	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15E681	A. BUILDING B. WING	<u>-</u>	01/04/2	
	PROVIDER OR SUPPLIEI		802	ET ADDRESS, CITY, STATE, ZI E 10TH ST DINAND, IN 47532	P COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	,	DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 01/04 Facility Number: 0 Provider Number: AIM Number: 200 At this Emergency Hildegard Health C compliance with Er Requirements for N Participating Provid 483.73 The facility has 17 census of 16.	4/23 004429 15E681 502430 Preparedness survey, Center Inc. was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds, with a current	E 0000			
E 0036 SS=F Bldg	The requirement at MET as evidenced 403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6 485.727(d), 494.62 EP Training and \$403.748(d), \$410.8441.184(d), \$460.8483.73(d), \$485.68(d), \$485.920(d), \$480.8494.62(d).	64(d), 418.113(d), 5(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 620(d), 486.360(d), 62(d)	GNATURE	TITLE		(X6) DATE

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

(X6) DATE

Michael Van Hoy Administrator 01/20/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CF5N21 Facility ID: 004429 If continuation sheet Page 1 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681	ľ	JILDING	NSTRUCTION	(X3) DATE : COMPL 01/04/	ETED
	PROVIDER OR SUPPLIER			802 E 1	ADDRESS, CITY, STATE, ZIP COD OTH ST JAND, IN 47532		
(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
	Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testir develop and main preparedness train that is based on the in paragraph (a) of assessment at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The land maintain an estraining and testin the emergency plate of this section, risk (a)(1) of this section at paragraph (b) of communication plate section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing prograte emergency plans this section, risk and testing prograte emergency plans	A403.748, ASCs at §416.54, 13, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at IC/FHQs at §491.12:] (d) and the facility of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be atted at least every 2 years. Seat §483.73(d):] (d) Training and the tis based on an set forth in paragraph (a) assessment at paragraph (b) assessment at paragraph (c) assessment at paragraph (d) assessment at paragraph (d) assessment at least every 2 years. Seat §483.73(d):] Training and the policies and procedures of this section, and the contained at least every 2 years. Seat §483.73(d):] Training and the policies and procedures of this section, and the contained at least every 2 years.					

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 2 of 28

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		15E681	B. WI	NG		01/04/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAVOE 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	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at paragraph (b) or communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facility Training, testing, a dialysis facility must emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation programupdated at every 2 Based on record revisual factories training was reviewed and used accordance with 42 practice could affect Findings include: Based on review of Plan on 01/04/23 be with the Administra Supervisor present, available to show the preparedness training available. Based on review of preparedness training available.	of this section, and the an at paragraph (c) of this ing and testing program and updated at least every ID must meet the evacuation drills and training ties at §494.62(d):] and orientation. The st develop and maintain an redness training, testing ation program that is based plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and 2 years. Friew and interview, the facility d maintain an emergency hig and testing program that polated at least annually in CFR 483.73(d). This deficient	E 00		E 036 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified uring the survey, all residents staff and visitors have the pote to be affected by this deficient practice. The facility has now developed and will maintain aremergency preparedness train and testing program which will reviewed and updated annually The corrective action taken for other residents that have the potential to be affected by the	ed s, ential n ning be y.	02/03/2023
	training and testing Emergency Manage	program available within the ment Plan.			same deficient practice is that although no specific residents		

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 3 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l` ′	IULTIPLE CO UILDING	ONSTRUCTION 	(X3) DATE S COMPLI	
		15E681	B. W			01/04/2	
	PROVIDER OR SUPPLIER			802 E 1	ADDRESS, CITY, STATE, ZIP COD OTH ST NAND, IN 47532		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	This finding was re and Maintenance St conference.	viewed with the Administrator apervisor during the exit 5.54(d)(1), 418.113(d)(1),		TAG	were identified during the survall residents, staff and visitors have the potential to be affect by this deficient practice. The facility has now developed and maintain an emergency preparedness training and test program which will be reviewed and updated annually. The measures that have been into place to ensure that the deficient practice does not received that the facility has developed emergency preparedness train and testing program. All facility staff members have now participated in the mandatory emergency preparedness train program and tested on the color of the material presented during the training session. The corrective action taken to monitor to ensure the deficient practice will not recur is that the facility Administrator and/or the designee will audit the facility's emergency preparedness and training program quarterly in conjunction with the facility's Quality Assurance program to ensure that all employee's have the documentation to support they have received the required emergency preparedness train at least annually and tested on content of the training program.	ed d will ting d put eur is an ning ty ning ntent ng t ne eir s	DATE
SS=F Bldg	441.184(d)(1), 482	2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1),					

