	T OF HEALTH AND HUI R MEDICARE & MEDIC							10/26/2023 PROVED 938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155720 B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023					
	NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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	COMP	(X5) PLETION ATE
E 0000	conducted by the In accordance with 42 Survey Date: 10/02 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency	2/23 00315 155720	E 00	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specif findings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact request that the plan of correct be considered our allegation of compliance effective November 1.	eerve s or sility tion		

The facility has a capacity of 65 certified beds and had a census of 52 at the time of this visit.

Quality Review completed on 10/11/23

compliance with Emergency Preparedness

Requirements for Medicare and Medicaid

Participating Providers and Suppliers, 42 CFR

The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:

E 0004 SS=F Bldg. --

403.748(a), 416.54(a), 418.113(a),

441.184(a), 482.15(a), 483.475(a), 483.73(a),

484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a),

491.12(a), 494.62(a)

Develop EP Plan, Review and Update

Annually

483.73

§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a),

§483.73(a), §483.475(a), §484.102(a),

\$485.68(a), \$485.625(a), \$485.727(a)

§485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),

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

TITLE

1st, 2023 to the survey completed

respectfully request a paper review

and will provide any additional information requested.

on October 2nd, 2023. We

(X6) DATE

Allision Betz HFA 10/26/2023

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED 10/02/2023	
	OF PROVIDER OR SUPPLIES		52	reet address, city, state, z 0 W 9TH ST .SPER, IN 47546	ZIP COD	
(X4) II PREFI TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CACH. (EACH CORRECTIVE ACTICATION OF CACH.) (EACH CORRECTIVE ACTICATION OF CACH.)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	Federal, State an preparedness recomprehensive e program that mee section. The eme program must incomprehensive en program must incomprehensive en program must incomprehensive en program must incomprehensive en preparedness pland updated at length and updated at length en preparedness recomprehensive en program that mee section, utilizing an end updated at length en preparedness pland updated and updated at length en preparedness pland updated at length en preparedness pland updated and updated at length en preparedness pland updated at length en preparedness plan	an. The [facility] must stain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must stain an emergency in that must be reviewed,				

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Event ID:

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Facility ID: 000315

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2023			
	PROVIDER OR SUPPLIEF		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	
(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)	(X5) COMPLETION DATE
	failed to develop an preparedness plan t at least annually in 483.73(a). This del residents in the faci Findings include: Based on review of 10/02/23 between 8 Maintenance Direct provide an emerger however, it has not during the past twel date of most recent Furthermore, there at the front of the bout follow the order Based on interview Maintenance Direct date provided in the show it has been repast twelve months Maintenance Direct book did not match	the Fire and Disaster Plan on :45 a.m. and 12:30 p.m. with the cor present, the facility did acy preparedness manual, been reviewed and updated eve months. There was no review and update found. was a table of contents located book, however, the book did or of the table of contents. at the time of review, the cor confirmed there was no experience and Disaster Plan to wiewed and updated within the cor agreed the order of the table of contents.	E 0004	The correction action taken is those residents found to be affected by the deficient practiculude: No residents were found to be affected by the deficient practicular of the potential to be affected have been identified by: Potentially all residents could affected but none were identified by: The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The Administrator/Maintenand Director is responsible for ensurable of contents matches the order of the book. The disaster plan has been updated and reviewed. The corrective action taken monitor performance to assist compliance through quality assurance is: The Administrator, or designed will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed updated, and the table of contents after the contents appropriately reviewed updated, and the table of contents appropriately reviewed updated, and the table of contents after the contents appropriately reviewed updated, and the table of contents appropriately reviewed updated.	ctice eice. be ide. ctinto ecur ce suring s d the er to ure ee, g s and

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Event ID:

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	OF CORRECTION OF CORRECTION 155720 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023
	PROVIDER OR SUPPLIER DRAL HEALTH CARE CENTER	520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	
(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
			matches the order of the book The Quality Assurance Comm will review the disaster preparedness policy a minimu annually or more often if chan for compliance with recommendations as needed. The date the systemic chan will be completed.	inittee im of ges
E 0013 SS=F Bldg	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures		November 1st, 2023	
	§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).			
	(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.			
	*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must			

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	OF CORRECTION	IDENTIFICATION NUMBER 155720	 JILDING	NSTRUCTION	COMPL 10/02/	ETED
	PROVIDER OR SUPPLIER		520 W 9	ADDRESS, CITY, STATE, ZIP COD OTH ST R, IN 47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAG	develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe reviewed and uthe *Additional Requires ESRD Facilities: *[For PACE at §46 procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe address managen nonmedical emergimited to: Fire; equilities failure; care-related disasters likely to safety of the particular the policies and previewed and upd *[For ESRD Facilitiand procedures. In the policies and preparedness poli on the emergency (a) of this section,	ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually. The ments for PACE and 100.84(b):] Policies and PACE organization must the ment emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and opencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. The dialysis facility must	TAG	DEFICIENCY)		DATE
	communication plants section. The police	an at paragraph (c) of this lies and procedures must updated at least every 2				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023
	PROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	
(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
	not limited to, fire, failures, care-relat supply interruption	rgencies include, but are equipment or power ed emergencies, water n, and natural disasters ne facility's geographic			
	Based on record reverse failed to develop and preparedness policies and proced updated at least and CFR 483.73(b). The all residents in the failer friendings include: Based on review of 10/02/23 between 8 Maintenance Direct documentation in the procedures, however have not been review most recent twelve date of most recent twelve date of most recent Based on interview Maintenance Direct and procedures port Plan had been review past twelve months, no review and update of the procedure of the pr	the Fire and Disaster Plan on :45 a.m. and 12:30 p.m. with the or present, there was the plan for facility policies and the policies and procedures wed by the facility within the month period. There was no review and update found. at the time of review, the or said he thought the policies ion of the Fire and Disaster wed and updated within the however, agreed there was the information found.	E 0013	The correction action taken those residents found to be affected by the deficient prainclude: No residents were found to be affected by the deficient pract. Other residents that have to potential to be affected have been identified by: Potentially all residents could affected but none were identified by: The measures or systematic changes that have been put place to ensure that the deficient practice does not a include: The Administrator/Maintenar Director is responsible for ensure that the fire and disaster plan policies and procedures are reviewed annually. The corrective action taken monitor performance to associate compliance through quality assurance is: The Administrator, or designwill be responsible for ensuring that the fire and disaster plan and disaster plan that the fire and disaster plan that the fir	e tice. he e d be fied. ic tinto recur nce suring

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	ľ	JILDING	NSTRUCTION	(X3) DATE COMPL 10/02/	ETED
	PROVIDER OR SUPPLIER			520 W 9	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546		
(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
					policies and procedures are reviewed annually. The Quali Assurance Committee will reviewed the disaster preparedness poliminimum of annually or more if changes for compliance with recommendations as needed. The date the systemic chanwill be completed.	iew licy a often	
E 0015 SS=C Bldg	(1), 482.15(b)(1), 485.625(b)(1) Subsistence Need §403.748(b)(1), §4 §441.184(b)(1), §4 §483.73(b)(1), §48 [(b) Policies and p must develop and preparedness poli on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and preparedness poli on the following: (1) The provision of staff and patients shelter in place, in to the following:	3.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), Is for Staff and Patients 418.113(b)(6)(iii), 460.84(b)(1), §482.15(b)(1), 33.475(b)(1), §485.625(b)(1) rocedures. [Facilities] implement emergency cies and procedures, based in plan set forth in paragraph risk assessment at of this section, and the ean at paragraph (c) of this cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address of subsistence needs for whether they evacuate or include, but are not limited			November 1st, 2023		

