08/28/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES							
	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/07/2024	
	PROVIDER OR SUPPLIE	ENIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST ILIN, IN 46131			
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR 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	
E 0000								
Bldg	conducted by the I accordance with 4 Survey Date: 08/0 Facility Number: Provider Number: AIM Number: 20 At this Emergency Otterbein Franklin Care was found no Preparedness Required Medicaid Participators (CFR 483.73). The facility has 20 the survey, the cere	001127: 155771: 00247220 y Preparedness survey, on Senior Life Comm Res & Commot in compliance with Emergency quirements for Medicare and stating Providers and Suppliers, 42: 08 certified beds. At the time of insus was 141. completed on 08/12/24		0000	The creation and submission this Plan of Correction do not constitute an admission by thi provider of any conclusion set in the statement of deficiencies any violation of the regulation. This provider respectfully requite that this 2567 Plan of Correctibe considered the Letter of Credible Allegation of Complia and requests a desk review in of a post-survey review.	is t forth es or uests ion		
E 0004	403.748(a), 416.	54(a), 418.113(a),						

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

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

484.102(a), 485.542(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

§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), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a),

SS=F

Bldg. --

Annually

(X6) DATE

TITLE

Shannon Logan Administrator 08/26/2024

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 08/07/2024				ETED			
		ROVIDER OR SUPPLIER EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST CARE FRANKLIN, IN 46131					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 62(a).		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		The [facility] must Federal, State and preparedness required must develop estate comprehensive errogram that mee section. The emer program must include the following eleminate (a) Emergency Pladevelop and main preparedness planand updated at least state (a) and updated at least state (b) and the section of the section o	comply with all applicable d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness lude, but not be limited to, ments: an. The [facility] must tain 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 ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],						

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Facility ID: 001127

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155771	B. Wl	NG		08/07	/2024
		1		STREET	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			W JEFFERSON ST		
OTTERR	EIN FRANKI IN SF	NIORLIFE COMM RES & COM CA	RF				
			_		1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
				20.4			00/00/00/4
		view and interview, the facility	E 00)04	What corrective action(s) wi	II	08/23/2024
		of 1 emergency preparedness		be accomplished for those			
	-	iewed and updated at least			residents found to have bee	n	
	-	ince with 42 CFR 483.73(a).			affected by the deficient		
	inis deficient pract	ice could affect all occupants.			practice?	_	
	Findings include: Based on review of emergency preparedness program documentation with the Maintenance				No residents were identified a		
					being affected by this alleged		
					deficient practice.	tho	
					How other residents having potential to be affected by the		
	Manager and the Maintenance Assistant during				same deficient practice will		
	record review from 9:10 a.m. to 12:40 p.m. on				identified and what corrective		
	08/07/24, emergency preparedness program				action(s) will be taken?	/ e	
		ch was reviewed within the			No other residents have been	ì	
		month period was not			identified as having the poten		
		v. Based on interview at the			be affected by the alleged de		
		ew, the Maintenance Manager			practice.	HOIOTTE	
		oreparedness program			Disaster Plan has been devel	oped	
		not documented as being			and in place; it was reviewed	-	
		e most recent twelve month			7/24/2024. Maintenance		
	period at the time o	f the survey.			Supervisor did not provide pla	an	
					during surveyor visit.		
	These findings were	e reviewed with the			What measures will be put i	nto	
	Maintenance Manag	ger during the exit conference.			place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					Red binders labeled Emerger	псу	
					Preparedness will be readily		
					available, with all updated ma		
					in the following offices: Exec		
					Director, Administrator, DON,		
					Maintenance. These binders		
					be updated each quarter in Q		
					An audit to ensure binders an		
					updated will be completed on	ce a	
					month for six months by the		
					Administrator.		
					How will the corrective		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/07/2024		
	PROVIDER OR SUPPLIER	I NIORLIFE COMM RES & COM CA	\RE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131	<u> </u>	
(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)	TE	(X5) COMPLETION DATE
E 0006 SS=F Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a), 483.475(a)(1)-(2), (1)-(2), 485.542(a), 485.68(a)(1)-(2), Plan Based on All §403.748(a)(1)-(2), §483.73(a)(1)-(2), §483.73(a)(1)-(2), §485.542(a)(1)-(2), §485.727(a)(1)-(2), §486.360(a)(1)-(2), §494.62(a)(1)-(2), g494.62	416.54(a)(1)-(2), 418.113(a) y(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) y(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a) y(1)-(2), 491.12(a)(1)-(2), Hazards Risk Assessment y, §416.54(a)(1)-(2), y, §441.184(a)(1)-(2), y, §482.15(a)(1)-(2), y, §485.68(a)(1)-(2), y, §485.625(a)(1)-(2), y, §485.920(a)(1)-(2), y, §491.12(a)(1)-(2), y, §491.12(a)(1)-(2), y, §491.12(a)(1)-(2), y, §485.68(a)(1)-(2), y, §491.12(a)(1)-(2), y, §491.12(a)(1)-(2)			action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI commit for further recommendation. By what date the systemic changes for each deficiency will be completed? 8/23/2024	ty ut be	

