	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF F	PROVIDER OR SUPPLIER F DALE	STREET ADDRESS, CITY, STATE, ZIP COI 510 W MEDCALF ROAD DALE, IN 47523			
(X4) ID PREFIX TAG E 0000	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 08/29/23  Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490  At this Emergency Preparedness survey, Core of Dale was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  The facility has 60 certified beds. At the time of the survey, the census was 39.  The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:  Quality Review completed on 09/13/23	E 0000	Preparation and/or execution this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals where draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's creditallegation of compliance.	e ts. e fault o nis	
E 0006 SS=F Bldg	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a) (1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) (1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) (1)-(2)  Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),				
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

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

(X6) DATE

Lorri Maples Administrator 09/28/2023

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.

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. W.	JILDING	<del></del>	COMPL	
		155270	B. W.			08/29/	2023
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
CORE O	F DALE				MEDCALF ROAD N 47523		
(X4) ID	T	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	§485.625(a)(1)-(2	), §485.727(a)(1)-(2),					
		), §486.360(a)(1)-(2),					
	§491.12(a)(1)-(2),	§494.62(a)(1)-(2)					
	[(a) Emergency P	lan. The [facility] must					
	develop and maintain an emergency						
	preparedness plan that must be reviewed,						
	and updated at least every 2 years. The plan						
	must do the follow	ving:]					
	(1) Be based on a	and include a documented,					
		community-based risk					
	1	ing an all-hazards					
	approach.*						
	(2) Include strategies for addressing						
		s identified by the risk					
	assessment.	,					
	* [For Hospices at	t §418.113(a):] Emergency					
		e must develop and					
	•	gency preparedness plan					
		ewed, and updated at least					
		e plan must do the					
	following:						
		ind include a documented,					
	-	community-based risk					
	· ·	ing an all-hazards					
	approach.						
	` '	gies for addressing					
		s identified by the risk Iding the management of					
		s of power failures, natural					
		er emergencies that would					
		's ability to provide care.					
	*IFor LTC fooilities	o at \$492 72(a):1					
	*[For LTC facilities	s at §483.73(a):] The LTC facility must					
		tain an emergency					
		n that must be reviewed,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155270	B. W	ING		08/29/	/2023
NAME OF I	PROVIDER OR SUPPLIEF	)		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	FRO VIDER OR SUFFLIER				MEDCALF ROAD		
CORE O	F DALE			DALE, I	IN 47523		
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	and updated at least annually. The plan must do the following:  (1) Be based on and include a documented,						
	1 ' '	community-based risk					
	1	ing an all-hazards					
		ng missing residents.					
		gies for addressing					
	emergency events identified by the risk						
	assessment.	,					
	*[For ICF/IIDs at §	§483.475(a):] Emergency					
	Plan. The ICF/IID must develop and maintain						
	an emergency preparedness plan that must						
	be reviewed, and updated at least every 2						
	years. The plan m	nust do the following:					
	(1) Be based on a	and include a documented,					
	facility-based and	community-based risk					
		ing an all-hazards					
		ng missing clients.					
		gies for addressing					
		s identified by the risk					
	assessment.					_	10/20/202
		view and interview, the facility	E 0	006	Preparation and/or execution	OŤ .	10/20/2023
		complete emergency			this plan do not constitute	_	
		hat was (1) based on and nted, facility-based and			admission or agreement by the provider that a deficiency exist		
		isk assessment, utilizing an			This response is also not to be		
	-	h, including missing clients			construed as an admission of		
		rategies for addressing			by the facility, its employees,	iauit	
	1 1	dentified by the risk			agents or other individuals wh	0	
		rdance with 42 CFR 483.73(a)			draft or may be discussed in the		
		3.73(a) (2). This deficient			response and plan of correction		
	practice could affect				This plan of correction is		
	1	1			submitted as the facility's cred	ible	
	Findings include:				allegation of compliance.		
					1 Immediate action(s) take	en	
	Based on review of	the Emergency Preparedness			for the resident(s) found to have		
	plan on 08/29/23 be	etween 9:30 a.m. and 1:30 p.m.			been affected include:		
	with the Administra	ator and Maintenance			The risk assessment that was	not	

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	OF CORRECTION	IDENTIFICATION NUMBER  155270	A. BUILDING B. WING		COMPI 08/29	LETED
NAME OF F	PROVIDER OR SUPPLIER F DALE		510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
(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 B CROSS-REFERENCED TO THE APPROPI	[ E RIATE	(X5) COMPLETION DATE
	the plan, however, t community-based ri all-hazards approach on interview at the t Administrator said s risk assessment for plan but it could not This finding was re-	sk hazards were addressed in here was no facility-based and sk assessment utilizing an h available for review. Based time of record review, the she knows the facility has a the Emergency Preparedness		available at the time of survey found and placed back into a Emergency Preparedness but was also updated to include strategies for addressing emergency events identified risk assessment.  2 Identification of other residents having the potential be affected was accomplish. The facility has determined residents have the potential affected.  3 Actions taken/system into place to reduce the rist future occurrence include: All staff were in-serviced regithe facility all hazards risk assessment and the important thereof.  The maintenance staff was in-serviced regarding ensuri documentation remains in the Emergency Preparedness be so it's easily accessible when needed.  The risk assessment was up to ensure that hazards were identified, and strategies we addressed.  4 How the corrective action(s) will be monitored ensure the practice will not recur:  The Maintenance Director we review and update the hazards assessment annually and as needed to keep the most cut information undated.	the inder. de la by the la to ed by: that all to be las put lak of garding lance las inder en las dated fre las dated fre las dated fre las dated	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 9/2023	
NAME OF P	ROVIDER OR SUPPLIER		510 W	ADDRESS, CITY, STATE, ZIP MEDCALF ROAD IN 47523	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 0009 SS=C Bldg	441.184(a)(4), 482.483.73(a)(4), 484.485.68(a)(4), 485.486.360(a)(4), 49.496.3748(a)(4), \$4.541.184(a)(4), \$4.541.184(a)	6.54(a)(4), 418.113(a)(4), 6.15(a)(4), 483.475(a)(4), 102(a)(4), 485.625(a)(4), 727(a)(5), 485.920(a)(4), 1.12(a)(4), 494.62(a)(4), Il Collaboration Process 16.54(a)(4), §418.113(a)(4), 160.84(a)(4), §482.15(a)(4), 183.475(a)(4), §485.727(a)(5), 186.360(a)(4), §491.12(a)(4), 187.625(a)(4), §491.12(a)(4), 188.360(a)(4), §491.12(a)(4), 189.625(a)(4), §491.12(a		The Maintenance Dire bring the Emergency Preparedness binder Emergency Prepared meetings and review management team and hazard assessment at Emergency Prepared reviewed by the Qualit Committee until such consistent substantial has been achieved as by the committee.  Corrective action community 10/20/23	to quarterly ness with the nd update the s needed. ness will be ity Assurance a time compliance s determined	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 08/29/2023		
	AME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD DALE, IN 47523				
PI	(4) ID REFIX 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
		and Federal emerofficials' efforts to response during a situation. *  * [For ESRD faciliti (4) Include a proceed collaboration with and Federal emerofficials' efforts to response during a situation. The dial the local emergen least annually to aware of the dialy event of an emerograph and the end of the dialy event of an emerograph and the end of the dialy event of an emerograph and the end of the dialy event of an emerograph and the end of the dialy event of an emerograph and the end of th	view and interview, the facility emergency preparedness plan for cooperation and ocal, tribal, regional, State, or preparedness officials' efforts grated response during a cy situation, including the LTC facility's efforts to and, when applicable, of its aborative and cooperative accordance with 42 CFR deficient practice could affect all of the Emergency Preparedness etween 9:30 a.m. and 1:30 p.m. attor and Maintenance no documentation was luded a process for laboration with local, tribal,	EO	009	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's crediallegation of compliance.  1 Immediate action(s) take for the resident(s) found to have been affected include: The maintenance director contacted the state and local emergency management officing for our district to inquire about meetings and/or community direct. A record will be kept of data and times contact was made of	e ts. e fault o nis on. ible en ve ials rills tes	10/20/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155270	B. WI	NG		08/29/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MEDCALF ROAD		
CORE O	F DALE			l	IN 47523		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	preparedness official	als' efforts to maintain an			attempted with emergency		
	integrated response	during a disaster or			officials.		
	emergency situation	n. Based on interview at the			2 Identification of other		
	time of review, the Administrator acknowledged				residents having the potential	to	
	there was no cooperation and collaboration				be affected was accomplished	l by:	
	process in the Emergency Preparedness plan				The facility has determined the	at all	
	available for review.  This finding was reviewed with the Administrator and Maintenance Supervisor during the exit				residents have the potential to	be	
					affected.		
					3 Actions taken/systems	put	
					into place to reduce the risk	of	
	conference.				future occurrence include:		
					Maintenance staff were in-ser	viced	
					regarding the facility policy for	. !	
					updating the emergency planr	ning	
					partners and contacting them		
					periodically to find out about		
					meetings and community drills	s, as	
					well as planning a collaborativ	⁄e	
					event involving the partners.		
					4 How the corrective		
					action(s) will be monitored to	0	
					ensure the practice will not		
					recur:		
					The maintenance director will		
					continue to be in contact with	the	
					emergency management offic	ials	
					for our district to inquire about	i	
					meetings and collaborative ev	ents.	
					The facility will participate in the	ne	
					collaboration with officials whe	∍n	
					scheduled.		
					The Administrator will review t	ihe	
					record of contact weekly for 6	ļ	
					months to ensure attempts are	e	
					made to schedule a collabora	tive	
					event and/or attend		
					trainings/meetings for the loca	al	
					area.		
					The records of phone/emails t	:O	