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023
	F PROVIDER OR SUPPLIEF		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	
(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
	supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency lig (C) Fire detections systems. (D) Sewage and w *[For Inpatient Ho Policies and proce (6) The following a for hospice-operation only. The policies address the follow (iii) The provision hospice employee they evacuate or a are not limited to the (A) Food, water, in supplies. (B) Alternate sour the following: (1) Temperatures and safety and for storage of provision (2) Emergency lig (3) Fire detection, systems. (C) Sewage and w	to protect patient health the safe and sanitary ons. Inhting. Inhting. In extinguishing, and alarm the safe at §418.113(b)(6)(iii):] Inducedures. In ear additional requirements and procedures must ving: In of subsistence needs for ear and patients, whether is helter in place, include, but the following: In edical, and pharmaceutical to protect patient health the safe and sanitary ons. Inhting. In extinguishing, and alarm the vaste disposal.			
	failed to ensure eme and procedures incl provision of subsist residents, whether t place, include, but a (i) Food, water, me	view and interview, the facility ergency preparedness policies ude at a minimum, (1) The tence needs for staff and hey evacuate or shelter in are not limited to the following: dical, and pharmaceutical ate sources of energy to	E 0015	The correction action taken to those residents found to be affected by the deficient practinclude: No residents were found to be affected by the deficient praction. Other residents that have the	ctice ce.
1	auppires. (II) AIRTH	are sources or energy to	1	I Guier residents that have th	□

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLE	ETED	
		155720	B. WI	NG		10/02/2	2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIEF	8		520 W 9				
CATHED	RAL HEALTH CAR	RE CENTER			R, IN 47546			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		peratures to protect resident			potential to be affected have			
		nd for the safe and sanitary			been identified by:			
		ns; (B) Emergency lighting; (C)						
		nguishing, and alarm systems;			Potentially all residents could			
		d waste disposal in accordance			affected but none were identifi	ed.		
		3(b)(1). This deficient practice						
	could affect all occupants. Findings include:				The measures or systematic			
					changes that have been put	into		
					place to ensure that the			
					deficient practice does not re	ecur		
	Based on review of the Fire and Disaster Plan on				include:			
		10/02/23 between 8:45 a.m. and 12:30 p.m. with the						
	Maintenance Director present, the plan provided				The Administrator/Maintenand			
	did not address medical, pharmaceutical supplies, and the loss of sewage and waste disposal to				Director is responsible for ens	-		
		-			that the disaster plan meets th			
	-	alth and safety in an			requirements. Documents added to disaster plan.			
		on interview at the time of			to disaster plan.			
		Maintenance Director			The second discount of the second second	4-		
	-	provided did not address utical supplies, and the loss of			The corrective action taken to			
	-	lisposal to protect residents			monitor performance to assure compliance through quality			
	health and safety in							
	-	- 1			assurance is:			
		viewed with the Maintenance			The Administrator, or designe	:e,		
	Director during the	exit conference.			will be responsible for ensuring	_		
					that the disaster preparedness			
					plan is appropriately reviewed	and		
					updated. The Quality Assuran	ce		
					Committee will review the disa			
					preparedness policy a minimu			
					annually or more often if chang	ges		
					for compliance with			
					recommendations as needed.			
					The date the systemic chang	ges		
					will be completed.			
					November 1st, 2023			

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	OF CORRECTION	IDENTIFICATION NUMBER 155720	 UILDING	NSTRUCTION	COMP1	
	PROVIDER OR SUPPLIER		520 W 9	DDRESS, CITY, STATE, ZIP COD DTH ST R, IN 47546		
(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 I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
E 0020 SS=C Bldg	403.748(b)(3), 416 441.184(b)(3), 485 483.73(b)(3), 485. 485.727(b)(1), 486 494.62(b)(2) Policies for Evac. §403.748(b)(3), §4 (ii), §441.184(b)(3) (3), §483.73(b)(3), (1), §485.625(b)(3) §485.920(b)(2), §4 [(b) Policies and p must develop and preparedness poli on the emergency (a) of this section, paragraph (a)(1) ocommunication pla section. The polici reviewed and upda [annually for LTC the policies and pr the following:] [(3) or (1), (2), (6)] [facility], which inca and treatment need responsibilities; tra of evacuation loca alternate means of external sources of *[For RNHCIs at § §416.54(b)(2):] Safe evacuation fr which includes the	6.54(b)(2), 418.113(b)(6)(ii), 2.15(b)(3), 483.475(b)(3), 625(b)(3), 485.68(b)(1), 5.920(b)(2), 491.12(b)(1), and Primary/Alt. Comm. 416.54(b)(2), §418.113(b)(6) (2), §460.84(b)(3), §482.15(b) (2), §483.475(b)(1), §485.727(b)(1), 191.12(b)(1), §494.62(b)(2) (2) (3) (3) (4) (4) (4) (4) (4) (5) (4) (5) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6				

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CENTERS FO	OR MEDICARE & MEDIC				OMB NO. 0938-039		
	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER 155720	B. WING		COMPLETED 10/02/2023		
	PROVIDER OR SUPPLIED DRAL HEALTH CAF		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	(X5)		
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
	(v) Primary and a communication wassistance. * [For CORFs at § Rehabilitation Age §485.727(b)(1), a §494.62(b)(2):] Safe evacuation for Rehabilitation Age Agencies as Prove Therapy and Spe Services; and ES includes staff respective patients. * [For RHCs/FQH evacuation from to include appropriest affect responsibilities patients. Based on record refailed to ensure emand procedures included appropriest affect and procedures included appropriest and procedures included appropriest and procedure	of evacuation location(s). Iternate means of ith external sources of Iternate means of ith external sources of Iternate means of ith external sources of Iternate means of Ite	E 0020	The correction action taken those residents found to be affected by the deficient prainclude: No residents were found to be affected by the deficient pract Other residents that have the potential to be affected have been identified by: Potentially all residents could affected but none were identified to the measures or systematic changes that have been put place to ensure that the	ctice e eice. he e fied.		

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evacuation plan within the Fire and Disaster Plan,

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deficient practice does not recur

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u></u>	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIER		520	EET ADDRESS, CITY, STATE, ZIP COE W 9TH ST SPER, IN 47546)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	JLD BE COMPLETION	
	however, the follow a. One of the facilit was the 10th Street longer in existence. b. The procedures of the evacuation of a facility is a two sto Based on interview the Maintenance Di discrepancies in the the Fire and Disaste	ring was noted: ry's listed as an evacuation site School in Jasper, which is no of evacuation do not discuss multi-story building. This ry facility with a basement. at the time of record review, rector acknowledged the evacuation procedures within r Plan.		include: The Administrator/Maint Director is responsible for that the disaster prepared plan is accurate. Disaster ensure no longer states of street school as evacuation and multi-story building ended into plan. The corrective action to the monitor performance to compliance through quassurance is: The Administrator, or derived will be responsible for enthat the disaster prepared plan is appropriately revieu pdated. The Quality Asson Committee will review the preparedness a minimum annually or more often if for compliance with recommendations as need. The date the systemic will be completed. November 1st, 2023	enance or ensuring dness or to 10th ion site evacuation aken to o assure eality esignee, issuring dness ewed and surance e disaster in of changes eded.	
E 0025 SS=C Bldg	482.15(b)(7), 483. 485.625(b)(7), 485 Arrangement with §403.748(b)(7), §4	118.113(b)(5), §441.184(b) , §482.15(b)(7), §483.73(b)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CURRECTION	155720	B. W			10/02/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2		520 W 9			
CATHED	RAL HEALTH CAR	RE CENTER			R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG	§485.920(b)(6), §4	R LSC IDENTIFYING INFORMATION 494 62(b)(6)		TAG	Dirichi. (C.)		DATE
	3400.020(0)(0), 3	434.02(8)(0).					
	[(b) Policies and p	procedures. The [facilities]					
	must develop and	implement emergency					
	preparedness policies and procedures, based on the emergency plan set forth in paragraph						
	. ,	risk assessment at of this section, and the					
		an at paragraph (c) of this					
	I	cies and procedures must					
		updated at least every 2					
	years [annually for LTC facilities]. At a						
	minimum, the policies and procedures must						
	address the follow	ving:]					
		§418.113(b), PRFTs at					
	_ , ,	pitals at §482.15(b), and §483.73(b):] Policies and					
	_	r (5)] The development of					
	. , , -	h other [facilities] [and]					
	other providers to	receive patients in the event					
		essation of operations to					
		nuity of services to facility					
	patients.						
	*[For PACE at §46	60.84(b), ICF/IIDs at					
		ls at §486.625(b), CMHCs					
	- ' '	d ESRD Facilities at					
	\ , , -	ies and procedures. (7) [or					
	` ' ` ` ' -	lopment of arrangements es] [or] other providers to					
	_	the event of limitations or					
		ations to maintain the					
	l	ces to facility patients.					
	*[For RNHCls at §	§403.748(b):] Policies and					
	procedures. (7) Ti	he development of					
	_	h other RNHCIs and other					
	1 '	ve patients in the event of					
	I limitations or cess	sation of operations to	1				I