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Event ID:

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ORRECTION (X5) ORRECTION (X5) SHOULD BE E APPROPRIATE COMPLETION DATE
N SHOULD BE COMPLETION E APPROPRIATE
DATE

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Facility ID: 001127

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` <i>′</i>		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155771	B. Wl	NG		08/07/	2024
	PROVIDER OR SUPPLIER BEIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST (LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE
TAG	an emergency prebe reviewed, and years. The plan model of the plan	eparedness plan that must updated at least every 2 nust do the following: and include a documented, community-based risk ing an all-hazards	E 00		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged definity practice. Disaster Plan has been develor and in place; it was reviewed on 7/24/2024. Maintenance Supervisor did not provide plate during surveyor visit. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Red binders labeled Emergency Preparedness will be readily	In the second or	08/23/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155771	B. W	ING		08/07/	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			JEFFERSON ST		
OTTERB	EIN FRANKLIN SF	NIORLIFE COMM RES & COM CA	ARE				
			-		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	These findings were	LSC IDENTIFYING INFORMATION		TAG		ha mi a l	DATE
					available, with all updated mat		
	Maintenance Manag	ger during the exit conference.			in the following offices: Execu		
					Director, Administrator, DON,		
					Maintenance. These binders be updated each quarter in QA		
					An audit to ensure binders are		
					updated will be completed once		
					month for six months by the	,∪ a	
					Administrator.		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	_	
					into place?		
					Any identified deficiencies will	be	
					corrected upon discovery and		
					reviewed by the QAPI commit	tee	
					for further recommendation.		
					By what date the systemic		
					changes for each deficiency		
					will be completed?		
					8/23/2024		
E 0040							
E 0013	403.748(b), 416.5						
SS=F		5(b), 483.475(b), 483.73(b),					
Bldg	484.102(b), 485.5						
	485.68(b), 485.72						
	486.360(b), 491.1	P Policies and Procedures					
	·	6.54(b), §418.113(b),					
	- , , -).84(b), §482.15(b),					
	- ' ' -	475(b), §484.102(b),					
		542(b), §485.625(b),					
		5.920(b), §486.360(b),					
	§491.12(b), §494.						
	3 · · · · · – (~), 3 · · · ·	(/-					
	(b) Policies and pr	ocedures. [Facilities] must					
	develop and imple						
	· · ·	cies and procedures, based					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING B. WING			COMPLETED 08/07/2024		
	PROVIDER OR SUPPLIER	R NIORLIFE COMM RES & COM (STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST 1 CARE FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	(a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and reviewed and reviewed and revelop and imples preparedness pole on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and reviewed a	icies and procedures, based plan set forth in paragraph, risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually. rements for PACE and 60.84(b):] Policies and PACE organization must						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPI	LETED
		155771	B. WI	NG	<u> </u>	08/07	/2024
				CED FEET	ADDRESS OF A STATE OF COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
OTTERR		NUODUIEE OOMA DEO A OOM OA	D E		JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	KE	FRANK	LIN, IN 46131		
(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	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For ESRD Facili	ties at §494.62(b):] Policies					
	_	The dialysis facility must					
	develop and imple	•					
		icies and procedures, based					
	1 ' '	plan set forth in paragraph					
	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the						
		an at paragraph (c) of this					
	1	cies and procedures must					
		updated at least every 2					
		ergencies include, but are					
	not limited to, fire, equipment or power failures, care-related emergencies, water						
		n, and natural disasters					
	likely to occur in the	he facility's geographic					
	area.						
	Based on record rev	view and interview, the facility	E 00)13	What corrective action(s) wil	I	08/23/2024
	failed to review and	d update its emergency			be accomplished for those		
	preparedness polici	es annually. The policies and			residents found to have beer	n	
	procedures must be	reviewed and updated at least			affected by the deficient		
	annually in accorda	nce with 42 CFR 483.73(b).			practice?		
	This deficient pract	ice could affect all occupants.			No residents were identified as		
					being affected by this alleged		
	Findings include:				deficient practice.		
					How other residents having	the	
		emergency preparedness			potential to be affected by th	ie	
	1	ation with the Maintenance			same deficient practice will b	ре	
	_	faintenance Assistant during			identified and what correctiv	e	
		9:10 a.m. to 12:40 p.m. on			action(s) will be taken?		
		cy preparedness policies and			No other residents have been		
	1 ~	d within the most recent			identified as having the potent	tial to	
	· -	d was not available for review.			be affected by the alleged defi	icient	
		at the time of record review,			practice.		
		anager agreed emergency			Disaster Plan has been devel	-	
		es and procedures reviewed			and in place; it was reviewed o	on	
		ent twelve month period was			7/24/2024. Maintenance		
	not available for rev	view at the time of the survey.			Supervisor did not provide pla	n	
					during surveyor visit.		
	1	e reviewed with the			What measures will be put in	nto	
	Maintenance Manag	ger during the exit conference.			place and what systemic		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. BUILDIN B. WING	IG <u></u>	UCTION	COMPI 08/07		
	ROVIDER OR SUPPLIER EIN FRANKLIN SEI	NIORLIFE COMM RES & COM CA	10		SSS, CITY, STATE, ZIP COD FERSON ST IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	G CR	PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOUL OSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
				ens prace Red Prep avai in th Dire Main be u An a upd mor Adn Hov acti ens will assa into Any corr revie for f By v cha will	nges will be made to ure that the deficient ctice does not recur? I binders labeled Emer paredness will be read illable, with all updated he following offices: Exector, Administrator, Dontenance. These bindupdated each quarter in audit to ensure binders ated will be completed of the for six months by the inistrator. In will the corrective on(s) be monitored to ure the deficient praction of recur, i.e., what quance program will be place? I identified deficiencies bected upon discovery sewed by the QAPI confurther recommendatio what date the systeminges for each deficiencies be completed? B/2024	material mat	
E 0029 SS=F Bldg	484.102(c), 485.54 485.68(c), 485.727 486.360(c), 491.12 Development of Co §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.5	5(c), 483.475(c), 483.73(c), 42(c), 485.625(c), 7(c), 485.920(c),					