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emergency management officials

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  X3) DATE SURVI  COMPLETED  08/29/2023			LETED		
NAME OF I	PROVIDER OR SUPPLIE F DALE	R		510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
	SUMMARY (EACH DEFICIENT REGULATORY OF 1997)  403.748(b)(7), 41 482.15(b)(7), 483 485.625(b)(7), 484 Arrangement with §403.748(b)(7), §460.84(b)(8)	8.113(b)(5), 441.184(b)(7), 475(b)(7), 483.73(b)(6), 494.62(b)(6) 0 Other Facilities 418.113(b)(5), §441.184(b)(7), §482.15(b)(7), §483.73(b)(7), §485.625(b)(7),		STREET A	MEDCALF ROAD	etings strict be lity uch a	(X5) COMPLETION DATE
	must develop and preparedness pole on the emergency (a) of this section paragraph (a)(1) communication p section. The poli be reviewed and years [annually for minimum, the pole address the follow	procedures. The [facilities] If implement emergency licies and procedures, based by plan set forth in paragraph control, risk assessment at control this section, and the lan at paragraph (c) of this coies and procedures must updated at least every 2 control this coies and procedures must updated at least every 2 cont					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155270		A. BUILDING C			COMPL 08/29/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF			510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	LTC Facilities at § procedures. (7) [o arrangements with other providers to of limitations or comaintain the contipatients.	pitals at §482.15(b), and [483.73(b):] Policies and r (5)] The development of n other [facilities] [and] receive patients in the event essation of operations to nuity of services to facility					
	§483.475(b), CAF at §485.920(b) an §494.62(b):] Polic (6), (8)] The deve with other [facilities receive patients in cessation of opera	ds at §486.625(b), CMHCs d ESRD Facilities at ies and procedures. (7) [or lopment of arrangements is ] [or] other providers to a the event of limitations or ations to maintain the ces to facility patients.					
	procedures. (7) To arrangements with providers to receival limitations or cess maintain the continuous services to RNHC						
	failed to ensure emand procedures includers arrangements with a providers to receive limitations or cessa the continuity of se accordance with 42 deficient practice of Findings include:	view and interview, the facility ergency preparedness policies ude the development of other LTC facilities and other eresidents in the event of tion of operations to maintain rvices to LTC residents in CFR 483.73(b)(7). This ould affect all occupants.	E 00	025	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals whe draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's crediallegation of compliance.	e ts. e fault o o nis	10/20/2023
	plan on 08/29/23 be	etween 9:30 a.m. and 1:30 p.m.			1 Immediate action(s) take	en	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	-	SURVEY LETED 1/2023
NAME OF I	PROVIDER OR SUPPLIEI F DALE	₹	510 W	ADDRESS, CITY, STATE, ZIP CO MEDCALF ROAD IN 47523	DD	
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	with the Administra Supervisor present, preparedness polici the development of facilities and other in the event of limit operations was ava list of facilities hav Furthermore, at lea list has currently ch Based on interview the Administrator at arrangements with updated.	ator and Maintenance documentation of emergency es and procedures including arrangements with other LTC providers to receive residents tations or cessation of ilable for review, however, the e not been updated since 2019. st one of the facility's on the hanged names and ownership. at the time of record review, higreed the documentation of other facilities needs to be eviewed with the Administrator upervisor during the exit		for the resident(s) found been affected include: The list of providers was in the Emergency Prepared binder and new agreem signed with the 2 other I nursing homes in the concept affected was accompared to the facility has determined affected.  3 Actions taken/systinto place to reduce the future occurrence included affected. All staff were in-serviced the facility Emergency Preparedness binder an agreements with other futures occurrence included affected. Maintenance staff were on keeping the Emergency Preparedness binder up current information and changed as needed. New agreements were staff as needed to keep the recur: The Maintenance Direct review and update the as needed to keep the recurrent information updated the maintenance Direct review and update the as needed to keep the recurrent information updated the maintenance Direct review and update the as needed to keep the recurrent information updated the maintenance Direct review and update the precurent information updated to Maintenance Direct review and update the precurent information updated to maintenance Direct review and update the precurent information updated to the precurent	s updated aredness ents were local punty. Their tential to blished by: ned that all intial to be stems put e risk of ude: d regarding and on the facilities for in-serviced ncy blated to will be signed with g homes in e have a and the facilities for it in the facilities for it in the signed with g homes in e have a facilities for it in the facilities for it in the facilities for in the signed with g homes in e have a facilities for it in the f	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 9/2023
NAME OF F	PROVIDER OR SUPPLIER		510 W	ADDRESS, CITY, STATE, ZIP MEDCALF ROAD IN 47523	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 0026 SS=C Bldg	(iv), 441.184(b)(8) (8), 483.73(b)(8), 47), 494.62(b)(7) Roles Under a Wa §403.748(b)(8), §4 (C)(iv), §441.184(l) §482.15(b)(8), §48 §485.625(b)(8), §4 [(b) Policies and p must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication plasection. The policibe reviewed and u years [annually forminimum, the policiaddress the follow	6.54(b)(6), 418.113(b)(6)(C) , 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b)  aiver Declared by Secretary 416.54(b)(6), §418.113(b)(6) b)(8), §460.84(b)(9), 33.73(b)(8), §483.475(b)(8), 485.920(b)(7), §494.62(b)(7).  rocedures. The [facilities] implement emergency cies 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 every 2 r LTC facilities]. At a cies and procedures must ring:]  (7), or (9)] The role of the		bring the Emergency Preparedness binder Emergency Prepared meetings and review management team ar agreements as neede Emergency Prepared reviewed by the mont Assurance Committe time consistent subst compliance has been determined by the co  Corrective action com 10/20/23	to quarterly thess with the nd update the ed. dness will be thly Quality e until such a cantial n achieved as mmittee.	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE ( A. BUILDING B. WING	<u></u>	DATE SURVEY COMPLETED 08/29/2023
NAME OF I	PROVIDER OR SUPPLIEF	3	510 V	T ADDRESS, CITY, STATE, ZIP COD V MEDCALF ROAD E, IN 47523	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Secretary, in according of the Act, in the particular treatment at an all by emergency material waiver declared by accordance with surprovision of care a identified by emerofficials.  Based on record regarded to ensure emand procedures includer a waiver declared to ensure emand procedures includer a waiver declared accordance with seprovision of care are acresite identified officials in accordance with seprovision of care are site identified officials in accordance.  Findings include:  Based on review of plan on 08/29/23 be with the Administration of the LTC fact the Secretary. Based record review, the Administration of the LTC fact the available plan of LTC facility under Secretary.  This finding was record finding was recor	vaiver declared by the ordance with section 1135 provision of care and ternate care site identified anagement officials.  A403.748(b):] Policies and the role of the RNHCl under a sy the Secretary, in section 1135 of Act, in the fact an alternative care site and the role of the LTC facility being an anagement wiew and interview, the facility being an anagement with the fact an alternative care site and the role of the LTC facility being an anagement and the role of the LTC facility being an anagement and the role of the Act, in the fact the role of the Act, in the fact the role of the Act, in the fact the role of the Act and the real treatment at an alternate by emergency management face with 42 CFR 483.73(b)(8). The Emergency Preparedness between 9:30 a.m. and 1:30 p.m. and and Maintenance the plan did not address the illity under a waiver declared by and on interview at the time of Administrator acknowledged and not address the role of the a waiver declared by the viewed with the Administrator supervisor during the exit	E 0026	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of faul by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.  1 Immediate action(s) taken for the resident(s) found to have been affected include: The facility has a new policy establishing roles for providing care during emergencies under blanket or specific 1135 waivers. 2 Identification of other residents having the potential to be affected was accomplished by The facility has determined that a residents have the potential to be affected. 3 Actions taken/systems put	