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155720	B. W	_		10/02/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					9TH ST		
CATHED	RAL HEALTH CAR	E CENTEK		JASPE	R, IN 47546		
(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
		nuity of non-medical					
	services to RNHC	view and interview, the facility	E 0	025	The correction action taken	for	11/01/2023
		ergency preparedness policies		023	those residents found to be	The correction action taken for	
		ude the development of			affected by the deficient pra	ctice	
	-	other LTC facilities and other			include:		
		e residents in the event of			No residents were found to be	;	
	limitations or cessar	tion of operations to maintain			affected by the deficient pract	ice.	
		rvices to LTC residents in					
	accordance with 42 CFR 483.73(b)(7). This				Other residents that have the		
	deficient practice could affect all occupants.				potential to be affected have	•	
					been identified by:		
	Findings include:						
	Dagad on ravious of	the Fire and Safety Plan on			Potentially all residents could affected but none were identif		
		:45 a.m. and 12:30 p.m. with the			affected but notile were identifi	iea.	
		for present, documentation of			The measures or systematic	_	
		dness policies and procedures		changes that have been put into			
		opment of arrangements with			place to ensure that the		
		and other providers to receive			deficient practice does not r	ecur	
	residents in the ever	nt of limitations or cessation			include:		
	-	vailable for review, however,					
		on the list was the 10th Street			The Administrator/Maintenan		
		longer in existence. Based on			Director is responsible for ens	_	
		e of record review, the			that the disaster preparedness		
		for agreed the documentation			plan is accurate. Disaster plan		
	corrected and updat	th other facilities needs to be			updated with correct facilities.		
	corrected and updat	.cu.			The corrective action taken	to	
	This finding was re	viewed with the Maintenance			monitor performance to ass		
	Director during the				compliance through quality	🕶	
					assurance is:		
					The Administrator, or designed	ee,	
					will be responsible for ensurin	-	
					that the disaster preparedness		
					plan is appropriately reviewed		
					updated. The Quality Assuran		
					Committee will review the disa		
1					preparedness at a minimum of	1	I

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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)	DATE		
				annually or more often if chan for compliance with recommendations as needed.			
				The date the systemic chan will be completed.	ges		
				November 1st, 2023			
E 0029 SS=F Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62(c) Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §485.6 §485.68(c), §485.6 §485.920(c), §486 §494.62(c). (c) The [facility] mu an emergency pre plan that complies local laws and mu	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					
	Based on record rev failed to develop an preparedness comm with Federal, State, and updated at least	iew and interview, the facility d maintain an emergency unication plan that complies and local laws was reviewed annually in accordance with This deficient practice could	E 0029	The correction action taken those residents found to be affected by the deficient prainclude: No residents were found to be affected by the deficient practi	ctice		
	Findings include:			Other residents that have the potential to be affected have been identified by:			
	Based on review of	the Fire and Disaster Plan on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155720		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING COMPLE B. WING 10/02/2			ETED		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OF 10/02/23 between 8 Maintenance Direct provided did includ maintain an emerge communication plat State, and local law plan has not been rethe most recent twe no date of most recent maintenance Direct Plan's communicati and updated within	R LSC IDENTIFYING INFORMATION 3:45 a.m. and 12:30 p.m. with the tor present, the facility's plan the a plan to develop and tency preparedness on that complies with Federal, see, however the communication the eviewed by the facility within the month period. There was tent review and update found. The eview and update found at the time of review, the tor said the Fire and Disaster on plan has not been reviewed the past twelve months. The eviewed with the Maintenance			Potentially all residents could affected but none were identification to the measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The Administrator/Maintenane Director is responsible for ensure that the disaster preparedness communication plan disaster is reviewed annually. The plan heen updated and reviewed. The corrective action taken monitor performance to assist compliance through quality assurance is: The Administrator, or designed will be responsible for ensuring that the disaster preparedness communication plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disast preparedness communication a minimum of annually or more often if changes for compliance with recommendations as need. The date the systemic change will be completed.	be ed. cinto cecur ce uring s sas to ure e, g s	
					November 1st, 2023		

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ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			ON	IB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMPI	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIE		520 W	address, city, state, zip coe 9TH ST R, IN 47546)		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 0036 SS=F Bldg	403.748(d), 416.4 441.184(d), 482.484.102(d), 485.485.727(d), 485.4 491.12(d), 494.6 EP Training and §403.748(d), §418.441.184(d), §48.5 §485.68(d), §48.5 §485.920(d), §48.5 §485.920(d), §48.5 §494.62(d). *[For RNCHIs at Hospice at §418.PACE at §460.84 HHAs at §484.10 CAHs at §486.62 485.727, CMHCs §486.360, and R Training and test develop and main preparedness trathat is based on in paragraph (a) assessment at passessment at passessmen	54(d), 418.113(d), 15(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 920(d), 486.360(d), 2(d)	IAG			DATE	

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(a)(1) of this section, policies and procedures at paragraph (b) of this section, and the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING		COMPL	
		155720	B. WIN	NG		10/02/	2023
	PROVIDER OR SUPPLIER			520 W 9	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546		
-				1	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		an at paragraph (c) of this		IAG			DATE
	section. The training and testing program must be reviewed and updated at least annually.						
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i).	D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every and updated at least every evacuation drills and training ties at §494.62(d):] and orientation. The last develop and maintain an					
	emergency prepart and patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at para and the communic of this section. The	redness training, testing ation program that is based r plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) ne training, testing and m must be evaluated and					
	Based on record rev failed to develop an preparedness trainin was reviewed and u	view and interview, the facility d maintain an emergency ng and testing program that updated at least annually in CFR 483.73(d). This deficient	E 00	36	The correction action taken to those residents found to be affected by the deficient practinclude: No residents were found to be affected by the deficient practic	ctice	11/01/2023