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	Γ OF HEALTH AND HUN R MEDICARE & MEDIC					TED: 08/28/2024 RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/07/2024	
	ı	NIORLIFE COMM RES & COM CA	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].		E 0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potential be affected by the alleged deficient practice. Disaster Plan has been developed and in place; it was reviewed to	heeeeial to cient	08/23/2024

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the Maintenance Manager agreed documentation

within the most recent twelve month period was

not available for review at the time of the survey.

Maintenance Manager during the exit conference.

for a complete emergency preparedness

These findings were reviewed with the

communication plan reviewed by the facility

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Facility ID: 001127

7/24/2024. Maintenance

place and what systemic changes will be made to

ensure that the deficient

practice does not recur? Red binders labeled Emergency Preparedness will be readily available, with all updated material in the following offices: Executive Director, Administrator, DON, and

during surveyor visit.

Supervisor did not provide plan

What measures will be put into

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NAME OF PROVIDER OR SUPPLIER		ONSTRUCTION ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 08/07/2024 TATE, ZIP COD				
		NIORLIFE COMM RES & COM C	1070 W JEFFERSON ST FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0036 SS=F Bldg	484.102(d), 485.5 485.68(d), 485.72 486.360(d), 491.1 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §483. §485.68(d), §485. §485.727(d), §485. §491.12(d), §494. *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102	5(d), 483.475(d), 483.73(d), 42(d), 485.625(d), 7(d), 485.920(d), 2(d), 494.62(d) resting 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 542(d), §485.625(d), 5.920(d), §486.360(d),			Maintenance. These binders to be updated each quarter in QAAn audit to ensure binders are updated will be completed one month for six months by the Administrator. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committed for further recommendation. By what date the systemic changes for each deficiency will be completed? 8/23/2024	ty ut	