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	OF CORRECTION	IDENTIFICATION NUMBER  155270	A. BUILDING B. WING	onstruction 	COMI	PLETED 9/2023
NAME OF P	ROVIDER OR SUPPLIEI DALE	2	510 W	ADDRESS, CITY, STATE, ZIP CO MEDCALF ROAD IN 47523	D	
(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)	ULD BE	(X5) COMPLETION DATE
				into place to reduce the future occurrence inclused. All staff were in-serviced the new facility policy for establishing roles for procare during emergencies blanket or specific 1135.  The maintenance staff win-serviced on the new pestablishing roles for procare during emergencies blanket or specific 1135 and keeping the policy uneeded as roles may chaperiodically.  The facility has a new procare during emergencies blanket or specific 1135.  4 How the corrective action(s) will be monitored ensure the practice will recur:  The Maintenance Direct review and update the Refundated.  The Maintenance Direct review and update the most current informat updated.  The Maintenance Direct bring the Emergency Preparedness binder to Emergency Preparedness meetings and review with management team and policy as needed.  Emergency Preparedness reviewed by the Quality Committee until such at	regarding reviding sunder waivers.  vas policy for oviding sunder waivers ange policy policy oviding sunder waivers.  e pred to I not to keep ation or will quarterly se h the update the Assurance	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/29/2023	
	PROVIDER OR SUPPLIE	R	510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD		
CORE O	F DALE 		DALE,	IN 47523		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0036 SS=F Bldg	403.748(d), 416.5 441.184(d), 482.4 484.102(d), 485.5 485.727(d), 485.5 491.12(d), 494.62 EP Training and \$403.748(d), \$41 \$441.184(d), \$46 \$483.73(d), \$485 \$485.68(d), \$485 \$485.920(d), \$485 \$494.62(d).  *[For RNCHIs at Hospice at \$418. PACE at \$460.84 HHAs at \$484.10 CAHs at \$486.62 485.727, CMHCs \$486.360, and RI Training and testi develop and mair preparedness trathat is based on tin paragraph (a) assessment at pasection, policies at (b) of this section plan at paragraph	54(d), 418.113(d), 15(d), 483.475(d), 483.73(d), 525(d), 485.68(d), 920(d), 486.360(d), 2(d)	TAG		DATE nnce ined	
	_	dated at least every 2 years.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	PLETED 29/2023	
NAME OF F	PROVIDER OR SUPPLIER F DALE	2	510 W	ADDRESS, CITY, STATE, ZIP CO MEDCALF ROAD IN 47523	OD	
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	*[For LTC facilities and testing. The and maintain and training and testing the emergency plans of this section, ris (a)(1) of this section at paragraph (b) of communication plans be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/IImaintain an emergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication plans be reviewed 2 years. The ICF/IImaintain and testing program the section. The training the reviewed 2 years. The ICF/IImaintain and testing program the section. The training the reviewed 2 years. The ICF/IImaintain and testing program the section. The training the training testing and patient orient on the emergency preparand patient orient on the emergency (a) of this section,	s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on 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 ing and testing program and updated at least  \$483.475(d):] Training and ID must develop and gency preparedness training am that is based on the et forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every	TAG	DEPICIENCY		DATE
	and the communion of this section. The	agraph (b) of this section, cation plan at paragraph (c) ne training, testing and m must be evaluated and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155270		r í	JILDING	ONSTRUCTION	(X3) DATE COMPL 08/29/	ETED	
	PROVIDER OR SUPPLIEI DF DALE	<b>R</b>		510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to develop ar preparedness training was reviewed and use accordance with 42 practice could affect Findings include:  Based on review of plan on 08/29/23 be with the Administration Supervisor present, available to show the preparedness training available for review time of record review there is no training for review within the plan.  This finding was residued and the straining for the straining for review within the plan.	view and interview, the facility and maintain an emergency and testing program that updated at least annually in CFR 483.73(d). This deficient	E 00	036	Preparation and/or execution this plan do not constitute admission or agreement by the provider that a deficiency exist a deficiency exist this response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction is submitted as the facility's creat allegation of compliance.  1 Immediate action(s) take for the resident(s) found to has been affected include:  A schedule has been develop complete the testing/training of staff over a period of 1 year, we allows a training/testing to be completed 1 x month. This schedule is based off the updarisk assessment, on hazards indicated.  The first training was completed on 9/23/23 with an active shoot scenario.  2 Identification of other residents having the potential be affected was accomplished. The facility has determined the residents have the potential to affected.  3 Actions taken/systems into place to reduce the risk future occurrence include:  All staff were in-serviced regat the facility policy for an active shooter on 9/23/23.	e ts. e fault o his on. lible en ve ed to of /hich ated et by: at all o be  put of	10/20/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155270	A. BUIL		<del></del>	COMPLE 08/29/2	
		100210				00/23/2	
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD		
CORE O	F DALE				N 47523		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	A schedule has been develope	ad to	DATE
					complete the testing/training o		
					staff over a period of 1 year, w		
					allows a training/testing to be		
					completed 1 x month. This		
					schedule is based off the upda	ated	
					risk assessment, on hazards		
					indicated.		
					4 How the corrective	,	
					action(s) will be monitored to ensure the practice will not	'	
					recur:		
					The Maintenance Director and	ı	
					Administrator will review and		
					update the training/testing		
					program as needed and annua	ally	
					to keep the most current		
					information updated. The Maintenance Director will		
					bring the Emergency		
					Preparedness binder, the		
					completed training or testing a	nd	
					the training/testing program to		
					quarterly Emergency		
					Preparedness meetings and		
					review with the management t	eam	
					and update the program as		
					needed. Emergency Preparedness will	he	
					reviewed by the monthly Quali		
					Assurance Committee until su	-	
					time consistent substantial		
					compliance has been achieve	d as	
					determined by the committee.		
					Corrective action completion of 10/20/23.	late:	
E 0037 SS=F	, , , ,	5.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1),					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 08/29/2023				PLETED	
NAME OF E	PROVIDER OR SUPPLIEF F DALE				DDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523	· •	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	TOPRIATE	DATE
Bldg	483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 49 EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §485.68(d)(1), §4 (1), §485.920(d)(1) §491.12(d)(1).  *[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training ir policies and proceexisting staff, indivunder arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docupreparedness trait (iv) Demonstrate semergency proceed (v) If the emergen and procedures a [facility] must concupated policies at The hospice must (i) Initial training ir policies and proceexisting hospice existing hospice e	102(d)(1), 485.625(d)(1), 1727(d)(1), 485.920(d)(1), 1.12(d)(1) ram 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d) 1), §486.360(d)(1), 6403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, 2, "Organizations" under at §486.360, RHC/FQHCs ram. The [facility] must do 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 1:					
	1 F. 5		i i				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING COMPLETED  B. WING 08/29/2023			
NAME OF P	PROVIDER OR SUPPLIER		510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	consistent with the (ii) Demonstrate s emergency proced (iii) Provide emergat least every 2 ye (iv) Periodically re emergency prepare employees (includ with special emph the procedures ne and others. (v) Maintain docur preparedness train (vi) If the emerger and procedures all hospice must concupdated policies a procedures.  *[For PRTFs at §4 program. The PRT following: (i) Initial training in policies and procedures and procedures and procedures arrangemer consistent with the (ii) After initial train preparedness train (iii) Demonstrate s emergency proced (iv) Maintain docupreparedness train (v) If the emergen and procedures and	cy Must be preceded by full also in expected roles. Itaff knowledge of dures. Itaff knowledge of dures. Itaff knowledge of dures. Itaff knowledge of dures are and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out reessary to protect patients are significantly updated, the duct training on the lind. Itaff knowledge of dures to all new and viduals providing services and volunteers, heir expected roles. Ining, provide emergency ning, provide emergency ning, provide emergency ning every 2 years. Itaff knowledge of dures. Itaff knowledge of all emergency mentation of all emergency mentation of all emergency mentation of all emergency mentation of all emergency		(EACH CORRECTIVE ACTION SHOULD I	DE COMPLETION
	-	edures. 60.84(d):] (1) The PACE do all of the following:			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	A. BU	A. BUILDING			3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF F	PROVIDER OR SUPPLIER F DALE		STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD DALE, IN 47523					
(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	
IAU	(i) Initial training in policies and proce existing staff, indiviservices under arrivarticipants, and witheir expected role (ii) Provide emerging at least every 2 yearticipants of whom to contact in (iv) Maintain docu (v) If the emerger and procedures and proce	remergency preparedness dures to all new and viduals providing on-site angement, contractors, volunteers, consistent with est. ency preparedness training ears. Staff knowledge of dures, including informing at to do, where to go, and in case of an emergency. In entation of all training. The contract training on the updated edures.  Is at §483.73(d):] (1)  The LTC facility must do all the emergency preparedness edures to all new and viduals providing services int, and volunteers, eit expected role. The ency preparedness training eatiff knowledge of dures.  485.68(d):](1) Training. The of the following: aining in emergency cies and procedures to all staff, individuals providing angement, and volunteers, eatiff knowledge of city and procedures to all staff, individuals providing angement, and volunteers,		IAU			DATE	