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLE	
		155720	B. W	/ING		10/02/2	2023
NAME OF P	PROVIDER OR SUPPLIER	- !			ADDRESS, CITY, STATE, ZIP COD 9TH ST		
CATHED	RAL HEALTH CAR	E CENTER			R, IN 47546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
	Findings include:				Other residents that have the	-	
	D 1	ed E' 1D' (N			potential to be affected have)	
		the Fire and Disaster Plan on :45 a.m. and 12:30 p.m. with the			been identified by:		
		for present, there was			Potentially all residents could	bo	
		lable to show the facility had			affected but none were identif		
		aredness training and testing			ansolog pat hone were identifi		
		he training and testing			The measures or systematic	c	
	program has not been reviewed by the facility				changes that have been put		
		ent twelve month period.			place to ensure that the		
	There was no date of	of most recent review and			deficient practice does not r	ecur	
	-	ed on interview at the time of			include:		
		nance Director said the Fire and					
		ing and testing program has			The Administrator/Maintenan		
		and updated within the past			Director is responsible for ens	-	
	twelve months.				that the disaster preparedness	S	
	This finding was re	viewed with the Maintenance			plan training and testing is reviewed annually. The disast	or	
	Director during the				plan training and testing has b		
	Director during the	call conference.			updated and reviewed.	Jeen	
					The corrective action taken	to	
					monitor performance to ass		
					compliance through quality		
					assurance is:		
					The Administrator, or designe	ee,	
					will be responsible for ensurin	g	
					that the disaster preparedness	s	
					plan training and testing is		
					appropriately reviewed and		
					updated annually. The Quality	I	
					Assurance Committee will rev		
					the disaster preparedness train and testing a minimum of ann	-	
					or more often if changes for	ually	
					compliance with recommenda	itions	
					as needed.		
					The date the systemic chan	ges	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155720		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
K 0000				will be completed. November 1st, 2023	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/02 Facility Number: 0 Provider Number: 1002 At this Life Safety Care Center was for Requirements for Power Medicare/Medicaid Life Safety from Fir National Fire Protectife Safety Code (Life Safety Code (Life Safety Code) This two story facility determined to be of was fully sprinklere system with hard we corridors, spaces op resident sleeping rocapacity of 65 and hof this survey. All areas where residence are sprinklered and survey in the survey were sprinklered and survey.	00315 155720 289030 Code survey, Cathedral Health und not in compliance with	K 0000	By submitting the enclosed materials, we are not admittruth or accuracy of any sp findings or allegations. We the right to contest the find allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations. The request that the plan of compliance effective Nove 1st, 2023 to the survey come on October 2nd, 2023. We respectfully request a paper and will provide any addition information requested.	etting the pecific reserve lings or lesse facility rection on of lember mpleted recreive review

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 01 COMPLET: B. WING 10/02/20			ETED	
	ROVIDER OR SUPPLIER		•	520 W 9	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546		
(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 APPROPRIAT	TF	(X5) COMPLETION
TAG	REGULATORY OR building, and a gree	LSC IDENTIFYING INFORMATION nhouse.		TAG	DEFICIENCY)		DATE
	Quality Review con	npleted on 10/11/23					
K 0211 SS=B Bldg. 01	NFPA 101 Means of Egress - Means of Egress - Aisles, passageward discharges, exit lo in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of corridors were controbstructions. This of 20 or more residents. Findings include: Based on observation the Maintenance Dissetting in the main 1 water fountain. The time of observation the wall or floor. B observation, the Maacknowledged the corridor and not corfloor and not in use	General Age, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1. 10.1 In and interview, the facility is exit means of egress inuously maintained free of deficient practice could affect s, as well as staff and visitors. In an on 10/02/23 between 12:30 during a tour of the facility with rector, there was a chair evel west corridor next to the e chair was not in use at the and was not connected/tied to ased on interview at the time of intenance Director hair being stored in the mected/tied to the wall or at the time of observation.	K 02	211	The correction action taken if those residents found to be affected by the deficient practiculude: No residents were found to be affected by the deficient practiculude: Other residents that have the potential to be affected have been identified by: Potentially all residents could affected but none were identified. The measures or systematicular changes that have been put in place to ensure that the deficient practice does not resinclude: The Administrator/Maintenand Director is responsible for ensut that the means of egress are in	ctice ce. be ed. cinto ecur	11/01/2023
	3.1-19(b)				place. A chair setting in main le west corridor by telephone not	evel	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIED		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY 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
				being utilized. The chair was removed. Signs posted.	
				The corrective action taken monitor performance to assi compliance through quality assurance is:	
				An audit will be completed by maintenance or designee on a means of egress weekly. Any negative findings will be immediately remedied, and administrator notified. The resof these audits will be reviewe the Quality Assurance Commitmentally in the Quality Assurant Meeting. The date the systemic change.	sults d by ttee nce
				will be completed.	yes
K 0222 SS=F Bldg. 01	be equipped with requires the use of egress side unless special locking ar CLINICAL NEEDS LOCKING Where special locklinical security not used, only one lockling permitted on each be made for the research.	ed means of egress shall not a latch or a lock that of a tool or key from the s using one of the following rangements: S OR SECURITY THREAT cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all		November 1st, 2023	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155720	B. W	NG		10/02	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		520 W 9			
CATHED	RAL HEALTH CAR	E CENTER			R, IN 47546		
(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		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	· ·	ied by staff at all times; or					
		e means available to the					
	staff at all times.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	LOOKINO					
	SPECIAL NEEDS LOCKING ARRANGEMENTS						
	Where special locking arrangements for the						
	· ·						
		e patient are used, all of curity Locking requirements					
		addition, the locks must be					
	-	at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
		by a complete smoke					
		(or is constantly monitored					
	_	ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
	Approved, listed of	lelayed-egress locking					
	systems installed	in accordance with					
	7.2.1.6.1 shall be	permitted on door					
	assemblies servin	g low and ordinary hazard					
	contents in building	igs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle	-					
	18.2.2.2.4, 19.2.2						
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2						
	ELEVATOR LOBE	BY EXIT ACCESS					

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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 10/02/2023 155720 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 520 W 9TH ST CATHEDRAL HEALTH CARE CENTER JASPER. IN 47546 (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 LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the K 0222 The corrective action taken for 11/01/2023 facility failed to ensure the means of egress those residents found to be through 13 of 13 exits was readily accessible for affected by the deficient practice residents without a clinical diagnosis requiring include. specialized security measures. Doors within a No residents were found to be required means of egress shall not be equipped affected by the deficient practice. with a latch or lock that requires the use of a tool or key from the egress side unless otherwise How other residents that have permitted by LSC 19.2.2.2.4. Door-locking the potential to be affected by arrangements shall be permitted in accordance the same defective practice will with 19.2.2.2.5.2. This deficient practice could be identified and what affect all residents staff and visitors needing to corrective action(s) will be exit the facility. taken: Findings include: Potentially all residents could be affected but none were identified. Based on observations on 10/02/23 between 12:30 p.m. and 3:15 p.m. during a tour of the facility with What measures will be put into the Maintenance Director, all ten exit doors place and what systemic (stairway and outside exit doors) were posted with changes will be made to ensure the incorrect code to actuate the door release. that the deficient practice does The Maintenance Director was able to open the not recur: door with the correct code. Furthermore, the west stairway access door on the main level was All egress doors were checked. equipped with a magnetic lock with a keypad and Doors updated with correct code the code was not posted. Based on interview at to actuate the door release

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the time of each observation, the Maintenance

beginning of each month but the first day of October was over the weekend and he was

preparing to change the codes today, furthermore,

Director said he changes the code at the

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monthly.