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"Organizations" under 485.727, CMHCs at

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	IULTIPLE CO UILDING 'ING	NSTRUCTION	(X3) DATE COMPI 08/07	LETED	
	OF PROVIDER OR SUPPLIE RBEIN FRANKLIN SE	R NIORLIFE COMM RES & COM (STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131					
(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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	testing. The [facili maintain an emerand testing prograemergency plans this section, risk a (a)(1) of this section. The trair must be reviewed 2 years. *[For LTC facilitie and testing. The and maintain an etraining and testir the emergency plot this section, risk (a)(1) of this section. The trair must be reviewed annually. *[For ICF/IIDs at testing. The ICF/I maintain an emerand testing prograemergency plans this section, risk a (a)(1) of this section. The trair must be reviewed annually.	at §486.360, and 91.12:] (d) Training and ty] must develop and gency preparedness training am that is based on the set forth in paragraph (a) of this section, and the an at paragraph (c) of this ning and testing program and updated at least every set forth in paragraph (a) Training LTC facility must develop emergency preparedness and procedures of this section, and the an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ning and testing program and updated at least set forth in paragraph (a) the test forth in paragraph (b) of this ning and testing program and updated at least set forth in paragraph (b) of this section, and the set forth in paragraph (c) of this ning and testing program and updated at least set forth in paragraph (b) of this section, and the set forth in paragraph (c) of this ning and testing program and updated at least every and updated at least every liD must meet the sevacuation drills and training						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/07/2024			
	PROVIDER OR SUPPLIER BEIN FRANKLIN SE	NIORLIFE COMM RES & COM	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST I CARE FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	Training, testing, a dialysis facility multiple emergency preparand patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation prograupdated at every and the develop are preparedness training was reviewed and unaccordance with 42 practice could affect Findings include: Based on review of program documental Manager and the Manager and the Manager and testing not reviewed within the most received. Based on in review, the Mainter facility's emergency testing program documental within the most received. These findings were the findings wer	view and interview, the facility and maintain emergency and testing program that applated at least annually in CFR 483.73(d). This deficient	E 0036	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken? No other residents have been identified as having the potential be affected by the alleged depractice. Disaster Plan has been dever and in place; it was reviewed 7/24/2024. Maintenance Supervisor did not provide pladuring surveyor visit. What measures will be put in place and what systemic	as d the he be ve n ntial to discient doped on		

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changes will be made to

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			UILDING	onstruction 	COMPLETED 08/07/2024			
	ROVIDER OR SUPPLIER EIN FRANKLIN SEI	NIORLIFE COMM RES & COM C	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131					
(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)	TE	(X5) COMPLETION DATE	
					ensure that the deficient practice does not recur? Red binders labeled Emergen Preparedness will be readily available, with all updated main the following offices: Execut Director, Administrator, DON, Maintenance. These binders be updated each quarter in QAAn audit to ensure binders are updated will be completed one month for six months by the Administrator. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committy for further recommendation. By what date the systemic changes for each deficiency will be completed? 8/23/2024	terial tive and will API. te a		
K 0000								
Bldg. 01	Licensure Survey w	01127	KO	0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set in the statement of deficiencie any violation of the regulation. This provider respectfully required that this 2567 Plan of Correctibe considered the Letter of	s forth s or lests		

