditing is necessary once 100% compliance threshold is achieved. This plan to be amended when indicated. o By what date the systemic changes will be completed o 10/11/2018	
		o Facility requests desk review in lieu of revisit	
K 0324	NFPA 101		
SS=D	Cooking Facilities		
Bldg. 01	Cooking Facilities		
	Cooking equipment is protected in		
	accordance with NFPA 96, Standard for		
	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:		
	* residential cooking equipment (i.e., small		
	appliances such as microwaves, hot plates,		
	toasters) are used for food warming or limited		
	cooking in accordance with 18.3.2.5.2,		
	19.3.2.5.2		
	* cooking facilities open to the corridor in		1

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155441		A. BUILDING <u>01</u> COMPLETED B. WING 09/11/2018					
	100441		D. W	_		09/11/	2016
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
CORYDO	ON NURSING AND	REHABILITATION CENTER			DUNTRY CLUB RD DON, IN 47112		
					T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ents with 30 or fewer		IAU			DATE
		rith the conditions under					
	18.3.2.5.3, 19.3.2						
		in smoke compartments					
	with 30 or fewer p	atients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
	_	protected according to					
	1	3 are not required to be					
	be open to the co	rdous areas, but shall not					
		1 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
	Based on observation and interview, the facility failed to ensure staff were instructed in the use of		K 0324		K324 Cooking Facilities		10/11/2018
		stem in 1 of 1 Kitchen. NFPA			o What corrective action (s) will be accomplished for those		
		structions for manually					
		xtinguishing system shall be		residents found to have been affected by the deficient practice; o Instructions for manually			
		lly in the kitchen and shall be					
	_	loyees by management. This ould affect staff only.					
	deficient practice co	outd affect staff offiy.			operating the fire extinguishing system have been posted	9	
	Findings include:				conspicuously in the kitchen o	n	
	Rased on observative	on with the Maintenance			9/19/2018.		
		8 at 11:05 p.m., the Kitchen					
) hood system. Based on			o How other residents having	the	
		ng Manager was asked what			potential to be affected by the		
		re was a large grease fire			same deficient practice will be		
		d. She replied she would grab			identified and what corrective		
		nguisher. She failed to indicate			action(s) will be taken;		
	pulling the hood pu	ll station.			o As noted in the 2567, this		
	2.1.10(b)				deficient practice could affect		
	3.1-19(b)				kitchen staff. o All Staff have been instruc	tod	
					in the use of the UL 300 hood	เซน	
					system on 9/19/2018 Instruction	ons	
					on its use have been added to		
					specific job orientation of kitch	en	
					staff 10/2/2018		

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet Page 24 of 33

10/02/2018 PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/11/2018	
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 315 COUNTRY CLUB RD CORYDON, IN 47112				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
					o What measures will be into place or what systemic change will be made to ensure that the deficient practice does not occor on All Staff have been instruct in the use of the UL 300 hood system on 9/19/2018 Instruction its use have been added to specific job orientation of kitch staff 10/2/2018	es eur; ed ons the en		
					will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place o Verification that the hood u instructions remain posted have been added to the maintenance daily check sheet. Said rounds will be conducted by the Maintenance Supervisor (or designee) and will take place to per week for assured compliar	se /e ce s		

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

Event ID:

91EZ21

Facility ID: 000338

Results of this audit will be

o By what date the systemic changes will be completed

for monitoring.

o 10/11/2018

lieu of revisit

presented to QAPI for further need

o Facility requests desk review in

If continuation sheet

Page 25 of 33

PRINTED: 10/02/2018 FORM APPROVED 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 09/11/2018 155441 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 315 COUNTRY CLUB RD CORYDON NURSING AND REHABILITATION CENTER CORYDON, IN 47112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0331 **NFPA 101** SS=F Interior Wall and Ceiling Finish Bldg. 01 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility K 0331 K 331 Interior Wall and Ceiling 10/11/2018 failed to ensure materials used as an interior finish Finish on the walls of 6 of 6 corridors had a flame spread rating of Class A or Class B in accordance with o What corrective action (s) will 19.3.3.1. LSC 101 10.2.3.4 states products required be accomplished for those to be tested in accordance with ASTM E 84, residents found to have been Standard Test Method For Surface Burning affected by the deficient practice; Characteristics of Building Materials or ANSI/UL o Fire protectant will be applied 723, Standard for Test for Surface Burning to the wainscoting wood simulated Characteristics of Building Materials shall be panels to ensure it has a flame grouped in the following classes in accordance spread classification of Class B by with their flame spread and smoke development. 10/11/2018 (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes o How other residents having the any material classified at 25 or less on the flame potential to be affected by the spread test scale and 450 or less on the smoke test same deficient practice will be scale. Any element thereof, when so tested, shall identified and what corrective not continue to propagate fire. action(s) will be taken; (b) Class B Interior Wall and Ceiling Finish. Flame o All residents have the potential spread 26-75; smoke development 0-450. Includes to be affected by the alleged any material classified at more than 25 but not deficient practice. more than 75 on the flame spread test scale and o The facility has been inspected 450 or less on the smoke test scale. to ensure that other interior walls (c) Class C Interior Wall and Ceiling Finish. Flame or ceilings have finishes in spread 76-200; smoke development 0-450. accordance with 19.3.3.1 LSC 101 Includes any material classified at more than 75 10.2.3.4. 10/11/2018 by the ED