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF P	ROVIDER OR SUPPLIEF	₹		510 W N	DDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523		
(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
	at least every 2 ye (iii) Maintain docu (iv) Demonstrate semergency procedures are sponsibilities recemergency plan workday. The traininstruction in the lessystems and signate equipment. (v) If the emerge and procedures a CORF must condupolicies and procedures and disaster authorized and disaster authorized and disaster authorized and procedures are gency pr	mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting ency preparedness policies re significantly updated, the uct training on the updated edures.  35.625(d):] (1) Training H must do all of the n emergency preparedness edures, including prompt inguishing of fires, here necessary, evacuation innel, and guests, fire properation with firefighting porities, to all new and widuals providing services int, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. ency preparedness policies re significantly updated, the cut training on the updated					

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	OF CORRECTION	IDENTIFICATION NUMBER  155270	A. BUILDING B. WING		nstruction 	COMPLETED 08/29/2023	
NAME OF F	PROVIDER OR SUPPLIER			510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The CMHC must pemergency prepare procedures to all rindividuals providi arrangement, and their expected role documentation of must demonstrate emergency proced CMHC must provipreparedness train Based on record revigated to conduct an Emergency Prepare LTC facility must distraining in emergen procedures to all neindividuals providing and volunteers, con roles; (ii) Provide estraining at least ann documentation of altraining; (iv) Demonemergency procedures to all residents in the findings include:  Based on review of plan on 08/29/23 be with the Administrate Supervisor present, Emergency Prepared documentation to skinowledge of the Ewas available for rethe time of record rec	volunteers, consistent with es, and maintain the training. The CMHC staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. riew and interview, the facility nual training for the dness Program (EPP). The o all of the following: (i) Initial cy preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain I emergency preparedness nistrate staff knowledge of res in accordance with 42 CFR deficient practice could affect	E 0	037	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credicallegation of compliance.  1	e e e e e e e e e e e e e e e e e e e	10/20/2023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155270	B. WING		08/29/2023
NAME OF T	DROLUDED OF CURRY		STREET A	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIEF	C	510 W	MEDCALF ROAD	
CORE O	F DALE		DALE,	IN 47523	
(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	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		edness plan training and no		knowledge of emergency	
		how staff could demonstrate		procedures.	
	I -	mergency Preparedness plan		The first monthly training was	
	was available for review.  This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.			completed on 9/23/23 with an	
				active shooter scenario.	
				2 Identification of other	
				residents having the potential	
				be affected was accomplished	-
				The facility has determined the	
				residents have the potential to	be
				affected.	
				3 Actions taken/systems	- I
				into place to reduce the risk	of
				future occurrence include:	
				All staff were in-serviced rega	rding
				the facility policy for an active	
				shooter on 9/23/23.	
				A schedule has been develop	
				complete the testing/training of	
				staff over a period of 1 year, w	hich
				allows a training/testing to be	
				completed 1 x month. This	
				schedule is based off the upda	ated
				risk assessment, on hazards	
				indicated. The schedule will ha	ave
				at least 1 annual emergency	
				preparedness training and	
				documentation to show trainin	-
				was completed as well as staf	T
				knowledge of emergency	
				procedures.	
				4 How the corrective	
				action(s) will be monitored to	P
				ensure the practice will not	
				recur:	1 41
				The Maintenance Director and	i tne
				Administrator will review and	
				update the training/testing	- II
	I		1	I program as needed and annu-	ווב עווב

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to keep the most current

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2023		
NAME OF F	PROVIDER OR SUPPLIEF		510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	information updated. The Maintenance Director and the Administrator will ensure that annual emergency preparedntraining is scheduled and inclustaff knowledge of emergency procedures.  The Maintenance Director will bring the Emergency Preparedness binder and the training/testing program to quarterly Emergency Preparedness meetings and review with the management and update the program as needed.  Emergency Preparedness will reviewed by the monthly Qual Assurance Committee until su time consistent substantial compliance has been achieve determined by the committee.  Corrective action completion of 10/20/23.	an ess udes  team be ity uch a d as
E 0041 SS=F Bldg	§482.15(e) Condii (e) Emergency an The hospital must standby power sy emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485.	LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.			