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 4 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E681		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 01/04/2023			
	PROVIDER OR SUPPLIEF		802 E	ADDRESS, CITY, STATE, ZIP CO 10TH ST INAND, IN 47532	DD .
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE COMPLETION
TAG	485.68(d)(1), 485.	1 LSC IDENTIFYING INFORMATION 727(d)(1), 485.920(d)(1),	TAG	DEFICIENCY)	DATE
	§441.184(d)(1), §4 §483.73(d)(1), §4 §485.68(d)(1), §4 (1), §485.920(d)(1 §491.12(d)(1).	am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)			
	Hospitals at §482. HHAs at §484.102 §485.727, OPOs a at §491.12:]	15, ICF/IIDs at §483.475, 2, "Organizations" under at §486.360, RHC/FQHCs			
	policies and proce existing staff, indi- under arrangement consistent with the	n emergency preparedness redures to all new and riduals providing services nt, and volunteers, eir expected roles.			
	at least every 2 ye (iii) Maintain docu preparedness trai (iv) Demonstrate s emergency proces	mentation of all emergency ning. staff knowledge of dures.			
	and procedures at [facility] must cond updated policies a	·			
	The hospice must (i) Initial training ir policies and proce existing hospice e	§418.113(d):] (1) Training. do all of the following: n emergency preparedness dures to all new and mployees, and individuals under arrangement, eir expected roles.			

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 5 of 28

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15E681	A. BUILDING B. WING		COMPLETED 01/04/2023
		102001		ADDRESS SITU STATE ZIR COD	0 1/0 1/2020
NAME OF P	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD 10TH ST	
HILDEGA	ARD HEALTH CEN	TER		NAND, IN 47532	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG	(ii) Demonstrate s		IAU		DATE
	emergency proced	•			
		gency preparedness training			
	at least every 2 ye	ears.			
	1 ' '	view and rehearse its			
		redness plan with hospice			
		ling nonemployee staff), asis placed on carrying out			
		ecessary to protect patients			
	and others.				
	(v) Maintain documentation of all emergency				
	preparedness trai	-			
	(vi) If the emergency preparedness policies and procedures are significantly updated, the				
	updated policies a	duct training on the			
	procedures.	inu			
	procedures.				
	*[For PRTFs at §4	l41.184(d):] (1) Training			
		TF must do all of the			
	following:				
	1 ''	n emergency preparedness			
	1 '	edures to all new and viduals providing services			
	_	nt, and volunteers,			
		eir expected roles.			
	(ii) After initial trair	ning, provide emergency			
	1 ' '	ning every 2 years.			
	(iii) Demonstrate s	_			
	emergency proced				
	preparedness trail	mentation of all emergency			
	1 ' '	cy preparedness policies			
	. , ,	re significantly updated, the			
	1	ict training on the updated			
	policies and proce	edures.			
	*[For PACF at 846	60.84(d):] (1) The PACE			
		do all of the following:			
	_	n emergency preparedness			

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 6 of 28

	T OF DEFICIENCIES OF CORRECTION	, ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/04/2023	
	PROVIDER OR SUPPLIER			802 E 1	DDRESS, CITY, STATE, ZIP COD OTH ST IAND, IN 47532			
(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)	ΛTE	(X5) COMPLETION DATE	
	existing staff, indiviservices under arriparticipants, and vitheir expected role (ii) Provide emergat least every 2 ye (iii) Demonstrate semergency proced participants of whom to contact in (iv) Maintain docur (v) If the emerger and procedures and existing and procedures	ency preparedness training ears. Staff knowledge of dures, including informing at to do, where to go, and in case of an emergency. Incomparedness policies are significantly updated, the lact training on the updated adures. Is at §483.73(d):] (1) The LTC facility must do all an emergency preparedness adures to all new and adures to all new and adured adures. In emergency preparedness and and volunteers, ear expected role. In ency preparedness training ementation of all emergency preparedness training at aff knowledge of dures. It is a second of the following: a sining in emergency cies and procedures to all staff, individuals providing angement, and volunteers,						