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 26 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155441		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/11/2018				
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 315 COUNTRY CLUB RD CORYDON, IN 47112					
	SUMMARY: (EACH DEFICIEN REGULATORY OR but not more than 2 scale and 450 or les deficient practice co Findings include: Based on observation Director on 09/11/1 a.m., wainscoting we throughout the build corridors. Based on observation, the Ma the MSDS sheet but	REHABILITATION CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 00 on the flame spread test s on the smoke test scale. This build affect all occupants. on with the Maintenance 8 between 10:40 a.m. and 11:52 ras applied to the walls ling in some rooms and interview at the time of intenance Director provided rewas unable to provide mentation for a flame spread	315 C	DUNTRY CLUB RD DON, IN 47112 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) and the Maintenance Director o What measures will be into place or what systemic chang will be made to ensure that th deficient practice does not oc o Interior walls and ceilings to be examined on a regular base the Maintenance Supervisor of designee to ensure they have finishes in accordance with 19.3.3.1 LSC 101 10.2.3.4. o The Maintenance Supervis will be educated on the importance of interior walls or ceilings having finishes in accordance with 19.3.3.1 LSC 10.2.3.4. by 10/11/2018 by EI o How the corrective action() will be monitored to ensure th deficient practice will not recu i.e., what quality assurance program will be put into place o A preventative maintenance form will be used to documen examinations of the interior w and ceilings monthly times the and quarterly thereafter by the Maintenance Supervisor or hi designee. Results will be report	es e cur; vill dis by or his cor			
				monthly to the ED who will may needed recommendation: The Maintenance Supervisor designee will be responsible follow up.	s. or his			

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 27 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155441		r í	MULTIPLE CONSTRUCTION (X3) DATE SURV UILDING 01 COMPLETED VING 09/11/2013		LETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112		
(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)	ATE	(X5) COMPLETION DATE
K 0355 SS=D Bldg. 01	installed, inspecte	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for			o By what date the systemic changes will be completed o 10/11/2018 o Facility requests desk reviellieu of revisit		
	failed to ensure 1 of extinguishers was in accordance with 19 for Portable Fire Exextinguishers havin exceeding 40 pound top of the fire exting above the floor. This affect staff only. Findings include: Based on observation Director on 09/11/1 fire extinguisher me the top of the extinguisher me the top of t	on and interview, the facility f 1 Boiler room portable fire installed correctly in 3.5.12. NFPA 10, the Standard tinguishers, 6.1.3.8.1 Fire g a gross weight not ds shall be installed so that the guisher is not more than 5 feet s deficient practice could on with the Maintenance 8 at 11:16 a.m., the Boiler room casured at least 72 inches from guisher to the floor. Based on e of observation, the cor confirmed the fire gher than he was and he	K 0	355	K 355 Portable Fire Extinguish o What corrective action (s) be accomplished for those residents found to have been affected by the deficient pract o AN audit of the facility was conducted 9/11/2018 to assur that all fire extinguishers mee applicable standards. The one deficient fire extinguisher was re-located to the appropriate height on 9/11/2018. o How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the pote to be affected by the alleged deficient practice.	will ice; re t the e	10/11/2018

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

3.1-19(b)

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

o The maintenance director has added fire extinguisher condition

Page 28 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 09/11/2018	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	315 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB RD DON, IN 47112	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				and inspection to his daily mechanical check sheet 10/2/2018 for assured compl	iance.
				o What measures will be interplace or what systemic chance will be made to ensure that the deficient practice does not one of the extinguisher condition and mounting has been added the daily mechanical checks by the Maintenance Supervisensure they meet and maintance compliance	ges he ccur; ns ed to sheet sor to
				o How the corrective action will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place or quality assurance program be put into place? Any deficiencies will be immediate corrected and reported to the The Maintenance Supervisor designee will be responsible follow up.	he ur, e m will ely e ED, r or his
				o By what date the systemic changes will be completed o 10/11/2018	
K 0363	NFPA 101			o Facility requests desk rev lieu of revisit	iew in