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posted. Doors code to be changed

How the corrective action(s)

will be monitored to ensure the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		155720	B. W	ING		10/02/	2023
NAME OF T	DOLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>C</u>		520 W 9			
	RAL HEALTH CAR	E CENTER		JASPE	R, IN 47546		
(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 rector said he was not sure		TAG			DATE
		ot posted at the main level			deficient practice will not red i.e., what quality assurance	Jui,	
	west stairway acces	-			program will be put into place	e.	
		3 4001.			program will be put little place		
	These findings were	e reviewed with the			An audit will be completed by		
	Maintenance Director during the exit conference.				maintenance or designee on a	all	
					egress doors monthly. Any		
	3.1-19(b)				negative findings will be		
	2 DJ 1	ain and incoming of			immediately remedied, and	14 -	
		ation and interview, the sure 1 of 13 exit door			administrator notified. The res of these audits will be reviewe		
	•	eypads was not located			the Quality Assurance Commi		
		d 40 to 48 inches vertically			monthly in the Quality Assurar		
	_	FPA 101 at 19.2.2.2.4(3) refers			Meeting.		
		s-Controlled Egress Door			9		
	assemblies installed	in accordance with 7.2.1.6.2					
	-	7.2.1.6.2(3)(a) states the					
		ce shall be located on the			The date the systemic chang	ges	
	-	o 48 in. vertically above the			will be completed:		
		t practice could affect at least					
	20 residents, as well	l as staff and visitors.			November 1st, 2023		
	Findings include:						
	Based on observation	on on 10/02/23 between 12:30					
		during a tour of the facility with					
		rector, the access-controlled					
	keypad on the main	level inside the west stairwell					
		oor was located on the wall at					
	•	pove the floor to the bottom of					
		as 12 inches over the required					
	_	Based on interview at the time of					
		intenance Director agreed the					
	keypad was placed	io ingii on inc wan.					
	These findings were	e reviewed with the					
	Maintenance Direct	or during the exit conference.					
	2.1.10(1)						
	3.1-19(b)						
			1				

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` ´		` ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING			COMPLETED 10/02/2023	
		155720	B. WIN	G		10/02/	2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
		ation and interview, the						
	-	sure the means of egress						
	_	ked exit doors was readily and residents, staff, and visitors.						
		ice could affect all residents,						
	-	visitors when the basement						
	Auditorium is used.							
	Findings include:							
	Based on observation	ons on 10/02/23 between 12:30						
	p.m. and 3:15 p.m. during a tour of the facility with							
	the Maintenance Director, the south exit door to							
	-	from the Auditorium required						
		when the door code was						
		ad. The magnetic locks did de was entered, however, the						
		ce several times to open.						
		at the time of observation, the						
		or acknowledged the exit door						
	required heavy force	_						
	This finding was re	viewed with the Maintenance						
	Director during the	exit conference.						
	3.1-19(b)							
K 0291	NFPA 101							
SS=C	Emergency Lightir	_						
Bldg. 01	Emergency Lightir	_						
		g of at least 1-1/2-hour						
	duration is provide	-						
	accordance with 7 18.2.9.1, 19.2.9.1	. y .						
		on and interview, the facility	K 029	91	The corrective action taken t	for	11/01/2023	
		f 10 battery powered	K 02	/1	those residents found to be affected by the deficient practice		11/01/2023	
		s was maintained in						
		C 7.9. LSC 7.9.2.6 states			include:			
	. –	ergency lights shall use only			No residents were found to be	;		
	reliable types of rec	hargeable batteries provided			affected by the deficient practi	ce.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<u>01</u>	COMPL	
		155720	B. WI	NG _		10/02/	2023
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CATHER					9TH ST		
CATHEDRAL HEALTH CARE CENTER		-	JASPE	R, IN 47546			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		ORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ties for maintaining them in					
		ondition. Batteries used in			How other residents that ha		
	_	shall be approved for their hall comply with NFPA 70			the potential to be affected by	-	
		Code. LSC 7.9.2.7 states the			the same defective practice be identified and what	WIII	
		g system shall be either			corrective action(s) will be		
		eration or shall be capable of			taken:		
		operation without manual			tunon.		
	*	deficient practice could affect			Potentially all residents could	be	
		ll as staff and visitors.			affected but none were identif		
	Findings include:				What measures will be put i	into	
					place and what systemic		
		ons on 10/02/23 between 12:30			changes will be made to ens	ure	
		during a tour of the facility with			that the deficient practice do	es	
		rirector, one of two battery			not recur:		
		ocated within the generator					
		lluminate when tested several			All emergency lightning checl		
		iterview at the time of			The only deficient battery back	-	
		aintenance Director agreed one			light set was within generator		
	1	cup light sets within the e did not illuminate when			enclosure. Battery backup light set corrected.	ıτ	
	tested several time				set corrected.		
	tested several time.	5.			How the corrective action(s	.)	
	This finding was re	eviewed with the Maintenance			will be monitored to ensure	-	
	Director during the				deficient practice will not rec		
					i.e., what quality assurance	,	
	3.1-19(b)				program will be put into place	ce:	
					,		
					An audit will be completed by	,	
					maintenance or designee on a	all	
					emergency lighting monthly. A	۱ny	
					negative findings will be		
					immediately remedied, and		
					administrator notified. The res		
					of these audits will be reviewe	-	
					the Quality Assurance Commi		
					monthly in the Quality Assuran	nce	
					Meeting.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		A. BUILDING <u>01</u> B. WING		COMPI	COMPLETED 10/02/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
K 0224	NEDA 404			The date the systemic c will be completed: November 1st, 2023	hanges			
K 0321 SS=F Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a do not exceed 48 if the door. Describe the floor hazardous areas the REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuelb. Laundries (large c. Repair, Mainten	are protected by a fire pur fire resistance rating rated doors) or an anguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. If closing or and permitted to have pplied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A Fired Heater Rooms er than 100 square feet) ance, and Paint Shops from (exceeding 64 in Rooms						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLET B. WING 10/02/20		PLETED			
		ROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 19TH ST ER, IN 47546		
TAG R f. Co (over		(EACH DEFICIEN REGULATORY OR f. Combustible Sto (over 50 square fe	classified as Severe	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETION DATE
		Based on observation failed to ensure 1 of basement area was material. This define mostly staff while in and visitors while in and visitors while in Findings include: Based on observation p.m. and 3:15 p.m. the Maintenance Dibasement area and obeing used to store as, cardboard boxes pallets, and a variety area was open to, an corridor. Based on observation, the Maitems have been remare still in the proceethe items.	on and interview, the facility of 1 egress corridor in the not used to store combustible cient practice could affect in the basement, plus residents in the adjacent Auditorium. Ons on 10/02/23 between 12:30 during a tour of the facility with rector, the main corridor in the outside the Auditorium was many combustible items, such , recliners, other old furniture, y of other storage items. This and a part of the egress interview at the time of intenance Director said some moved from this area and they ss of cleaning up the rest of wiewed with the Maintenance	K 0321	The corrective action taken those residents found to be affected by the deficient princlude: No residents or staff were for be affected by the deficient practice. How other residents that he the potential to be affected the same defective practice be identified and what corrective action(s) will be taken: Potentially staff and resident could be affected but none widentified. What measures will be purplace and what systemic changes will be made to enthat the deficient practice of not recur: Administrator/Maintenance director are responsible for ensuring the main corridor we gress is open. Main corridor we gress is open. Main corridor will be monitored to ensure deficient practice will not rive, what quality assurance program will be put into place.	e ractice und to nave by e will ts vere t into nsure does vithin or area	11/01/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOI	R MEDICARE & MEDIC	AID 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	ЛLDING	01	COMPL	LETED	
		155720	B. W	ING		10/02	/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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	ΔTE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer patients of the cooking facilities	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under			The Maintenance Director/designee will ensure items are in the main corridor weekly. The Quality Assurance Committee will review the disa preparedness policy a minimulannually or more often if chan for compliance with recommendations as needed. The date the systemic chan will be completed: November 1, 2023	area ce aster um of ages		