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. W	NG		08/07/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	RE		LIN, IN 46131		
(X4) ID	CHMMADY	STATEMENT OF DEFICIENCIE	I	ID			(V5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
mo	AIM Number: 200			1110	Credible Allegation of Complia	nce	BITTE
	At this Life Safety Code Survey, Otterbein Franklin Senior Life Comm Res & Com Care was			and requests a desk review in lie			
					of a post-survey review.		
		ance with Requirements for					
	_	dicare/Medicaid, 42 CFR					
	_	Life Safety from Fire and the					
		National Fire Protection					
	Association (NFPA) 101, Life Safety Code (LSC),					
	Chapter 19, Existing	g Health Care Occupancies and					
	410 IAC 16.2.						
		Senior Life Comm Res & Com					
	Care consists of four separate but connected						
	_	ed at four different times:					
	_	C facility built in 1957, is a three					
		nilding of Type I (332)					
		basement; Building 02 built in					
		y sprinklered building of Type I					
		with a basement; Building 03 ne story sprinklered building of					
		uction with a basement; and					
		2000 is a three story					
	_	g of Type I (332) construction.					
		gs are of the same type of					
		cility was surveyed as one					
		ity has a fire alarm system with					
	•	the corridors and all areas					
		. In Building 02, 47 battery					
	-	were provided in resident					
	-	nter 2 and Health Center 3. All					
	other resident room	s in Building 02 are provided					
		oke detectors. In Building 03					
		ard wired smoke detectors are					
	installed in all resid	ent rooms except in Room 23 in					
	Building 03. The h	ealthcare portion of the facility					
	has a capacity of 20	8 and had a census of 141 at					
	the time of this surv	ey.					
	All areas where resi	idents have customary access					

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CENTERS FOI		OMB NO. 0938-039						
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	X3) DATE	SURVEY	_
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u>01 </u>	COMPL	ETED	
		155771	B. W	ING		08/07/	/2024	
		.		CTDEET	ADDRESS, CITY, STATE, ZIP COD			_
NAME OF I	PROVIDER OR SUPPLIEF	₹			V JEFFERSON ST			
OTTERR	EIN EDANKI IN SE	NIORLIFE COMM RES & COM	CARE		(LIN, IN 46131			
OTTLINE	-	INOREII E GOWN REG & GOW	OAINE .	HVAIN				
(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 CROSS-REFERENCED TO THE APPRO		E	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	_
	-	nd all areas providing facility						
	services were sprin	klered.						
	Quality Review cor	mpleted on 08/12/24						
IX 0000	NEDA 404							
K 0232 SS=E	NFPA 101	D 14/: 44/-						
	Aisle, Corridor, or							
Bldg. 01	l '	Aisle, Corridor or Ramp Width 2012 EXISTING						
		o or corridore (alcor or						
		s or corridors (clear or						
	unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the							
	convenient removal of nonambulatory patients							
		ept as modified by						
	19.2.3.4, exceptio 19.2.3.4, 19.2.3.5							
		on and interview, the facility	17.0	232	What corrective action(s) will		08/23/2024	
		lear width requirement for 4 of	I K U	1232	be accomplished for those		08/23/2024	
		met an exception per			residents found to have been			
		9.2.3.4(5) states where the			affected by the deficient			
		least 8 feet, projections into			practice?			
		shall be permitted for fixed			No residents were identified as			
	_	that all of the following			being affected by this alleged			
	conditions are met:				deficient practice.			
		are is securely attached to the			How other residents having th	16		
	floor or to the wall.				potential to be affected by the			
		are does not reduce the clear			same deficient practice will be			
	1 1	or width to less than six feet,			identified and what corrective			
	except as permitted				action(s) will be taken?			
		re is located only on one side			No other residents have been			
	of the corridor.	, and the second			identified as having the potentia	al to		
		are is grouped such that each			be affected by the alleged defic			
		exceed an area of 50 square			practice.			
	feet.	1			All bench seats and wooden			
	(e) the fixed furnitu	re groupings addressed in			chairs were removed from the			
	1 1	separated from each other by a			corridors by the maintenance s	taff		
	distance of at least	-			on 8/13/2024			

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protection equipment.

(f) the fixed furniture is located so as to not

obstruct access to building service and fire

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What measures will be put into