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 7 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING		COMPL 01/04	
		15E681	B. W	NG	_	01/04	/2023
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
LIII DEC	ARD HEALTH CEN	TED			OTH ST		
ПІСОЕСЬ	ARD HEALTH CEN	IER	-	FERDIN	NAND, IN 47532		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	at least every 2 ye	R LSC IDENTIFYING INFORMATION		TAG	Dia relative i		DATE
		mentation of the training.					
	(iv) Demonstrate	_					
	, ,	dures. All new personnel					
	must be oriented	and assigned specific					
	responsibilities re	garding the CORF's					
	emergency plan within 2 weeks of their first						
	workday. The training program must include						
	instruction in the location and use of alarm						
	systems and signals and firefighting						
	equipment. (v) If the emergency preparedness policies						
	and procedures are significantly updated, the						
	CORF must conduct training on the updated						
	policies and procedures.						
	-	35.625(d):] (1) Training					
		H must do all of the					
	following:						
	.,	n emergency preparedness					
	reporting and exti	edures, including prompt					
		nguishing of files, here necessary, evacuation					
	•	nnel, and guests, fire					
		poperation with firefighting					
		orities, to all new and					
	existing staff, indiv	viduals providing services					
	under arrangemer	nt, and volunteers,					
	consistent with the	eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
	` '	mentation of the training.					
	(iv) Demonstrate s emergency proces	_					
		ncy preparedness policies					
	, ,						
	and procedures are significantly updated, the CAH must conduct training on the updated						
	policies and proce						
	-						
	*[For CMHCs at §	485.920(d):] (1) Training.					

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet

Page 8 of 28

PRINTED: 01/26/2023 FORM APPROVED 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. BU	ILDING		COMPL	ETED
		15E681	B. W	NG		01/04/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8		802 E 1	0TH ST		
HILDEG/	ARD HEALTH CEN	TER	_	FERDIN	NAND, IN 47532		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		provide initial training in					
		redness policies and					
		new and existing staff,					
	individuals providi	_					
	arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of						
		<u> </u>					
		dures. Thereafter, the					
	CMHC must provi	- ·					
		ning at least every 2 years.	F 04	27	F 007		02/02/2022
		view and interview, the facility	E 00)3 /	E 037		02/03/2023
		nual training for the dness Program (EPP). The			The corrective action taken for		
		lo all of the following: (i) Initial			those residents found to have		
		cy preparedness policies and			been affected by the deficient practice is that although no		
		w and existing staff,			specific residents were identifi	ad	
	_	ng services under arrangement,			during the survey, all residents		
	_	sistent with their expected			staff and visitors have the pote		
		mergency preparedness			to be affected by this deficient		
		ually; (iii) Maintain			practice. The facility has revie		
	-	ll emergency preparedness			and revised all policies and	,wcu	
		nstrate staff knowledge of			procedures related to the facili	itv's	
	- ' '	ares in accordance with 42 CFR			emergency preparedness train	-	
		deficient practice could affect			All facility staff as well as all	9.	
	all residents in the f	-			individuals providing services	under	
		,			arrangement and volunteers w		
	Findings include:				now be receiving training		
					consistent with their roles upor	n	
	Based on review of	the Emergency Management			hire and at least annually. The		
		etween 9:45 a.m. and 1:00 p.m.			facility will maintain		
	with the Administra	ator and Maintenance			documentation of all emergen	cy	
	Supervisor present,	no documentation of annual			preparedness training as well	-	
		ement Plan training and no			supportive documentation that		
		now staff could demonstrate			demonstrates the staff member		
	knowledge of the E	mergency Management Plan			knowledge level of their		
	was available for re	eview. Based on an interview at			responsibilities and role during	j an	
	the time of record re	eview, the Administrator			emergency.		
	confirmed there was	s no documentation of annual			The corrective action taken for	r the	
	Emergency Manage	ement Plan training and no			other residents that have the		

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 9 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E681		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/04/2023	
	PROVIDER OR SUPPLIER		802 E	ADDRESS, CITY, STATE, ZIP COD 10TH ST NAND, IN 47532	•
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	documentation to sl knowledge of the E was available for re This finding was re	now staff could demonstrate mergency Management Plan		potential to be affected by the same deficient practice is that although no specific residents were identified during the sur all residents, staff and visitors have the potential to be affect by this deficient practice. The facility has reviewed and revisall policies and procedures reto the facility's emergency preparedness training. All factstaff as well as all individuals providing services under arrangement and volunteers now be receiving training consistent with their roles upon hire and at least annually. The facility will maintain documentation of all emerger preparedness training as well supportive documentation that demonstrates the staff members knowledge level of their responsibilities and role during emergency. The measures that have been into place to ensure that the deficient practice does not rethat a mandatory in-service here onducted for all facility members as well as all individually providing services under arrangement and volunteers at their specific responsibilities aroles during an emergency. It raining attendee has also demonstrated their knowledglevel of their responsibilities arole during an emergency with documentation to support the	t t s vey, s ted e sed elated cility will on he he hey as at ers g an h put cur is as staff duals on and Each e and h