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Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLE	
		155720	B. WI	NG		10/02/2	2023
NAME OF A			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C	520 W 9TH ST				
	RAL HEALTH CAR	E CENTER		JASPE	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	be open to the co						
	_	1 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility		K 0	224	The corrective action taken i	for	11/01/2022
		If were instructed in the proper	K U.	324	those residents found to be	101	11/01/2023
		nood fire suppression system in			affected by the deficient pra	ctico	
		PA 96, Standard for Ventilation			include:		
		otection of Commercial			No residents were found to be	,	
	Cooking Operations, Section 10.5.7 states				affected by the deficient practi	I	
		provided to employees			l series by the deficient proof		
		r use of portable fire			How other residents that ha	ve	
		ne manual activation of			the potential to be affected b		
	_	equipment. Section 11.1.4 states			the same defective practice	-	
	instructions for manually operating the fire				be identified and what		
	extinguishing system	m shall be posted			corrective action(s) will be		
	conspicuously in th	e kitchen and shall be			taken:		
	_	loyees by management. This					
	_	ould affect kitchen staff plus		Potentially all residents could be			
	any residents while	in the adjacent main dining		affected but none were		ied.	
	room.						
					What measures will be put i	into	
	Findings include:				place and what systemic		
	Deceded 1	10/02/22 h.v. 12.20			changes will be made to ens		
		ons on 10/02/23 between 12:30			that the deficient practice do	es	
		during a tour of the facility with			not recur:		
		rector, the kitchen was 300 hood system. Based on			Education provided to all dist	on/	
	_	nen staff #1 (head cook), when			Education provided to all diet	aı y	
		ild do if there was a fire			personnel.		
		d. She said she didn't really			How the corrective action(s	,	
		aybe grab a fire extinguisher.			will be monitored to ensure	1	
		would pull the range hood fire			deficient practice will not rec		
	-	pull station, however, when			i.e., what quality assurance		
		w where it was located. This			program will be put into place	:e:	
	was acknowledged by the Maintenance Director						
		vation and interview with the			An audit will be completed by	,	
		ad cook). The Maintenance			maintenance or designee on		
	-	training for kitchen staff would			dietary personnel knowledge	of	
	be a priority.	-			hood system monthly. Any		
					negative findings will be		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720	A. BUILDING 01 B. WING	COMPLETED 10/02/2023			
NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	immediately remedied, and administrator notified. The re of these audits will be review the Quality Assurance Commonthly in the Quality Assurance Meeting.	red by nittee			
	The date the systemic cha will be completed: November 1st, 2023	nges			
	November 1st, 2023				
K 0353 SS=F Bldg. 01 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial					
automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection	K 0353 The corrective action taken those residents found to be	11/01/2025			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	TED	
		155720	B. W	ING		10/02/2	.023	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
					9TH ST			
CATHED	CATHEDRAL HEALTH CARE CENTER			JASPER, IN 47546				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
1110		with NFPA 25, 2011 Edition,			affected by the deficient pra	BIIIE		
					include:	Circe		
	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department				No residents were found to be			
	1 -				affected by the deficient pract	ice.		
		nspected quarterly to verify			l			
	the following:				How other residents that ha			
	(1) The fire department connections are visible and accessible.(2) Couplings or swivels are not damaged and rotate smoothly.(3) Plugs or caps are in place and undamaged.				the potential to be affected b	-		
					the same defective practice	will		
					be identified and what			
					corrective action(s) will be			
					taken:			
		lace and in good condition.						
	(5) Identification signs are in place.				Potentially all residents could	be		
	(6) The check valve	e is not leaking.			affected but none were identif	ied.		
	(7) The automatic d	lrain valve is in place and						
	operating properly.				What measures will be put i	into		
	(8) The fire departn	nent connection clapper(s) is in			place and what systemic			
	place and operating				changes will be made to ens	sure		
		ice could affect all occupants.			that the deficient practice do			
	1	•			not recur:			
	Findings include:				1.001.004.1			
					FDC signage was added to h	eln		
	Based on observation	ons on 10/02/23 between 12:30			the fire department identify	۹		
		during a tour of the facility with			location of connection.			
		rector, the facility's fire			location of confidention.			
		tion (FDC) was located on the			How the corrective action/s	,		
	_	ility. There was FDC signage			How the corrective action(s			
					will be monitored to ensure			
	_	department connection,			deficient practice will not re	cur,		
	· ·	no FDC signage at the front of			i.e., what quality assurance			
	_	responding fire department to			program will be put into place	ce:		
		OC for easy identification.						
		at the time of observation, this			An audit will be completed by			
		by the Maintenance Director			maintenance or designee on I			
	_	nould be FDC signage at the			signage for identifying location			
	front of the facility.				connection annually. Any neg	ative		
					findings will be immediately			
	This finding was re	viewed with the Maintenance			remedied, and administrator			
	Director during the	exit conference.			notified. The results of these			
					audits will be reviewed by the			

3.1-19(b)

Quality Assurance Committee

]	DEPARTMENT OF HEALTH AND HUMAN SERVICES							
•	CENTERS FOR MEDICARE & MEDICAID SERVICES							
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 10/02/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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)	DATE	
					monthly in the Quality Assurar Meeting. The date the systemic chang will be completed:		
K 0355 SS=E Bldg. 01	installed, inspecte	iguishers guishers are selected, d, and maintained in IFPA 10, Standard for iguishers.			November 1st, 2023		
	failed to inspect 3 or each month during to NFPA 10, Standard Section 7.2.1.2 state inspected either many electronic device/sy intervals. Section 7 or electronic monitor include a check of a (1) Location in design (2) No obstruction to (3) Pressure gauge roperable range or pot (4) Fullness determines elf expelling-type of cartridge-operated electronic monitor of the control of t	o access or visibility reading or indicator in the osition ned by weighing or hefting for extinguishers, xtinguishers, and pump tanks res, wheels, carriage, hose, and	K 0	355	The corrective action taken of those residents found to be affected by the deficient practiculate: No residents were found to be affected by the deficient practiculate. How other residents that has the potential to be affected by the same defective practice to be identified and what corrective action(s) will be taken: Potentially all residents could affected but none were identified. What measures will be put in place and what systemic.	ctice ce. ve y will be ed.	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2023					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
	(EACH DEFICIEN REGULATORY OR (6) Indicator for nor using push to-test p Section 7.2.4.1 state inspections shall ke extinguishers inspections shall ke extinguishers inspection require corrective as where at least mont conducted, the date performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a tax extinguisher, on an maintained on file, section 7.2.4.5 requiredemonstrate that at inspections have be practice could affect staff and visitors. Findings include: Based on observation p.m. and 3:15 p.m. the Maintenance Diemployee Break Regard the outside geninspected monthly in 2023. The annual in extinguishers by the performed in Februal interview at the time Maintenance Direct aforementioned por been inspected monthly or the performed in present aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforementioned por been inspected monthly in the maintenance Direct aforement on the maintenance Direct a	cy MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION prechargeable extinguishers ressure indicators. The precords of all fire exted, including those found to extion. Section 7.2.4.3 requires the manual inspections are the manual inspection was initials of the person ection shall be recorded. The person extensively manual inspections are gor label attached to the fire inspection checklist for by an electronic method. The person electronic method. The person extensively manual inspections are stated to the fire inspection checklist for by an electronic method. The person electronic method in the person electronic method. The person extensively manual inspection of the facility with rector, fire extinguishers in the form, Physical Therapy room, the person of all fire extinguishers of the person of all fire extinguishers of the person of all fire extinguishers had not the person of a person of		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	sure oes si the ecur, ce: y all gs will d esults eed by nittee ance			
	September of 2023. This finding was re Director during the	viewed with the Maintenance						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE CO A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 0363 SS=B Bldg. 01	3.1-19(b) NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mater hardware. Roller la CMS regulation. T apply to auxiliary s flammable or com Clearance betwee covering is not exi doors complying w if provided with a of the door closed wi applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be laf other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material gire for at least 20 fully sprinklered smoke only required to resist the c. Corridor doors and doors in glammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the ris. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Dutch doors of are permitted. Door opeled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments					
		ctions in area or fire s or frames in window					