place and what systemic

changes will be made to

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771		JILDING	nstruction 01	(X3) DATE COMPI 08/07	LETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	ARE	1070 W	DDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	are protected by an automatic smoke de with 19.3.4, or the farranged and locate by the facility staff space. (h) the smoke compthroughout by an apprinkler system in This deficient pract residents, staff and Findings include: Based on observation Manager during a top.m. to 3:25 p.m. or stored in the corridor Room 217, Room 3 Room 353 in Buildinot affixed to the flowooden chairs were seat outside Room eighteen inches into In addition, one ber corridor up against Room 5B and Room Building 3 and were the wall. Based on observations, the M furniture was stored aforementioned locate floor or to the was the seaf indings were aforementioned located to the floor or to the was the seaf indings were seaf indings w	ons with the Maintenance our of the facility from 1:15 in 08/07/24, one bench seat was or up against the wall outside 07, Room 316, Room 324 and ing 2 and Building 4 and were our or to the wall. Two is also stored next to the bench 353. The furniture extended of the eight foot wide corridor, inch seat was stored in the the wall outside Room 3B, in 9 in Murphy's Special Care in the outside to the floor or to interview at the time of the aintenance Manager agreed thin the corridor at the ations and was not affixed to fall.			ensure that the deficient practice does not recur? Audits of corridors will be conducted by the Maintenar Manager and/or his designe weekly for four weeks and the monthly for three months. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what que assurance program will be into place? The Maintenance Director is responsible for ensuring auc completed. Audit will be revelope the QA committee. Once initial audit is completed and 100% compliance is met, the committee may choose to discontinue the audit. By what date the systemic changes for each deficient will be completed? 8/23/2024	ce ality put dits are iewed	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OME	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/07/2024		•	
	PROVIDER OR SUPPLIER BEIN FRANKLIN SE	NIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST (LIN, IN 46131			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0341 SS=E Bldg. 01	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit detection is also in appliance circuit p supervising statio Fire alarm system transmission path integrity. 18.3.4.1, 19.3.4.1 Based on record revinterview; the facility alarm systems was 19.3.4.1. NFPA 72 Signaling Code, 20 states spot-type smoon the ceiling not be sidewall or on the sidewall or on th	n - Installation m is installed with systems approved for the purpose in NFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification in ower extenders, and in transmitting equipment. wiring or other is are monitored for 1, 9.6, 9.6.1.8 In exicute to ensure 1 of 1 fire installed in accordance with in National Fire Alarm and in Edition, Section 17.7.3.2.1 Toke detectors shall be located the sidewalls between 4 inches and ceiling. This deficient practice in residents, staff and visitors in the econd floor elevator machine	K 0	341	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged defipractice. The Fire Alarm System Contrawas at the facility on 7/26/2024 check broken detector. It was determined that parts needed	the e pe ide to icient actor 4 to	08/23/2024	

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system smoke detector is not properly installed.

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be ordered and the contractor was