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet

Page 10 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

02:11210101	THE CONTENTS	TID DERIVICED				211010703 007		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPL	ETED		
		15E681	B. WING		01/04/			
			<u> </u>	_	,,	-		
NAME OF P	ROVIDER OR SUPPLIER	L		ADDRESS, CITY, STATE, ZIP COD				
	ADD HEALTH OFFI	TED	802 E 10TH ST					
HILDEGA	ARD HEALTH CEN	IEK	FEKDII	NAND, IN 47532				
(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		
				knowledge level which will be maintained in the facility's emergency preparedness reconstruction taken to monitor to ensure the deficient practice will not recur is that the facility Administrator and/or the designee will audit the facility's emergency preparedness in-service training records quarterly in conjunction with the facility's Quality Assurance program to ensure that each employee, individuals providing services under arrangement and volunteers have documentation support their specific training of their roles and responsibilities during an emergency. The administrator will also audit to ensure there is supportive documentation of those individuals provided their specific training of their specific training of their roles and responsibilities during an emergency.	t ne eir s ne g nd nn to of			
E 0039 SS=C Bldg	441.184(d)(2), 482.483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requii §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)						

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

OPO, "Organizations" under §485.727,

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 11 of 28

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/04/2023	
	PROVIDER OR SUPPLIEI			802 E 1	DDRESS, CITY, STATE, ZIP COD OTH ST IAND, IN 47532		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	020, RHCs/FQHCs at RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct the emergency plan cility] must do all of the					
	(i) Participate in a full-scale exercise that is community-based every 2 years; or						
	(A) When a community-based exercise is not accessible, conduct a facility-based						
		e every 2 years; or					
	(B) If the [facility] experiences an actual natural or man-made emergency that requires						
		mergency plan, the [facility]					
	-	ngaging in its next required					
	1	l or individual, facility-based					
		e following the onset of the					
	actual event.						
	` '	lditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
	· ·	limited to the following:					
	1 ' '	scale exercise that is					
	-	l or individual, facility-based					
	functional exercis (B) A mock disast						
	1 ' '	ercise or workshop that is					
		and includes a group					
	discussion using	-					
	_	emergency scenario, and a					
	set of problem sta	- ·					
	1	pared questions designed					
	to challenge an e	·					
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ergency plan, as needed.					

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 12 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E681		r í	UILDING	NSTRUCTION	COMPL 01/04/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532					
(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	
	the patient's home conduct exercises plan at least annuithe following: (i) Participate in a community based (A) When a commaccessible, conduit based functional et (B) If the hospice man-made emerging of the emergency exempt from engascale community-facility-based functional exercise of the emerging of the emerging scale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exiled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an er (3) Testing for hos care directly. The exercises to test the	spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or aunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual etional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed						

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 13 of 28

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681		UILDING	NSTRUCTION	(X3) DATE COMPI 01/04	LETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532						
(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 APPROPR DEFICIENCY)	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE			
	that is community (A) When a commaccessible, condutacility-based functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exfacilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency scena statements, direct questions designed emergency plan.	nunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based to following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based to; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared							
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per year CAH] must do the	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following: an annual full-scale exercise							

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 14 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		15E681	B. W	ING		01/04	/2023
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF P	ROVIDER OR SUPPLIER				0TH ST		
HILDEGA	ARD HEALTH CEN	TER		FERDIN	NAND, IN 47532		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	nunity-based exercise is not					
		ct an annual individual,					
	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences						
		or man-made emergency					
		ation of the emergency					
		is exempt from engaging in ull-scale community based					
	· ·	· ·					
		ty-based functional exercise et of the emergency event.					
	_	an [additional] annual					
		at may include, but is not					
	limited to the follo						
		scale exercise that is					
	community-based						
	-	ctional exercise; or					
	•	ock disaster drill; or					
	, ,	exercise or workshop that					
	. ,	or and includes a group					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
		emergency scenario, and a					
	set of problem sta						
	•	pared questions designed					
	to challenge an er	·					
	_	he [facility's] response to					
	. , ,	umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	- · · · · · · · · · · · · · · · · · · ·					
	*[For PACE at §46	60.84(d):]					
	-	PACE organization must					
	` '	s to test the emergency					
	plan at least annu	9					
	organization must	-					
	-	an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
	, ,	ict an annual individual,					
	facility based fund		1				