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	OF CORRECTION	IDENTIFICATION NUMBER  155270	A. BUILDING B. WING		COMI	PLETED 9/2023
NAME OF F	PROVIDER OR SUPPLIER F DALE		510 W I	ADDRESS, CITY, STATE, ZIP COE MEDCALF ROAD IN 47523	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TAG	The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Cool Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildin 482.15(e)(2), §483 Emergency generator the [hospital, CAI implement the eminspection, testing requirements foun Facilities Code, NIC Code.  482.15(e)(3), §483 Emergency generator and LTC facilities] source to power end LTC facilities] source to power end the emergency, unless the systems open emergency, unless the systems open emergency, unless the systems on the systems open emergency, unless the systems of the systems open emergency, unless the systems of the systems open emergency, unless the systems of the systems o	and the CAH] must ency and standby power the emergency plan set (a) of this section.  33.73(e)(1), §485.625(e)(1) ator location. The clocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA dd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, dd NFPA 110, when a new of when an existing ing is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. Hand LTC facility] must ergency power system and [maintenance] dd in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency erational during the	TAG	CROSS-REFERENCED TO THE APP	ROPRIATE	DATE
	§483.73(g), and C The standards inc this section are ap	AHs §485.625(g):] orporated by reference in proved for incorporation by Director of the				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		A. BUILDING B. WING	<del></del>	(X3) DATE SURVEY  COMPLETED  08/29/2023	
	PROVIDER OR SUPPLIE DF DALE	R	510 W	ADDRESS, CITY, STATE, ZIP COI MEDCALF ROAD IN 47523	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APF	ULD BE COMPLETION	
TAG	Federal Register	in accordance with 5 U.S.C.	TAG	DEFICIENCY	DATE	
	the material from You may inspect Information Reso Boulevard, Baltim	R part 51. You may obtain the sources listed below. a copy at the CMS urce Center, 7500 Security tore, MD or at the National cords Administration				
	(NARA). For informathis material at Nago to:	mation on the availability of ARA, call 202-741-6030, or				
	_of_federal_regu If any changes in incorporated by re	es.gov/federal_register/code lations/ibr_locations.html. this edition of the Code are eference, CMS will publish a Federal Register to				
	(1) National Fire I Batterymarch Par Quincy, MA 0216 1.617.770.3000.	Protection Association, 1 k, 9, www.nfpa.org,				
	2012 edition, issu (ii) Technical inte NFPA 99, issued	Ith Care Facilities Code, led August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9,				
	2013.	FPA 99, issued March 7,				
	2014.	FPA 99, issued March 3, ife Safety Code, 2012				
	edition, issued Au (viii) TIA 12-1 to I 11, 2011. (ix) TIA 12-2 to N 30, 2012.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING COMP			ETED		
		155270	B. WING			08/29	
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CODE O	E DALE				MEDCALF ROAD		
CORE O	F DALE			DALE, I	IN 47523		
(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
	(xi) TIA 12-4 to NF	FPA 101, issued October					
	22, 2013.	,					
		tandard for Emergency and					
	• •	ystems, 2010 edition,					
		chapter 7, issued August 6,					
	2009	3 -7					
		view and interview, the facility	E 0	041	Preparation and/or execution	of	10/20/2023
		the emergency power system			this plan do not constitute		= 0. 20. 2025
	_	and maintenance requirements			admission or agreement by th	е	
		Care Facilities Code, NFPA			provider that a deficiency exis		
		y Code in accordance with 42			This response is also not to be		
	CFR 483.73(e)(2).	,			construed as an admission of		
	GTR 103.75(0)(2).				by the facility, its employees,		
	Based on record	review and interview, the			agents or other individuals wh	10	
		ercise the generator annually to			draft or may be discussed in t		
		nts of NFPA 110, 2010 Edition,			response and plan of correction		
	-	nergency and Standby Powers			This plan of correction is		
		.4.2. Section 8.4.2 states diesel			submitted as the facility's cred	lible	
		rvice shall be exercised at least			allegation of compliance.		
		minimum of 30 minutes, using			1 Immediate action(s) take	en	
	one of the following				for the resident(s) found to ha		
		intains the minimum exhaust			been affected include:		
		recommended by the			The Administrator signed a		
	manufacturer	•			contract with Cummins Sales	and	
	(2) Under operating	temperature conditions and at			Service to maintain the genera	ators	
	not less than 30 per	cent of the EPS (Emergency			annual/1.5-hour load bank tes		
	Power Supply) nam	eplate kW rating.			the 36 month/4 hour load bank	k	
	Section 8.4.2.3 state	es diesel-powered EPS			test and annual fuel quality tes	st.	
		not meet the requirements of			The 4-hour load bank test was		
	8.4.2 shall be exerc	ised monthly with the available			performed on 9/18/23 and		
	EPSS (Emergency l	Power Supply System) load and			documented.		
	shall be exercised a	nnually with supplemental			2 Identification of other		
	loads (Load Bank T	est) at not less than 50 percent			residents having the potential	to	
	of the EPS namepla	te kW rating for 30 continuous			be affected was accomplished		
		ess than 75 percent of the EPS			The facility has determined the	at all	
	nameplate kW ratin	g for 1 continuous hour for a			residents have the potential to	be	
	total test duration of	f not less than 1.5 continuous			affected.		
	hours. This deficien	t practice could affect all			3 Actions taken/systems	put	
	occupants in the fac	eility.			into place to reduce the risk		
					future occurrence include:		
					•		•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE C A. BUILDING B. WING	construction 	(X3) DATE SURVEY  COMPLETED  08/29/2023			
NAME OF P	PROVIDER OR SUPPLIER	<b>R</b>	STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD DALE, IN 47523				
CORE OF CASE O	SUMMARY (EACH DEFICIEN REGULATORY OF Findings include:  Based on record revalue a.m. and 1:30 p.m. Supervisor present, for the diesel power less than 30% during Based on interview the Maintenance Sugenerator ran under does not achieve 30 Additionally, the Macknowledged a loahas not occurred with the maintenance Sugenerator ran under does not achieve 30 Additionally, the Macknowledged a loahas not occurred with the maintenance Sugenerators.  2. Based on record facility failed to enswas performed for generators. NFPA 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA 110, St Standby Power Syst NFPA 110, Section shall be performed approved by ASTM practice could affect and visitors.  Findings include:	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  View on 08/29/23 between 9:30 with the Maintenance the monthly load percentage red generator was documented ag the past 12 month period. at the time of record review, apervisor acknowledged the r load on a monthly basis but 0% of the name plate rating. faintenance Supervisor ad bank test for the generator athin the past 12 month period.  Viewed with the Administrator apervisor during the exit  review and interview, the sure an annual fuel quality test 1 of 1 diesel powered 99, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states the performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 18.3.8 states a fuel quality test at least annually using tests If standards. This deficient at all residents, as well as staff	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTED ACTION SHOOL CROSS-REFERENCED TO THE APPLICATION SHOUL CROSS-REFERENCED TO THE APPLICATION SHOULD SHOUL CROSS-REFERENCED THE APPLICATION SHOULD SHOULD SHOUL CROSS-REFERENCED THE APPLICATION SHOULD SHOUL CROSS-REFERENCED THE APPLICATION SHOULD SHOUL CROSS-REFERENCED THE APPLICATION SHOULD	in-serviced cy for in-service in		
		view on 08/29/23 between 9:30 with the Maintenance					

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	OF CORRECTION	IDENTIFICATION NUMBER  155270	A. BU	A. BUILDING  B. WING		COMPLETED 08/29/2023	
NAME OF F	PROVIDER OR SUPPLIER			510 W N	DDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	an annual generator however, there was annual fuel quality to available for review period. The most rediesel generator was almost a month past the time of record resupervisor said she inspection vendor at the facility by the enduel sample at that to the fuel sample at that to the fuel sample at that to the facility failed to profor the testing of 1 conference.  3. Based on record facility failed to profor the testing of 1 conference.  3. Based on record facility failed to profor the testing of 1 conference for the testing of 1 conference.  5. Section 8.4.9, as reconference for Emergency and Section 8.4.9 states Power Systems shall every three years. Sugreater than 4 hours terminate the test afford. In the facility failed to proform the facilities of the faci	there was documentation of inspection dated 02/07/23, no documentation of an est for the diesel generator during the past 12 month event fuel quality test for the stated 08/03/22, which was a due. Based on interview at eview, the Maintenance called the generator and was told they would be at and of the month and take the ime.  Wiewed with the Administrator apervisor during the exit  review and interview, the vide complete documentation of 1 Emergency Power Standby the with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care tion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 1 be tested at least once within Where the assigned class is a tishall be permitted to the standard to the standar					