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771			UILDING	01	COMPL 08/07/	ETED	
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	ARE	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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)	ΓE	(X5) COMPLETION DATE
	inspection report sta floor- Elevator Mac The smoke detector the base is broken o reattaching it to the broke off inside the base needs to be mo interview at the time Maintenance Manas system inspection of make the necessary Based on observation Manager during a to p.m. to 3:25 p.m. or for the facility's fire second floor elevator from its base.	section of the 07/26/24 ated "Smoke Detector - 2nd hine Room Deficiency Found: head functioned properly but ff the electrical box, I tried box but a piece of plastic was base. A new smoke detector functed to the box". Based on the of record review, the ger stated the fire alarm contractor is scheduled to frepairs on August 13th. The swith the Maintenance four of the facility from 1:15 108/07/24, the smoke detector functional review of the facility from the f			scheduled for a revisit on 8/13/2024. On 8/13/2024, contractor completed the repair to the broken detector. The unit was working properly however, the base of the alarm was broken and in need of repair which was scheduled. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? An audit will be completed by a Maintenance Supervisor and/ordesignee, once a week for four weeks to ensure all smoke detectors are secured and wor properly. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committed for further recommendation. By what date the systemic changes for each deficiency will be completed? 8/23/2024	to the or his r king ty ut	
K 0907 SS=D Bldg. 01	NFPA 101 Gas and Vacuum Maintenance Pr Gas and Vacuum Maintenance Prog Medical gas, vacu	Piped Systems -					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	
		155771	B. W	ING		08/07/	/2024
NAME OF F	DROVIDED OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			1070 W	/ JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	ARE	FRANK	(LIN, IN 46131		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	1 -	cumented maintenance					
	1 ' - '	ogram includes an inventory ems, control valves, alarms,					
	1						
	manufactured assemblies, and outlets. Inspection and maintenance schedules are						
		gh risk assessment					
	considering manufacturer recommendations.						
	1	ures and testing methods					
	are established th	rough risk assessment.					
	Persons maintaini	ng systems are qualified as					
	demonstrated by training and certification or						
	1	e requirements of AASE					
	6030 or 6040.	00 5 4 45 5 0 4 4					
		.2.2, 5.1.15, 5.2.14,					
	5.3.13.4.2 (NFPA	yiew and interview, the facility	K 0907		\M/hat corrective action(a) will	11	09/30/2024
		ne facility's piped gas systems			What corrective action(s) will be accomplished for those	11	09/30/2024
		NFPA 99, Health Care			residents found to have been	n	
		2 Edition. This deficient			affected by the deficient		
		t three residents should the			practice?		
	1 -	ystem not be operational.			No residents were identified a	S	
					being affected by this alleged		
	Findings include:				deficient practice.		
					How other residents having		
		the piped gas system			potential to be affected by the		
	_	or's "Medical Gas Annual			same deficient practice will be		
	_	entation dated 06/13/24 with anager and the Maintenance			identified and what correctiv action(s) will be taken?	' U	
		cord review from 9:10 a.m. to			No other residents have been		
	_	7/24, annual inspection			identified as having the potent		
		the facility's piped gas systems			be affected by the alleged def		
		ent twelve month period			practice.		
	indicated a total of	three patient outlet terminals			On 6/13/2024, the contractor t	for	
	_	right vacuum outlet terminal in			the Medical Gas Annual		
		ed as "outlet damaged". The			Inspection noted three areas t		
	1 -	terminal in Room 306 was			needed repair. A quote for re	-	
		. The 1st oxygen outlet			was submitted to the Executiv		
		12 was listed as "leaks without			Director for approval. Contract		
	_	Based on interview at the time			will be at the facility by 9/30/20	024	
	of record review, th	e Maintenance Manager			to complete repairs.		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		01	(X3) DATE SURVEY COMPLETED 08/07/2024	
	PROVIDER OR SUPPLIER	R NIORLIFE COMM RES & COM C	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF agreed annual inspersal facility's piped gas three resident sleep needed repair. These findings were	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION extion documentation for the systems indicated a total of ing room outlet terminals er reviewed with the ger during the exit conference.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? On annual inspections, any deficiency found will be address immediately. An audit will be completed by Maintenance Manager and/or designee once a month for six months to ensure proper functioning. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI commit for further recommendation. By what date the systemic changes for each deficiency will be completed? 9/30/2024	ssed the his c	(X5) COMPLETION DATE
Bldg. 01	STANDARDS 3.1-19(a) The facili constructed, equipp	MENT AND PHYSICAL ty must be designed, ed and maintained to protect y of residents, personnel, and	K 9	999	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice. How other residents having	n IS	08/30/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. BUILDING <u>01</u>		COMPL	3) DATE SURVEY COMPLETED 08/07/2024	
	PROVIDER OR SUPPLIE	R NIORLIFE COMM RES & COM C	1070	ET ADDRESS, CITY, STATE, ZIP COD) W JEFFERSON ST NKLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPEDEFICIENCY)		(X5) COMPLETION DATE
	Based on observatifailed to provide stresident sleeping recould affect over 10 the vicinity of Roof Findings include: Based on observatifa Manager during a true p.m. to 3:25 p.m. or rooms in the facilital detector except result building 3. A ceiling smoke detector to troom but no smoke mounting ring. Bathe observations, the agreed resident sleecurrently provided	on and interview, the facility noke detectors in 1 of over 50 tooms. This deficient practice 0 residents, staff and visitors in m 23 in Building 3. ons with the Maintenance our of the facility from 1:15 in 08/07/24, all resident sleeping by were equipped with a smoke ident sleeping Room 23 in ing mounted ring to affix a the ceiling was noted in the electron was mounted in the electron was mounted in the sed on interview at the time of the Maintenance Manager eping Room 23 was not with a smoke detector. The reviewed with the ger during the exit conference.		potential to be affected by same deficient practice will identified and what correct action(s) will be taken? No other residents have bee identified as having the pote be affected by the alleged depractice. The contractor will be in by 8/30/2024 to ensure the smodetector is secured in place. What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits to ensure all smoke detectors are mounted and secured will be completed by Maintenance Supervisor and designee daily for one week times a week for one week, then twice weekly for two well the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e., what quassurance program will be into place? Any identified deficiencies we corrected upon discovery and reviewed by the QAPI commor for further recommendation. By what date the systemic changes for each deficiency will be completed?	n htial to efficient loke into	

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