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 15 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		15E681	B. W	ING		01/04/	/2023
****				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	t .		1	0TH ST		
HILDEGA	ARD HEALTH CEN	TER		1	NAND, IN 47532		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY)	
	` '	xperiences an actual natural					
		ergency that requires					
	activation of the emergency plan, the PACE						
	-	gaging in its next required					
		nity based or individual,					
	•	tional exercise following the					
	onset of the emer						
	, ,	n additional exercise every					
		he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to	•					
	' '	scale exercise that is					
	-	or individual, a facility					
	based functional e						
	(B) A mock disas	ercise or workshop that is					
		and includes a group					
	discussion, using	- .					
	_	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
		,, p,					
	*[For LTC Facilitie	es at §483.73(d):]					
	_	ity] must conduct exercises					
		ency plan at least twice per					
	year, including un	announced staff drills using					
	the emergency pro	ocedures. The [LTC facility,					
	ICF/IID] must do t						
	_	an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
		ict an annual individual,					
	facility-based fund						
	-	ility] facility experiences an					

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 16 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		15E681	B. WI	NG		01/04	/2023
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			OTH ST		
HILDEGA	ARD HEALTH CEN	TER			NAND, IN 47532		
	ı						
(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 DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
		nan-made emergency that					
	-	n of the emergency plan, the					
	LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise						
		et of the emergency event.					
	_	dditional annual exercise					
	' '	but is not limited to the					
	following:						
	_	scale exercise that is					1
	` '	or an individual, facility					
	based functional e						
	(B) A mock disas						
	, ,	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the [l	LTC facility] facility's					
	1	naintain documentation of					
	·	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	·					1
		CF/IID must conduct					1
		he emergency plan at least					
		e ICF/IID must do the					
	following:	n annual full again aversion					
		n annual full-scale exercise					
	that is community	-based; or nunity-based exercise is not					
	` '						
	accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires						
		mergency plan, the ICF/IID					
		igaging in its next required					
I	I is evenibrillen on	igaging in ito hoat required	1				Ī

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 17 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681		UILDING	NSTRUCTION	(X3) DATE COMPL 01/04/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532						
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	full-scale community-based functions facility-based functions for the emer (ii) Conduct an additional that may include, following: (A) A second full-community-based facility-based function facility-based functions facility-based functions facility-based functions facility-based functions facility-based functions facility-based functions for the facility-relevant set of problem star messages, or present or challenge an error for the facility functions for the facility for HHAs at §48 (d)(2) Testing. The exercises to test the facility-based function for the facility-based function facility-based functions for the exempt from engage full-scale community-based full-scale full-sc	nity-based or individual, ctional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed. 34.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is gor ommunity-based exercise conduct an annual based functional exercise. A experiences an actual adde emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the							

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 18 of 28

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SU COMPLET 01/04/2	ΓED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532						
(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 CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE			
	years, opposite the functional exercises is led by group discussion, relevant exercises to test to OPO must do the (i) Conduct a paper or workshop at lea exercise is led by group discussion, relevant emergen problem statemer prepared question entered in exercises activation of the emergency (ii) Analyze the OPO is exempt for required testing exercises activation of the emergency (ii) Analyze the OPO is exempt for required testing exercises activation of the emergency (ii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises of the open control of the emergency (iii) Analyze the OPO is exempt for required testing exercise is led of the emergency (iii) Analyze the OPO is exempt for required testing exercises of the emergency (iii) Analyze the OPO is exempt for required testing exercises of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required testing exercises activation of the emergency (iii) Analyze the OPO is exempt for required t	limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and station of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] e OPO must conduct she emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of sts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset							

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 19 of 28

LENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		15E681	B. WING		01/04/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532				
(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		
	exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paperat least annually. If group discussion In narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversible for the transport of the emergency plan at least twice punannounced staff or procedures. The LT following: (i) Participate in an is community-based a. When a community-based function of the emergency plan of the e	dergency events, and revise OPO's] emergency plan, as 3.748]: RNHCI must conduct the emergency plan. The me following: Per-based, tabletop exercise and tabletop exercise is a med by a facilitator, using a relevant emergency plan. The me following and the mergency plan and the mergency plan. The mergency plan and the mergency plan as needed. The mergency events, and revise regency plan, as needed. The mergency plan as needed. The mergency plan are mergency plan			DATE DATE 02/03/2023 r ed s, ential the es ness		
	full-scale functional exercise for 1 year following the onset of the actual event.			year.			
				The corrective action taken for	r the		
	(ii) Conduct an additional exercise that may			other residents that have the			
		imited to the following:		potential to be affected by the			
	a. A second full-sca	le exercise that is		same deficient practice is that			