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

Corridor - Doors

SS=E

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 29 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441		UILDING	nstruction 01	COM	TE SURVEY MPLETED 11/2018
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	-	315 CO	ADDRESS, CITY, STATE, ZIP C UNTRY CLUB RD OON, IN 47112	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF THE VINCE DIFFERENCE DEFORMATION.		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION
Bldg. 01	Corridor - Doors Doors protecting than required end exits, or hazardor of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containi combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or com Clearance betwee covering is not ex doors complying if provided with a the door closed w applied. There is closing of the door release when the permitted. Nonrat unlimited height a meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. I there are no restr resistance of glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARI	erials have positive latching latches are prohibited by These requirements do not spaces that do not contain abustible material. In the position of door and floor acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is no impediment to the positions. Hold open devices that door is pushed or pulled are acceed protective plates of are permitted. Dutch doors 6 are permitted. Door abeled and made of steel or compliance with 8.3, a compartment is differ window assemblies are in sprinklered compartments in area or fire as or frames in window. Parts 403, 418, 460, 482,		TAG			DATE
	Tire protection rati	ings, automatics closing	1				1

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet Page 30 of 33

10/02/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 09/11/2018 155441 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 315 COUNTRY CLUB RD CORYDON NURSING AND REHABILITATION CENTER CORYDON, IN 47112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0363 K363 Corridor - Doors 10/11/2018 failed to ensure 1 of 1 Central Supply room and 1 of 1 Activity Director's office corridor doors had o What corrective action (s) will no impediment to closing and positively latched be accomplished for those into the frame. This deficient practice could affect residents found to have been staff and at least 10 residents. affected by the deficient practice; o All door stops used to prop Findings include: open any door have been removed on 9/11/2018. o The Maintenance Director and Based on observation with the Maintenance Director on 09/11/18 at 11:28 a.m. then again at the Administrator have completed 11:36 a.m., the Central Supply room contained a walking rounds in the facility to door stop. Then again, the Activity Director's verify that no additional door stops office contained a door stop. Based on interview are being used in the facility at the time of each observation, the Maintenance 9/19/2018. Director confirmed each door was prevented from o All staff has been in serviced closing with a door stop. that door stops are not permissible and will not be allowed 3.1-19(b) in the facility on 9/19/2018. o How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; o All residents have the potential to be affected by the alleged deficient practice o The Maintenance Director/ Designee will add "Door stops" to the daily mechanical check sheet, which will identify if any door stops are being utilized in any locations throughout the facility.

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

91EZ21 Event ID:

Facility ID: 000338

o What measures will be into place or what systemic changes will be made to ensure that the

If continuation sheet

Page 31 of 33

PRINTED: 10/02/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155441	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/11/2018			
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 315 COUNTRY CLUB RD CORYDON, IN 47112					
(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)	5.112			
				o The Maintenance Directo Designee will add "Door stop the daily mechanical check s which will identify if any door are being utilized in any loca throughout the facility. o Specifically, any and all d stops will be removed by the Maintenance director or desi o Staff persons who utilize of stops in the facility will be summarily disciplined as the of door stops are identified. o How the corrective action will be monitored to ensure the deficient practice will not rece i.e., what quality assurance program will be put into place o The results of the daily mechanical check sheet will reviewed at the monthly Qua Assurance Meeting for a per six months to allow for tracki and trending, recommendation the committee and follow-up further trends are identified be committee after the six-mont period of review, the commit will then review the audit too an as needed basis. The Executive Director/ Designee ensure that the recommendation of the committee are comple allow for regulatory compliant	r/ ps" to sheet, estops tions oor gnee. door use (s) he ur, e be ality iod of ng pns by . If no by the h tee ls on e will ations ted to			
			1	i				

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

Event ID:

91EZ21

Facility ID: 000338

If continuation sheet

Page 32 of 33

PRIN'

PRINTED: 10/02/2018

FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155441		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 09/11 /	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 315 COUNTRY CLUB RD CORYDON, IN 47112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE
				By what date the systemic changes will be completed 10/11/2018 Facility requests desk revie lieu of revisit	ew in	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 91EZ21 Facility ID: 000338 If continuation sheet Page 33 of 33