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					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155720	B. WI	ING		10/02/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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
	483, and 485 Show in REMARK fire protection ratir devices, etc. Based on observation failed to ensure 2 of impediment to closi could affect mostly Findings include: Based on observation p.m. and 3:15 p.m. of the Maintenance Di office door and the both held open with interview at the time Maintenance Direct open with door wed	ons on 10/02/23 between 12:30 during a tour of the facility with rector, the Director of Nursing Staff Training room door were a door wedges. Based on e of each observation, the or both doors being held wide liges.	K 0	363	The corrective action taken at those residents found to be affected by the deficient practinclude: No residents were found to be affected by the deficient practice be identified and what corrective action(s) will be taken: Potentially all residents could affected but none were identified what measures will be put if place and what systemic changes will be made to ensith the deficient practice do not recur: All corridor doors were check Only 2 corridor doors had impediments to closing. Wedg removed from doors. How the corrective action(s) will be monitored to ensure a deficient practice will not recite, what quality assurance program will be put into place	ctice dice. ve Dy will be died. into cure des	11/01/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155720	B. WI	NG		10/02/	2023
NAME OF T	DOMINED OF STREET	D	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEI			520 W 9			
CATHED	RAL HEALTH CAR	RE CENTER		JASPEI	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		,	DATE
					An audit will be completed by maintenance or designee on a		
					corridor doors monthly. Any	ail	
					negative findings will be		
					immediately remedied, and		
					administrator notified. The res	sults	
					of these audits will be reviewe	d by	
					the Quality Assurance Commi		
					monthly in the Quality Assura	nce	
					Meeting.		
					The date the systemic chan	aes	
					will be completed:	goo	
					November 1st, 2023		
K 0374	NFPA 101						
SS=E		ilding Spaces - Smoke					
Bldg. 01	Barrie	- '					
		ilding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
		arriers are 1-3/4-inch thick					
		d-core doors or of resists fire for 20 minutes.					
		ve plates of unlimited height					
		ors are permitted to have					
	1	assemblies per 8.5. Doors					
		r automatic-closing, do not					
		and are not required to swing					
		egress travel. Door opening					
	I •	um clear width of 32 inches					
	for swinging or ho						
	19.3.7.6, 19.3.7.8		IZ O	274	The commention action to be a	fo	11/01/2022
		on and interview, the facility f 4 sets of smoke barrier doors	K 0.	5/4	The corrective action taken to those residents found to be	ror	11/01/2023

STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/02/2023
	PROVIDER OR SUPPLIED		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST .R, IN 47546	
	SUMMARY (EACH DEFICIEN REGULATORY OF would close completed barrier. LSC, Section barriers to close the minimum clearance which is defined as movement of smoke affect at least 20 revisitors. Findings include: Based on observation p.m. and 3:15 p.m. the Maintenance Deformed by the more service of the completely when the allow the completely when the completely whe	RE CENTER STATEMENT OF DEFICIENCIE REY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION etely to form a smoke resistant ion 19.3.7.8 requires that doors hall comply with LSC, Section in 8.5.4.1 requires doors in smoke to opening leaving only the te necessary for proper operation 1/8 inch to restrict the te. This deficient practice could sidents, as well as staff and ons on 10/02/23 between 12:30 during a tour of the facility with irector, the set of smoke barrier main level west unit and the on area did not close tested several times. There was ch gap between the entire when closed fully. This was the Maintenance Director at the interviewed with the Maintenance	520 W	9TH ST	ctice cce. ve by will be ded. nto ure bes
				How the corrective action(s) will be monitored to ensure to deficient practice will not red i.e., what quality assurance program will be put into place. An audit will be completed by maintenance or designee on a smoke barrier doors monthly, negative findings will be immediately remedied, and	the cur, re:

administrator notified. Updated

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/02/2023	
			STREET ADDRESS, CITY, STATE, ZIP COD			. 0, 02,	
NAME OF I	PROVIDER OR SUPPLIE	R		520 W 9			
CATHED	RAL HEALTH CAF	RE CENTER	_		R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0531 SS=C Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply Elevators are insy specified in ASMI Elevators and Es Service is operate record. Existing elevators A17.3, Safety Co and Escalators. A a travel distance below the level th emergency perso purposes, confort Requirements of (Includes firefight recall and smoke firefighter's service key operation, madetectors, and ele detectors.) 19.5.3, 9.4.2, 9.4. Based on record re	view, observation, and	K 0:	TAG	annual latch and gap inspection list. The results of these audits be reviewed by the Quality Assurance Committee months the Quality Assurance Meeting. The date the systemic change will be completed: November 1st, 2023	s will y in g. ges	11/01/2023
	interview; the facil	ity failed to accurately maintain			those residents found to be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/02/2023 155720 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 520 W 9TH ST CATHEDRAL HEALTH CARE CENTER JASPER. IN 47546 (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 testing documentation for 1 of 2 elevators affected by the deficient practice firefighter recall in accordance with 9.4.6, Elevator include: Testing. LSC 9.4.6.2 states that all elevators with No residents were found to be fire fighters' emergency operations in accordance affected by the deficient practice. with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and How other residents that have kept on the premises as required by ASME the potential to be affected by A17.1/CSA B44, Safety Code for Elevators and the same defective practice will Escalators. This deficient practice could affect all be identified and what residents, staff and visitors in the facility. corrective action(s) will be taken: Findings include: Potentially all residents could be Based on record review on 10/02/23 between 8:45 affected but none were identified. a.m. and 12:30 p.m. with the Maintenance Director present, there was documentation available for the What measures will be put into monthly firefighter recall test for the elevators for place and what systemic the past twelve months, however, the changes will be made to ensure documentation provided did not list two separate that the deficient practice does elevators. Based on interview at the time of not recur: record review, the Maintenance Director said the documentation provided for the testing of the Monthly firefighters recall test for firefighter recall was for the two elevators, but was both elevators was on one form. only documented once. Based on observations Each elevator will have its own on 10/02/23 between 12:30 p.m. and 3:15 p.m. form ongoing. during a tour of the facility with the Maintenance Director, both elevators were equipped with a How the corrective action(s) firefighter recall key operation at the main floor will be monitored to ensure the level. This was confirmed by the Maintenance deficient practice will not recur, Director at the time of each observation. i.e., what quality assurance program will be put into place: This finding was reviewed with the Maintenance Director during the exit conference. An audit will be completed by maintenance or designee on 3.1-19(b)elevator firefighters recall test monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the Quality Assurance Committee

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	(3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155720	B. WING			10/02/2	2023
	ROVIDER OR SUPPLIER			520 W 9	ADDRESS, CITY, STATE, ZIP COD OTH ST R, IN 47546		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROMISSING BY AN 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 APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	- L	DATE
					monthly in the Quality Assurant Meeting. The date the systemic change will be completed:		
					November 1st, 2023		
K 0761 SS=F Bldg. 01							
	interview; the facilitiannual inspection are fire door assemblies room door assembly with LSC 19.1.1.4.1 dividing fire barriers permitted only in comparative by approved self-clossic (See also Section 8. required to have a fix 8.3.4.2 shall be protabled fire door assemblies and their including all frames and sills in accordar NFPA 80, Standard Opening Protectives specified in this Cood door assemblies shall be sha	on, record review, and ty failed to ensure a complete and testing of 8 of 8 stairway s, and the oxygen transfilling y was completed in accordance 1.1. Communicating openings in s required by 19.1.1.4.1 shall be orridors and shall be protected cosing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table sected by approved, listed, semblies and fire window r accompanying hardware, s, closing devices, anchorage, nee with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both	K 07	761	The corrective action taken of those residents found to be affected by the deficient practiculude: No residents were found to be affected by the deficient practicular of the potential to be affected by the potential to be affected by the same defective practice who identified and what corrective action(s) will be taken: Potentially all residents could affected but none were identified. What measures will be put in place and what systemic changes will be made to ensith at the deficient practice do not recur: All smoke barrier doors were	ce. ve y will be ed. nto	11/01/2023
		verall condition of door			checked. Annual check chang	jed	