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 20 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIEF		802 E	ADDRESS, CITY, STATE, ZII 10TH ST INAND, IN 47532	P COD	
	SUMMARY (EACH DEFICIENT REGULATORY OF Community-based of functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or prepare challenge an emerg (iii) Analyze the LT maintain documents exercises, and emer LTC facility's emer accordance with 42 This deficient pract in the facility. Findings include: Based on review of Plan on 01/04/23 be with the Administra Supervisor present, provide documentate exercise during the facility was unable second exercise commonths. The Administra Conduct a second exercise commonth period.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION or an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using sy-relevant emergency scenario, on statements, directed dred questions designed to ency plan. TC facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in			residents g the survey, nd visitors be affected ctice. The ducted an acilities he facility will duct dness facility east twice a have been put that the es not recur is service has e facility's isor on their ty to develop ncy ises to test hcy plan at hat the e deficient hr is that the and/or their he e facility's he acility's	(X5) COMPLETION DATE
K 0000	-	apervisor during the exit		exercises of the facil emergency plan at le annually.	lity	

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

Event ID:

CF5N21

Facility ID: 004429

If continuation sheet

Page 21 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15E681	B. WI	NG _		01/04/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				OTH ST		
HII DEGA	ARD HEALTH CENT	ΓER			NAND, IN 47532		
Т							
(X4) ID	SUMMARY S	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'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
	•	Recertification and State	K 0	000	By submitting the enclosed		
		as conducted by the Indiana			materials, we are not admitting the		
	-	th in accordance with 42 CFR			truth or accuracy of any specif	ic	
	483.90(a).				findings or allegations. We		
	Survey Date: 01/04/23				reserve the right to contest the		
					findings or allegations as part		
	T 111 17 1 0				any proceedings and submit th	nese	
	Facility Number: 0				responses pursuant to our		
	Provider Number:				regulatory obligations. The fac	-	
	AIM Number: 200502430 At this Life Safety Code survey, Hildegard Health Center Inc. was found not in compliance with Requirements for Participation in Medicaid, 42				requests the plan of correction	be	
					considered our allegation of		
					compliance effective 2/3/23 to		
					state findings of the Emergence	;y	
	-	-			Preparedness and Life Safety		
	-	O(a), Life Safety from Fire and the National Fire Protection			Code Survey conducted on		
) 101, Life Safety Code (LSC),			01-04-23.		
		g Health Care Occupancies and					
	410 IAC 16.2.	g Health Care Occupancies and					
	410 IAC 10.2.						
	This facility was loc	cated on the third floor of this					
	-	which was determined to be of					
	Type I (332) constru						
		cility has a fire alarm system					
	•	oke detectors in the corridors,					
		orridors, and all resident					
		e facility has a capacity of 17					
		16 at the time of this survey.					
	4.14 1144 4 551 1545 51	10 40 400 4000 01 4000 001 001					
	All areas where the	residents have customary					
		ered and all areas providing					
	facility services wer						
	•	•					
	Quality Review con	npleted on 01/09/23					
	-						
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm System	n - Testing and					