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	of correction identification number 155270	A. BUILDING COMPLETED  B. WING 08/29/2023				
NAME OF I	PROVIDER OR SUPPLIER F DALE	STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD DALE, IN 47523				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0000	Supervisor present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record review.  This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.					
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date: 08/29/23  Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490  At this Life Safety Code survey, Core of Dale was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping	K 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals where draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's creditallegation of compliance.	e ts. e fault o nis		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 02 COMPLETED B. WING 08/29/2023			ETED		
NAME OF F	PROVIDER OR SUPPLIER			510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
(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
K 0281 SS=E Bldg. 02	All areas where the access were sprinkl facility services were detached laundry by detached laundry by Quality Review corn.  NFPA 101  Illumination of Me Illumination of Me Illumination of Me Illumination of me discharge, is arrar and shall be either or capable of automanual intervention 18.2.8, 19.2.8  Based on observation failed to ensure the egress was properly leave the area in darillumination shall be failure of any single in an illumination shall be failure of any single in an illumination lain any designated accould affect at least and visitors.  Findings include:  Based on observation p.m. and 3:15 p.m. the Maintenance Sure Man, there were ligoutside the 100 unit both controlled by a door. The Maintenance Maintenance Sure Maintenance Maintenanc	residents have customary ered and all areas providing re sprinklered, except a milding.  Impleted on 09/13/23  Impleted on 09/13/23  Impleted on Egress Impleted on Geress Impleted on G	K 0	281	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals who draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's credical equation of compliance.  1 Immediate action(s) take for the resident(s) found to have been affected include: The 2 lights that were not photocells, have been replace with automatic dusk to dawn operation lights and the switch have been taken out of services.	e ts. e fault o nis on. lible en ve d	10/20/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	_	SURVEY LETED 0/2023	
NAME OF I	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD DALE, IN 47523				
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE	
	generator. The swi unit exit, but turned time of each observ Supervisor said she were equipped with automatically come	res are connected to the tch was turned on at the 100 d off at the 200 unit exit at the ration. The Maintenance of didn't think the light fixtures a photo cells that would on when it turns dark outside. Wiewed with the Administrator supervisor during the exit		covered.  2 Identification of or residents having the pote affected was accommand the pote affected.  3 Actions taken/sy into place to reduce the future occurrence included in the maintenance staff in-serviced on ensuring outside lighting is maining good working order to eat they come on automatification.  2 dusk to dawn lights we purchased and installed continuous operation.  4 How the correctification(s) will be moniting ensure the practice with recur:  The maintenance direct complete weekly audits consecutive weeks to be lighting is operational to the walkways. After 12 maintenance director we monthly audits for 3 monthly audits	otential to plished by: ined that all ential to be stems put the risk of lude: was a that all the tained in the ensure that cally at the ensure that cally at the ensure to ensure the ensure to ensure the ensure to ensure the ensure that call in the ensure to ensure the ensure to ensure the ensure to ensure the ensure that ensure the ensure to ensure the ensure that ensu		

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155270		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2023			
NAME OF PROVIDER OR SUPPLIER  CORE OF DALE		STREET ADDRESS, CITY, STATE, ZIP COD 510 W MEDCALF ROAD						
	T	STATEMENT OF DEFICIENCIE		ID	IN 47523 T		(V5)	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
					Corrective action completion 10/20/23	date:		
K 0374 SS=E Bldg. 02	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that I Nonrated protecti are permitted. Do fixed fire window are self-closing of require latching, a in the direction of provides a minimu for swinging or ho 19.3.7.6, 19.3.7.8 Based on observati failed to ensure 1 o would close comple barrier. LSC, Sectio barriers to close the minimum clearance which is defined as movement of smoke		K 03	74	Preparation and/or execution this plan do not constitute admission or agreement by the provider that a deficiency exist. This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals with draft or may be discussed in response and plan of correction. This plan of correction is submitted as the facility's creallegation of compliance.	ne ets. e fault no this	10/20/2023	

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Findings include:

Based on observations on 08/29/23 between 1:30

p.m. and 3:15 p.m. during a tour of the facility with

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been affected include:

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Immediate action(s) taken for the resident(s) found to have

Maintenance staff had previously

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 08/29/2023 155270 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 510 W MEDCALF ROAD CORE OF DALE **DALE. IN 47523** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the Maintenance Supervisor and Maintenance identified the problem with the Man, the set of smoke barrier doors between the smoke barrier door on the 100 hall 100 Unit and the center corridor did not close and an order for the doors was completely when tested several times. There was placed on 8/25/23, prior to survey. a 1/4 inch to 1/2 inch gap between the entire The invoice/order was given to length of the doors when closed fully. This was surveyor at the time of survey, The acknowledged by the Maintenance Supervisor at facility is still awaiting delivery and the time of observation, who further said this set installation of the doors as of this of smoke barrier doors are going to be replaced plan of correction submission. when the new smoke barrier doors are delivered. Calls have been placed for an estimated time of This finding was reviewed with the Administrator delivery/installation. and Maintenance Supervisor during the exit Identification of other conference. residents having the potential to be affected was accomplished by: 3.1-19(b) The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Maintenance staff had previously identified the problem with the smoke barrier door on the 100 hall and an order for the doors was placed on 8/25/23, prior to survey. The invoice/order was given to surveyor at the time of survey, The facility is still awaiting delivery and installation of the doors as of this plan of correction submission. Calls have been placed for an estimated time of delivery/installation. How the corrective action(s) will be monitored to ensure the practice will not recur: The maintenance director will

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complete 2 random weekly audits

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	02	COMPLETED	
155270		B. WING		08/29/2023	
NAME OF F	PROVIDER OR SUPPLIEI	3	510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523	
(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	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and conditions. Fire di	the transmission of a fire simulation of emergency fire rills are held at expected imes under varying st quarterly on each shift.		for 12 consecutive weeks to ensure all smoke barrier doors maintained in good condition a working order. Thereafter, maintenance director will commonthly audits ongoing to ensure doors remain in compliance. Audit records will be reviewed the monthly Quality Assurance Committee until such a time consistent substantial compliants been achieved as determined by the committee.  Corrective action completion of 10/20/23	s are and  plete sure  by e ince ined
	The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record refailed to provide qu for 2 of 3 shifts dur	ar with procedures and is re part of established rills are conducted between 0 AM, a coded ay be used instead of 19.7.1.7 view and interview, the facility parterly fire drill documentation ring 4 of 4 quarters. This could affect all residents, as well	K 0712	Preparation and/or execution this plan do not constitute admission or agreement by th provider that a deficiency exis This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals wh	e ts. e fault

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 08/29/2023 155270 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 510 W MEDCALF ROAD CORE OF DALE **DALE. IN 47523** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on review of the facility's fire drill reports draft or may be discussed in this on 08/29/23 between 9:30 a.m. and 1:30 p.m. with response and plan of correction. the Maintenance Supervisor present, the facility This plan of correction is lacked fire drill documentation for the following submitted as the facility's credible shifts and quarters: allegation of compliance. a. First shift (day) of the second quarter (April, Immediate action(s) taken May, and June) of 2023, and the third quarter for the resident(s) found to have (July, August, and September) of 2022 and so far been affected include: in 2023 A monthly fire drill is scheduled on b. Third shift (night) of the first quarter (January, September 28th on second shift at February, and March) of 2023, third quarter (July, 6pm per the new calendar. August, and September) of 2022 and so far in A calendar was initiated for each 2023, and fourth quarter (October, November, and month of the year to show what December) of 2022. day, shift, and time the fire drill will Based on interview at the time of record review, be conducted. The calendar is the Maintenance Supervisor confirmed the lack of placed in the maintenance fire drill reports during the previously mentioned director's office and te shifts and quarters of 2022 and 2023. Administrators' office to ensure the drills are performed. This finding was reviewed with the Administrator Identification of other and Maintenance Supervisor during the exit residents having the potential to conference. be affected was accomplished by: The facility has determined that all 3.1-19(b) residents have the potential to be 3.1-51(c)affected. Actions taken/systems put into place to reduce the risk of future occurrence include: All maintenance staff were in-serviced regarding the facility policy for conducting fire drills monthly, at various times and different shifts. A calendar was initiated for each month of the year to show what day, shift and time the fire drill will be conducted. The calendar is placed in the maintenance director's office and the Administrators' office to ensure

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF P	PROVIDER OR SUPPLIEF	8		510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 02	NFPA 101 Smoking Regulati Smoking Regulati Smoking Regulati Smoking regulati shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib used or stored an location, and such signs that read No posted with the in smoking. (2) In health care smoking is prohib prominently place	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable ble gases, or oxygen is d in any other hazardous n area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ited and signs are d at all major entrances, with language that prohibits			the drills are performed.  4 How the corrective action(s) will be monitored to ensure the practice will not recur:  The Administrator will comple monthly audits of the mainten records to ensure fire drills are conducted per the new calend initiated. Any noncompliance result in counseling's up to an including termination.  Audit records will be reviewed the monthly Quality Assurance Committee for one year or un such a time consistent substate compliance has been achieved determined by the committee.  10/20/23	ete nance re dar will nd d by re till antial ed as	