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		A. BUILDING	B. WING 10/02/2023		
	PROVIDER OR SUPPLIE		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	•
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF assembly. NFPA 80, 5.2.4.2 s following items sh		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) to show itemized list of the inspected that passed. All door assemblies checked.	DBE COMPLETION DATE items fire
	either the door or f (2) Glazing, vision are intact and secure equipped. (3) The door, frame noncombustible the	or breaks exist in surfaces of rame. light frames, and glazing beads rely fastened in place, if so e, hinges, hardware, and reshold are secured, aligned, ler with no visible signs of		How the corrective actio will be monitored to ensu deficient practice will not i.e., what quality assuran program will be put into p An audit will be completed maintenance or designee of smoke barrier doors and file	ure the t recur, ce place: d by on all
	(4) No parts are mi (5) Door clearance listed in 4.8.4 and 6 (6) The self-closing the active door con- from the full open (7) If a coordinator closes before the ac (8) Latching hardw door when it is in t	s do not exceed clearances 6.3.1.7. g device is operational; that is, expletely closes when operated position. exist installed, the inactive leaf extractive leaf. exarc operates and secures the		assemblies annually. Any if findings will be immediately remedied, and administrate notified. The results of the audits will be reviewed by Quality Assurance Commit monthly in the Quality Assurance Meeting.	negative y or ese the ttee
	frame. (10) No field modi have been perform (11) Gasketing and inspected to verify This deficient prac as well as staff, and Findings include: Based on record re a.m. and 12:30 p.m present, the facility documentation for	fications to the door assembly ed that void the label. I edge seals, where required, are their presence and integrity. Itice could affect all residents, it visitors. View on 10/02/23 between 8:45 in with the Maintenance Director was able to provide the annual inspection of all is smoke barrier door		The date the systemic ch will be completed: November 1st, 2023	hanges

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	TE SURVEY MPLETED 02/2023
	PROVIDER OR SUPPLIER		520 W 9	ADDRESS, CITY, STATE, ZIP (9TH ST R, IN 47546	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
I/ 0000	was only a "Pass" for door assemblies and the items inspected facility was unable to an annual inspection assemblies and 1 ox door assembly. Bas record review, the Mocumentation provand testing documentation provand testing documentation assemblies. Based of the facility with the between 12:30 p.m. stairway fire door as transfilling room fire facility. This finding was revoluted by the property of the facility.	r, the documentation provided or each set of smoke barrier I did not have a itemized list of that passed. Furthermore, the to provide documentation for nof 8 stairway fire door tygen transfilling room fire sed on interview at the time of Maintenance Director said the rided was the only inspection intation available for the esting of the facility's fire door on observations during a tour the Maintenance Director and 3:15 p.m., there were 8 seemblies and 1 oxygen the door assembly noted in the sexificaction with the Maintenance exit conference.				
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vir non-PCREE (e.g., except in long-terr do not use PCREE	ent - Power Cords and ent - Power Stript are only ent of movable delectrical equipment des that have been elified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), ent care resident rooms that E. Power strips for PCREE er UL 60601-1. Power strips				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	(outside of vicinity non-patient care re other UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (N	rowave oven, coffee maker, gged into a power strip in the som. tee maker plugged into a power gged into another power strip m.	K 0920	The corrective action taken those residents found to be affected by the deficient prainclude: No residents were found to be affected by the deficient practice be identified and what corrective action(s) will be taken: Potentially all residents could affected but none were identified and what taken: What measures will be put place and what systemic changes will be made to entit the deficient practice denot recur: Power strip removed in Direct Nursing office. Power strip removed in therapy room. Postrip removed in activity room.	e tice. ave by e will d be fied. into sure loes ctor of	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/02/2023
	ROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	
(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 CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) LD BE COMPLETION DATE
	three staff areas.	se of the power strips in the viewed with the Maintenance		How the corrective active will be monitored to ensideficient practice will not i.e., what quality assurate program will be put into. An audit will be completed maintenance or designee power strips monthly. Any negative findings will be immediately remedied, an administrator notified. The of these audits will be reverthe Quality Assurance Comporthly in the Quality Assumeting. The date the systemic of will be completed: November 1st, 2023	ure the of recur, nce place: d by on all d e results iewed by emmittee surance
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in according another is in according of High Oxygen Used for I any gas from one prohibited in patie to liquid oxygen occurainers over 50 under 11.5.2.3.1 (Transfilling Cylinders Transfilling Cylinders Gen from one cylinder to rdance with CGA P-2.5, In Pressure Gaseous Respiration. Transfilling of cylinder to another is Int care rooms. Transfilling Intainers or to portable In posi comply with conditions INFPA 99). Transfilling to ainers or to portable			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	G <u>01</u> C		ETED
		155720	B. WING 10/02/2023			2023	
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
		FOENTED			9TH ST		
CATHED	RAL HEALTH CAR	ECENTER		JASPE	R, IN 47546		
(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)	.12	DATE
	containers under s	50 psi comply with					
		11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99	• • •					
		on and interview, the facility	K 0	927	The corrective action taken	for	11/01/2023
		f 1 oxygen storage room where	110	721	those residents found to be		11/01/2023
		takes place, was provided			affected by the deficient pra-	ctice	
		igned mechanical ventilation			include:		
		ent practice could affect at			No residents were found to be	<u> </u>	
	least 20 residents, s				affected by the deficient practi		
	,						
	Findings include:				How other residents that ha	ve	
	8				the potential to be affected by		
	Based on observation	ons on 10/02/23 between 12:30			the same defective practice	-	
p.m. and 3:15 p.m. during a tour of the facility with					be identified and what		
	the Maintenance Di	•			corrective action(s) will be		
		room was equipped with a wall			taken:		
		ally vented exhaust fan,			tunen.		
		st vent fan was located on the			Potentially all residents could	he	
		the door and expelled the air			affected but none were identif		
		orage/transfilling room back			anotica par none were lacrian	iou.	
		dor. Based on interview at the			What measures will be put i	into	
	-	, the Maintenance Director			place and what systemic	,,,,	
		cally vented exhaust fan from			changes will be made to ens	ure	
		transfilling room should not			that the deficient practice do		
	be vented to the egr	C			not recur:		
	-8-						
	This finding was re	viewed with the Maintenance			Facility has had work comple	ted	
	Director during the				by local HVAC company to ha		
	<i>§</i>				oxygen storage/transfilling roc		
	3.1-19(b)				vented to outside of facility.		
]		
					How the corrective action(s)	
					will be monitored to ensure		
					deficient practice will not red	cur,	
					i.e., what quality assurance	-	
					program will be put into place	:e:	
					The Administrator, or designe	26	
					will be responsible for ensurin		
					that the oxygen storage/transf	-	
					Linat the oxygen storage/transi	ming	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2023	
	PROVIDER OR SUPPLIE		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546		
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				room ventilation is in proper working order. Administrator, designee will check ventilation weekly. The Quality Assurance Committee will review the disa preparedness policy with a focon oxygen storage and ventila a minimum of annually or more often if changes for compliance with recommendations as need. The date the systemic change will be completed: November 1st, 2023	e e e e e e e e e e e e e e e e e e e	

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