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 22 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3		(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		15E681	B. WI	NG		01/04	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OTH ST		
HII DEGA	ARD HEALTH CEN	TER			NAND, IN 47532		
THEBLO	· · · · · · · · · · · · · · · · · · ·	TEN		1 LINDII	17 (14), 114 +7 002		
(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
	Maintenance						
	1	m is tested and maintained					
	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.						
		n acceptance, maintenance					
	and testing are re	-					
		IFPA 70, NFPA 72		2.4.5			00/00/2005
		view and interview, the facility	K 0	345	K 345		02/03/2023
	failed to ensure documentation was available to				The corrective action taken for		
		e detectors were sensitivity			those residents found to have		
	tested within the past 24 months or prior. NFPA				been affected by the deficient		
		larm Code, 2010 Edition,			practice is that although no		
		states detector sensitivity shall			specific residents were identifi		
		l year of installation, and every			during the survey, all residents		
	-	after. After the second			staff and visitors have the potential		
	_	test, if sensitivity tests tector has remained within its			to be affected by this deficient		
		ensitivity range, the length of			practice. All smoke detectors		
		ration tests shall be permitted			have now had a sensitivity tes		
		maximum of 5 years. If the			completed to ensure their prop		
		led, records of detector caused			functioning. The facility has o		
		d subsequent trends of these			a copy of the sensitivity testing support this action. The facilit	•	
		ntained. In zones or areas			will also ensure that the smoke	-	
		rms show an increase over the			detector sensitivity testing is	C	
		pration tests shall be performed.			conducted at least every 24		
		smoke detector is within its			months and maintain a		
		ensitivity range, it shall be			documented record of this tes	tina	
	tested using any of				The corrective action taken for	•	
	(1) Calibrated test r				other residents that have the		
	* /	calibrated sensitivity test			potential to be affected by the		
	instrument.	J			same deficient practice is that		
		quipment arranged for the			although no specific residents		
	purpose.				were identified during the surv		
		fire alarm control unit			all residents, staff and visitors	<i>,</i>	
	arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside				have the potential to be affect	ed	
					by this deficient practice. All		
	its listed sensitivity				smoke detectors have now ha	ıd a	
		l sensitivity method acceptable			sensitivity test completed to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E681		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/04/2023		
	PROVIDER OR SUPPLIER		802 E	ADDRESS, CITY, STATE, ZIP CO 10TH ST INAND, IN 47532	DD	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PPROPRIATE	(X5) COMPLETION DATE
	listed and marked s cleaned and recalib The detector sensiti measured using any an unmeasured condetector. This defic residents, staff, and Findings include: Based on record rev a.m. and 1:00 p.m. Maintenance Super unable to produce a report for all smoke month period. The sensitivity test avail Based on interview the Maintenance Su no smoke detector s documentation avail This finding was re and Maintenance Su conference.	have sensitivity outside the ensitivity range shall be rated, or replaced. vity cannot be tested or spray device that administers centration of aerosol into the cient practice could affect all visitors in the facility. View on 01/04/23 between 9:45 with the Administrator and visor present, the facility was smoke detector sensitivity detectors for the past 24 most recent smoke detector lable was dated 01/09/20. at the time of record review, pervisor confirmed there was		ensure their proper fund. The facility has on file at the sensitivity testing to this action. The facility ensure that the smoke of sensitivity testing is concleast every 24 months at maintain a documented this testing. The measures that have into place to ensure that deficient practice does in that a mandatory in-sensitivity tested at 24 months and to maint record of this testing for facility's records. The corrective action that monitor to ensure the depractice will not recur is facility administrator and designee will conduct at least annually in conjunt the Quality Assurance in to ensure that there is documentation to suppose smoke detectors have be sensitivity tested at least months and that there is this testing on file at the	a copy of support will also detector ducted at and record of the been put at the not recur is vice has naintenance consibility to detectors least every tain a the that the d/or their n audit at ction with meetings out that all been at every 24 is record of	
K 0353 SS=C Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the				

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 24 of 28

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
		15E681	B. WI	NG		01/04	/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD	-		
					OTH ST			
HILDEGARD HEALTH CENTER				FERDIN	NAND, IN 47532			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		g, and Maintaining of						
		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 record review, observation, and		K 03	K 0353 K 353			02/03/2023	
		ity failed to document sprinkler			The corrective action taken fo	r		
		in accordance with NFPA 25			those residents found to have			
	_	system. NFPA 25, Standard for			been affected by the deficient			
	_	ting, and Maintenance of			practice is that although no			
		Protection Systems, 2011			specific residents were identif			
		2.4.1 states gauges on wet pipe			during the survey, all resident			
	1 -	hall be inspected monthly to			staff and visitors have the pot			
		e in good condition and the			to be affected by this deficient			
	1	ure is being maintained.			practice. The facility has now			
		valves and fire department			conducted and will continue to			
	connections shall be inspected, tested, and maintained in accordance with Chapter 13.				conduct monthly inspections of			
	Section 13.1.1.2 states Table 13.1.1.2 shall be				the sprinkler system gauges a control values. These inspect			
		on, testing and maintenance of			will be documented monthly a			
	_	onents and trim. Section 4.3.1			maintained in the facility's	iiu		
		be made for all inspections,			sprinkler system preventative			
	tests, and maintenance of the system and its				maintenance files.			
	components and shall be made available to the				The corrective action taken fo	r the		
	authority having jurisdiction upon request. This				other residents that have the			
		ould affect all residents, staff,			potential to be affected by the			
	and visitors in the f				same deficient practice is that			
		-			although no specific residents			
	Findings include:				were identified during the surv			
					all residents staff and visitors	•		