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CU6621

Facility ID: 000170

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155270	B. W	ING		08/29/2023
NAME OF F	PROVIDER OR SUPPLIEF	2		510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
IAG	(3) Smoking by paresponsible shall (4) The requirement apply where the pare supervision. (5) Ashtrays of notes afe design shall where smoking is (6) Metal contained devices into which shall be readily as smoking is permit 18.7.4, 19.7.4  Based on observation failed to ensure cigal disposed of at 1 of a smoked by resident practice could affect in the properties of the maintenance Supermit the Maintenance Supertrash mixed with at Based on interview Maintenance Supertrash mixed with cican, furthermore, the bag within the 1 observation.  This finding was resident in the properties of t	atients classified as not be prohibited. ent of 18.7.4(3) shall not eatient is under direct encombustible material and be provided in all areas permitted. ers with self-closing cover a ashtrays can be emptied vailable to all areas where ted. encombustible material and be provided in all areas permitted. ers with self-closing cover a shrays can be emptied vailable to all areas where ted. encompared to all areas where ted.	K 0		Preparation and/or execution this plan do not constitute admission or agreement by th provider that a deficiency exis This response is also not to be construed as an admission of by the facility, its employees, agents or other individuals where draft or may be discussed in the response and plan of correction. This plan of correction is submitted as the facility's creat allegation of compliance.  1 Immediate action(s) take for the resident(s) found to has been affected include:  Maintenance disposed of the cigarette butts and trash at time survey.  A sign was placed at the smol area to remind staff not to dispose of cigarette butts in the trash cans, to use the ash cans.  2 Identification of other residents having the potential be affected was accomplished. The facility has determined the	of 10/20/2023 e ts. e fault o his on. dible en ve ne of ke pose to d by:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COMP	E SURVEY PLETED 9/2023
NAME OF P	PROVIDER OR SUPPLIE	R	510 W	ADDRESS, CITY, STATE, ZIP CO MEDCALF ROAD IN 47523	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				residents have the poter affected.  3 Actions taken/sysinto place to reduce the future occurrence incluance All staff were in-serviced the facility policy for disposing of the cigarette butts properly in the ash cans, not the cans.  Maintenance staff were on disposing of the cigaretre butts properly when cleaning smoking areas and not them in the trash.  A sign was placed at the area to remind staff not of cigarette butts in the cans, to use the ash can the action(s) will be monitorensure the practice will recur:  The maintenance direct complete 5 audits per will months, then 3 audits per will months, then 3 audits per will months are disposing properly in the ash cansitrash cans.  Audit records will be reverthe monthly Quality Ass Committee until such a consistent substantial contains the committee.  Corrective action complete 20/20/23	e risk of ude: d regarding cosing of and safely trash in-serviced rette butts the throwing e smoke to dispose trash as. ve cored to il not or will reek for 3 er week for g areas to ed of s, not the riewed by urance time compliance letermined	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155270 B. WING 08/29/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 510 W MEDCALF ROAD CORE OF DALE **DALE. IN 47523** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0761 SS=C Bldg. 02 Based on observation, record review, and K 0761 Preparation and/or execution of 10/20/2023 interview; the facility failed to ensure an annual this plan do not constitute inspection and testing of 1 of 1 oxygen room fire admission or agreement by the door assembly was completed in accordance with provider that a deficiency exists. LSC 19.1.1.4.1.1. Communicating openings in This response is also not to be dividing fire barriers required by 19.1.1.4.1 shall be construed as an admission of fault permitted only in corridors and shall be protected by the facility, its employees, by approved self-closing fire door assemblies. agents or other individuals who (See also Section 8.3.) LSC 8.3.3.1 Openings draft or may be discussed in this required to have a fire protection rating by Table response and plan of correction. 8.3.4.2 shall be protected by approved, listed, This plan of correction is labeled fire door assemblies and fire window submitted as the facility's credible assemblies and their accompanying hardware, allegation of compliance. including all frames, closing devices, anchorage, Immediate action(s) taken and sills in accordance with the requirements of for the resident(s) found to have NFPA 80, Standard for Fire Doors and Other been affected include: Opening Protectives, except as otherwise Our fire safety vendor has specified in this Code. NFPA 80 5.2.1 states fire completed the annual inspection door assemblies shall be inspected and tested not and testing the oxygen room fire less than annually, and a written record of the door and assembly. inspection shall be signed and kept for inspection Identification of other by the AHJ. NFPA 80, 5.2.4.1 states fire door residents having the potential to assemblies shall be visually inspected from both be affected was accomplished by: sides to assess the overall condition of door The facility has determined that all assembly. residents have the potential to be affected. NFPA 80, 5.2.4.2 states as a minimum, the Actions taken/systems put following items shall be verified: into place to reduce the risk of (1) No open holes or breaks exist in surfaces of future occurrence include: either the door or frame. The maintenance staff were (2) Glazing, vision light frames, and glazing beads in-serviced regarding the facility

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equipped.

are intact and securely fastened in place, if so

(3) The door, frame, hinges, hardware, and

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completed timely.

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policy for testing and inspections

of all fire doors and ensuring it's

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	COM	e survey pleted 9/2023
NAME OF I	PROVIDER OR SUPPLIE	R	510 W	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD IN 47523		
	SUMMARY (EACH DEFICIENT REGULATORY OF Noncombustible thand in working or damage.  (4) No parts are mined in the active door confirm the full open (7) If a coordinator closes before the active door when it is in the self-closing the active door when it is in the self-closes before the active door	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION reshold are secured, aligned, ler with no visible signs of ssing or broken. s do not exceed clearances 6.3.1.7. g device is operational; that is, npletely closes when operated position. r is installed, the inactive leaf ective leaf. vare operates and secures the he closed position. ware items that interfere or are not installed on the door or fications to the door assembly ed that void the label. I edge seals, where required, are their presence and integrity. tice could affect all residents,			ce will to and red to not r will at future ed or salendar nistrator e that it's tor will ders with monthly ed and t and fill be Quality atil such a al nieved as ittee.	(X5) COMPLETION DATE
	facility in the center	er corridor near the dining room.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A DIFFUSION (A2)  COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLETED B. WING 08/29/2023				
		155270	B. WI	NG		08/29/	/2023
NAME OF P	PROVIDER OR SUPPLIER		-	510 W N	DDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523		
(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	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator upervisor during the exit					
	3.1-19(b)						
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est	other alternate power inted equipment is capable be within 10 seconds. If the in is not met during the posess shall be provided to this capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised intervals include.					
	and readily availal	nd testing are maintained ble. EES electrical panels arked, readily identifiable,					
	· ·	n normal power circuits.					
	Minimizing the pos	ssibility of damage of the					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 08/29/2023 155270 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 510 W MEDCALF ROAD CORE OF DALE **DALE. IN 47523** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) K 0918 1. Based on record review and interview, the Preparation and/or execution of 10/20/2023 facility failed to exercise the generator annually to this plan do not constitute meet the requirements of NFPA 110, 2010 Edition, admission or agreement by the the Standard for Emergency and Standby Powers provider that a deficiency exists. Systems, Chapter 8.4.2. Section 8.4.2 states diesel This response is also not to be generator sets in service shall be exercised at least construed as an admission of fault once monthly, for a minimum of 30 minutes, using by the facility, its employees, one of the following methods: agents or other individuals who (1) Loading that maintains the minimum exhaust draft or may be discussed in this gas temperatures as recommended by the response and plan of correction. manufacturer This plan of correction is (2) Under operating temperature conditions and at submitted as the facility's credible not less than 30 percent of the EPS (Emergency allegation of compliance. Power Supply) nameplate kW rating. Immediate action(s) taken Section 8.4.2.3 states diesel-powered EPS for the resident(s) found to have installations that do not meet the requirements of been affected include: 8.4.2 shall be exercised monthly with the available The Administrator signed a EPSS (Emergency Power Supply System) load and contract with Cummins Sales and shall be exercised annually with supplemental Service to maintain the generators loads (Load Bank Test) at not less than 50 percent annual/1.5-hour load bank test. of the EPS nameplate kW rating for 30 continuous the 36 month/4 hour load bank minutes and at not less than 75 percent of the EPS test and annual fuel quality test. nameplate kW rating for 1 continuous hour for a The 4-hour load bank test was total test duration of not less than 1.5 continuous performed on 9/18/23 and hours. This deficient practice could affect all documented. occupants in the facility. Identification of other residents having the potential to Findings include: be affected was accomplished by: The facility has determined that all Based on record review on 08/29/23 between 9:30 residents have the potential to be a.m. and 1:30 p.m. with the Maintenance affected. Supervisor present, the monthly load percentage Actions taken/systems put for the diesel powered generator was documented into place to reduce the risk of less than 30% during the past 12 month period. future occurrence include: Based on interview at the time of record review, Maintenance staff were in-serviced the Maintenance Supervisor acknowledged the regarding the facility policy for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 02 COMPLETED			ETED
		155270	B. W	ING		08/29/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			MEDCALF ROAD		
CORE O	EDALE						
CORE O	r DALE			DALE,	IN 47523		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	generator ran under	load on a monthly basis but			ensuring that testing the		
	does not achieve 30	% of the name plate rating.			generator, maintaining it prope	erly,	
	-	aintenance Supervisor			and ensuring scheduled vendo	or	
	acknowledged a loa	d bank test for the generator			performs tests per contract an	ıd	
	has not occurred wi	thin the past 12 month period.			regulation.		
					The Administrator signed a		
	•	viewed with the Administrator			contract with Cummins Sales		
		upervisor during the exit			Service to maintain the genera		
	conference.				1.5-hour load bank test, 4-hou		
					load bank test and fuel sample	∋s.	
	3.1-19(b)				4 How the corrective		
					action(s) will be monitored to	<b>o</b>	
		review and interview, the			ensure the practice will not		
	•	sure an annual fuel quality test			recur:		
	_	1 of 1 diesel powered			The maintenance director will		
	-	99, Health Care Facilities Code,			perform and/or ensure vendor		
		on 6.5.4.1.1.2 states Type 2 EES			conduct the weekly, monthly,		
		l System) generator sets shall			annual maintenance, fuel, and		
	-	sted in accordance with			load tests on the generator. The		
		Section 6.4.4.1.1.3 states			maintenance director will bring	រ the	
		be performed in accordance			documentation to the	_	
		andard for Emergency and			Administrator to review weekly	/ tor	
		tems, 2010 Edition, Chapter 8.			6 months to ensure tests are		
		8.3.8 states a fuel quality test			documented and present.		
		at least annually using tests I standards. This deficient			Records will be reviewed by the	ie	
	* *	t all residents, as well as staff			monthly Quality Assurance Committee for 6 months or un	. <b>+</b> i1	
	and visitors.	t an residents, as wen as stan			such a time consistent substa		
	and visitors.				compliance has been achieve		
	Findings include:				determined by the committee.		
	i manigo metade.				determined by the committee.		
	Based on record rev	view on 08/29/23 between 9:30			Corrective action completion of	tate <sup>.</sup>	
		with the Maintenance			10/20/23		
	-	there was documentation of			. 5,25,25		
		inspection dated 02/07/23,					
	_	no documentation of an					
		test for the diesel generator					
		during the past 12 month					
		ecent fuel quality test for the					
	-	s dated 08/03/22, which was					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 02	COM	TE SURVEY MPLETED 29/2023
NAME OF F	PROVIDER OR SUPPLIER	2	510 W	address, city, state, zif MEDCALF ROAD IN 47523	P COD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	the time of record resupervisor said she inspection vendor a the facility by the effuel sample at that the sample at the sample at the sample at the sample s	t due. Based on interview at eview, the Maintenance called the generator and was told they would be at and of the month and take the time.  Viewed with the Administrator appervisor during the exit  Treview and interview, the ovide complete documentation of 1 Emergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care atton 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency ll be tested at least once within Where the assigned class is so, it shall be permitted to at Type 1 and Type 2 essential ower sources shall be classified a				
	İ		I	1		I

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155270	B. WI	NG		08/29/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
CORE OF DALE					MEDCALF ROAD		
CORE O	r DALE			DALE, I	IN 47523		
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review.						
	This finding was re	viewed with the Administrator					
	and Maintenance St	upervisor during the exit					
	conference.						
	3.1-19(b)						
	, ,						
K 0927	NFPA 101						
SS=F	Gas Equipment -	Transfilling Cylinders					
Bldg. 02	Gas Equipment -	Transfilling Cylinders					
	Transfilling of oxyg	gen from one cylinder to					
	another is in acco	rdance with CGA P-2.5,					
		h Pressure Gaseous					
		Respiration. Transfilling of					
		cylinder to another is					
		nt care rooms. Transfilling					
		ontainers or to portable					
		) psi comply with conditions					
		NFPA 99). Transfilling to					
	,	tainers or to portable					
	containers under	· · · · · · · · · · · · · · · · · · ·					
		11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99						
		on and interview, the facility	K 0	927	Preparation and/or execution of	of	10/20/2023
		f 1 oxygen storage/transfer	I K U	121	this plan do not constitute	,	10/20/2023
		with a sign indicating that			admission or agreement by the	e	
	_	rring and not occurring. NFPA			provider that a deficiency exist		
	_	tes, the area is posted with			This response is also not to be		
	` '	t trans-filling is occurring, and			construed as an admission of		
		immediate area is not			by the facility, its employees,	iauit	
		ficient practice could affect all				0	
	residents.	noish practice could affect all			agents or other individuals who draft or may be discussed in the		
	residents.				-		
	Findings include:				response and plan of correction This plan of correction is	л.	
	i maniga menude.					iiblo	
	Dagad on abassur-4:	on and interview on 08/29/23			submitted as the facility's cred	inie	
					allegation of compliance.	, n	
	_	and 3:15 p.m. during a tour of			1 Immediate action(s) take		
	une racinity with the	Maintenance Supervisor and	I		for the resident(s) found to have	ve ∣	I

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Maintenance Man, the oxygen storage/transfilling

Event ID: (

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Facility ID: 000170

been affected include:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155270	B. W	ING		08/29/	/2023
			<u> </u>	CENTRE	ADDRESS CITY OF THE STROOP		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
0005.0	- DAL -				MEDCALF ROAD		
CORE O	F DALE			DALE, I	IN 47523		
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	room in the center of	corridor near the dining room,			The oxygen room now has a		
	did not have a poste	ed sign indicating when			temporary sign indicating		
	transferring of oxyg	gen occurs in this location and			transferring is occurring. A new	N	
	when it is not occur	ring. Based on interview at			sign is on order from our vend		
	the time of observat	tion, the Maintenance			replace the temporary sign wh	en it	
	Supervisor agreed t	here was not a sign stating			comes in.		
	when trans-filling o	xygen is occurring and when it			2 Identification of other		
	was not.				residents having the potential	to	
					be affected was accomplished	l by:	
	This finding was re	viewed with the Administrator	1		The facility has determined the	at all	
	and Maintenance St	upervisor during the exit			residents have the potential to	be	
	conference.				affected.		
					3 Actions taken/systems	put	
	3.1-19(b)				into place to reduce the risk	of	
					future occurrence include:		
					All staff will be in-serviced		
					regarding the facility policy for		
					using the signage on the oxyg	en	
					room door when they are filling	g	
					oxygen tanks.		
					Maintenance staff were in-ser	viced	
					to ensure signage always rem		
					on the door and to perform we	ekly	
			1		audits to ensure signage is be	ing	
					utilized.		
					4 How the corrective		
					action(s) will be monitored to	)	
					ensure the practice will not		
					recur:		
					The maintenance director will		
					complete 5 weekly audits for 3		
			1		months then 3 weekly audits t	0	
			1		ensure the signage is being		
					utilized.		
					Audit records will be reviewed		
					monthly by the Quality Assura	nce	
					Committee until such a time		
					consistent substantial complia		
					has been achieved as determ	ned	
			1		by the committee.		I

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155270	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF PROVIDER OR SUPPLIER  CORE OF DALE				510 W I	ADDRESS, CITY, STATE, ZIP COD MEDCALF ROAD N 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)			TE	(X5) COMPLETION DATE
					Corrective action completion d 10/20/23	ate:	

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