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

Event ID:

CF5N21 Facility ID: 004429

If continuation sheet Page 25 of 28

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/04/2023		
NAME OF PROVIDER OR SUPPLIER HILDEGARD HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		view on 01/04/23 between 9:45			have the potential to be affect			
	-	with the Administrator and			by this deficient practice. The			
	_	visor present, there was no			facility has now conducted an	monthly		
	monthly sprinkler g				continue to conduct monthly			
		lable during the past 12 month			inspections of the sprinkler	· ·		
	_	e quarterly sprinkler system		system gauges and control				
		ned by the facility's vendor on		values. These inspections will be				
		08/18/22 and 11/10/22. was no monthly sprinkler			documented monthly and			
		es inspection documentation			maintained in the facility's			
	•	r that the quarterly sprinkler			sprinkler system preventative maintenance files.			
				The measures that have been put		n nut		
	system inspections performed by the facility's vendor on 08/18/22 and 11/10/22. Based on			into place to ensure that the		ι ραι		
				deficient practice does not recur is				
	interview at the time of record review, the Maintenance Supervisor confirmed the lack of			that a mandatory in-service has				
	sprinkler system inspections on the gauges and			been provided for the maintenance				
	control valves during the past 12 months.				supervisor on their responsib			
	control varves during the past 12 months.				conduct monthly inspections	-		
	This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)				the sprinkler system gauges a			
					control values and document	ariu		
					these findings in the facility's			
					sprinkler system preventative			
					maintenance files.			
					The corrective action taken to)		
					monitor to ensure the deficier			
				practice will not recur is that the				
				facility administrator and/or their				
					designee will conduct a quart			
					audit in conjunction with the	•		
					facility's Quality Assurance			
					meetings to ensure that the			
					maintenance supervisor is			
					inspecting the facility's sprink	ler		
					system gauges and control va	alues		
					monthly and documenting the	ese		
					inspections in the facility's			
				sprinkler system preventative				
					maintenance files.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CF5N21 Facility ID: 004429 If continuation sheet Page 26 of 28

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681		JILDING	lding <u>01</u>		(X3) DATE SURVEY COMPLETED 01/04/2023	
NAME OF PROVIDER OR SUPPLIER HILDEGARD HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532					
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills include to an auditions, at lease that drills are that drills are that drills are that drills are routine. Where drills are drills along the staff is familiar aware that drills are routine. Where drills are	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying at quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of 19.7.1.7 Firew and interview, the facility arterly fire drill documentation ing 3 of 4 quarters. This buld affect all residents, as well	K 0'		K 712 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors have the pote to be affected by this deficient practice. The facility has now conducted a fire drill on each of and will continue to conduct quarterly fire drills on each of three shifts. A record of these drills will be maintained in the facility files by the maintenance supervisor. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that although no specific residents were identified during the surveall residents, staff and visitors have the potential to be affected.	ed s, ential shift he fire e	02/03/2023	

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

Event ID: CF5N21 Facility ID: 004429

If continuation sheet Page 27 of 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/26/2023 FORM APPROVED OMB NO. 0938-039

STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E681		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/04/2023		
NAME OF PROVIDER OR SUPPLIER HILDEGARD HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 802 E 10TH ST FERDINAND, IN 47532					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
TAU	shifts and quarters. This finding was re			IAU	by this deficient practice. The facility has now conducted a f drill on each shift and will cont to conduct quarterly fire drills each of the three shifts. A record these fire drills will be maintained in the facility files the maintenance supervisor. The measures that have been into place to ensure that the deficient practice does not record that a mandatory in-service has been provided for the facility maintenance supervisor on the responsibility to conduct and maintain documentation to su the completion of quarterly fire drills on each of the three shift. The corrective action taken to monitor to ensure the deficient practice will not recur is that the facility administrator and/or the designee will conduct quarterly audits in conjunction with the facility Quality Assurance meetings of the facility fire dril records to ensure there is supportive documentation of the completion of quarterly fire dril being conducted on each of the three shifts.	ire tinue on cord by n put cur is as eir pport e ts. ut he eir y	DATE		

Event ID: $CF5N21 \qquad {\tt Facility\ ID:} \quad 004429$ Page 28 of 28 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet