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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING CO			ETED
		155539	B. W	B. WING		12/14/	2023
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEDTILA		IAMAMEMODIAL CENTED			RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER		ODON,	IN 47562		
(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 APPROPRIATE		ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 00	000	By submitting the enclosed		
	conducted by the Indiana Department of Health in				materials, we are not admitting	ງ the	
	accordance with 42	CFR 483.73.			truth or accuracy of any specif	ic	
					findings or allegations. We		
	Survey Date: 12/13	2/23 and 12/14/23			reserve the right to contest the	<u>;</u>	
					findings or allegations as part	of	
	Facility Number: 0				any proceedings and submit th	nese	
	Provider Number:	155539			responses pursuant to our		
	AIM Number: 1002	287340			regulatory obligations. The fa	cility	
					requests the plan of correction	ı be	
	At this Emergency Preparedness survey, Bertha D. Garten Ketcham Memorial Center was found				considered our allegation of		
					compliance effective January	19,	
	not in compliance w	vith Emergency Preparedness			2024 to the state findings of th	е	
	Requirements for M	ledicare and Medicaid			Life Safety Code Recertification	n	
	Participating Provid	lers and Suppliers, 42 CFR			State Licensure Survey and		
	483.73				Emergency Preparedness Sur	vey	
					conducted on December 14, 2	.023.	
	The facility has a ca	pacity of 72 certified beds and					
	had a census of 48 a	at the time of this visit.					
	Quality Review con	npleted on 12/21/23					
	The requirement at	42 CFR, Subpart 483.73 is NOT					
	MET as evidenced 1	by:					
E 0015	403.748(b)(1), 418	3.113(b)(6)(iii), 441.184(b)					
SS=F	(1), 482.15(b)(1),	483.475(b)(1), 483.73(b)(1),					
Bldg	485.625(b)(1)						
	Subsistence Need	ls for Staff and Patients					
	§403.748(b)(1), §4	118.113(b)(6)(iii),					
	§441.184(b)(1), §4	460.84(b)(1), §482.15(b)(1),					
	§483.73(b)(1), §48	33.475(b)(1), §485.625(b)(1)					
	-, ,	rocedures. [Facilities]					
	•	implement emergency					
		cies and procedures, based					
	on the emergency	plan set forth in paragraph					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	TITLE		(X6) DATE
12 (1 142)							04/04/0004

Kathy Wittmer HFA 01/24/2024

Any definency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED 12/14/2023	
		155539	B. WING	_		12/14/	/2023	
NAME OF F	PROVIDER OR SUPPLIEF	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD			
DEDTUA	D CADTEN KETO	HAM MEMODIAL CENTED			ACE ST			
BEKIHA	. D GARTEN KETC	HAM MEMORIAL CENTER	OD	UN,	IN 47562			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAC	j	DEFICIENCY		DATE	
	` '	risk assessment at						
		of this section, and the						
	-	an at paragraph (c) of this cies and procedures must						
	-	updated every 2 years						
		facilities]. At a minimum,						
		rocedures must address						
	the following:	Toccurres must duriess						
	are following.							
	(1) The provision of subsistence needs for							
	staff and patients whether they evacuate or							
	shelter in place, include, but are not limited							
	to the following:							
	(i) Food, water, medical and pharmaceutical							
	supplies							
	' '	ces of energy to maintain						
	the following:							
		to protect patient health						
	_	the safe and sanitary						
	storage of provision							
	(B) Emergency lig	_						
	, ,	, extinguishing, and alarm						
	systems.							
	(D) Sewage and v	vaste disposal.						
	*[For Inpatient Ho	spice at §418.113(b)(6)(iii):]						
	Policies and proce							
	·	are additional requirements						
	, ,	ted inpatient care facilities						
		and procedures must						
	address the follow	-						
		of subsistence needs for						
	, ,	es and patients, whether						
		shelter in place, include, but						
	are not limited to t							
	(A) Food, water, n	nedical, and pharmaceutical						
	supplies.							
	(B) Alternate sour	ces of energy to maintain						
	the following:							
	(1) Temperatures	to protect patient health						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		155539	B. W	NG		12/14/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER			, IN 47562		
(Y4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>		(Y5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710	Ì	r the safe and sanitary		1710			Dille
	storage of provision						
	(2) Emergency lighting.						
		extinguishing, and alarm					
	systems.	oxungaioning, and diann					
	(C) Sewage and v	waste disposal.					
		view and interview, the facility	E 0	015	By submitting the enclosed		01/05/2024
	failed to ensure emergency preparedness policies			<del>.</del>	materials, we are not admittin	g the	
		lude at a minimum, (1) The			truth or accuracy of any speci	-	
	provision of subsist	tence needs for staff and			findings or allegations. We		
	residents, whether t	they evacuate or shelter in			reserve the right to contest the	е	
	place, include, but are not limited to the following:				findings or allegations as part	of	
	(i) Food, water, medical, and pharmaceutical				any proceedings and submit t	hese	
	supplies. (ii) Alternate sources of energy to				responses pursuant to our		
	maintain - (A) Temperatures to protect resident				regulatory obligations. The fa	acility	
		nd for the safe and sanitary			requests the plan of correction	n be	
		ns; (B) Emergency lighting; (C)			considered our allegation of		
		nguishing, and alarm systems;			compliance effective January		
		d waste disposal in accordance			2024 to the state findings of the		
		3(b)(1). This deficient practice			Life Safety Code Recertification	on	
	could affect all occ	upants.			State Licensure Survey and		
					Emergency Preparedness Su	-	
	Findings include:				conducted on December 14, 2	2023.	
	D 1	24 F /D' :			E 015		
		the Emergency/Disaster			The corrective action taken for		
	•	on 12/13/23 between 2:20 p.m.			those residents found to have		
	_	the Assistant Administrator ovided did not address the			been affected by the deficient	!	
		waste disposal to protect			practice is that although no	fied	
	_	d safety in an emergency.			specific residents were identification during the survey, this deficie		
		at the time of records review,			practice has the potential to a		
		nistrator confirmed the plan			all residents, staff and visitors		
		ldress the loss of sewage and			The facility has now develope		
	•	rotect residents health and			implemented a plan with police		
	safety in an emerge				and procedures to address th		
	and the same of th	· <i>y</i> ·			loss of sewage and waste	-	
	This finding was re	eviewed with the Administrator			disposal in the event of an		
		inistrator during the exit			emergency to protect the hea	lth	
	conference on 12/1	_			and safety of the residents, st		
					and visitors.	·	

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 12/14/2023	
ROVIDER OR SUPPLIER  D GARTEN KETCI	HAM MEMORIAL CENTER	60	1 E R	DDRESS, CITY, STATE, ZIP COD ACE ST IN 47562		
D GARTEN KETCI SUMMARY ( (EACH DEFICIEN		60	ot E RADON, I	ACE ST	all ve this has ted a lires and an th aff  put  ur is he of  the w lity's h, dure and e	(X5) COMPLETION DATE

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155539		JILDING	INSTRUCTION	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER		601 E R	ADDRESS, CITY, STATE, ZIP COD		
DERTHA	D GARTEN KETCE	HAM MEMORIAL CENTER	ODON,	IN 47562		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0024		6.54(b)(5), 418.113(b)(4),	1110			Ditte
	` ' ' '					
SS=F Bldg	441.184(b)(6), 482 483.73(b)(6), 484. 485.68(b)(4), 485. 491.12(b)(4), 494. Policies/Procedure §403.748(b)(6), §4 §441.184(b)(6), §4 §485.68(b)(4), §48 §485.68(b)(4), §48 §485.920(b)(5), §4  [(b) Policies and preparedness policon the emergency (a) of this section, paragraph (a)(1) o communication plasection. The policibe reviewed and u years [annually for	2.15(b)(6), 483.475(b)(6), 102(b)(5), 485.625(b)(6), 727(b)(4), 485.920(b)(5),				
		7) as noted above] The use				
	emergency staffing process and role for Federally designat	emergency or other g strategies, including the or integration of State and ted health care ddress surge needs during				
	procedures. (6) The emergency and ot	403.748(b):] Policies and ne use of volunteers in an her emergency staffing ess surge needs during an				
	*[For Hospice at §	418.113(b):] Policies and				

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STREET ADDRESS, CITY, STATE, ZIP COD		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/14/2023	
RECULATORY OR LSC IDENTIFYING NFORMATION  PROCEdures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency other emergency staffing strategies, including the process and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CTR  483.73(b)(6). This deficient practice could affect all occupants.  Findings include:  Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Assistant Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.  This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.  The corrective action taken for the object is that all residents, staff and visitors. The facility and visitors. The facility and review of the Emergency and the facility's emergency preparedness plan to address the use of volunteers in an emergency.  The corrective action taken for the object is that all residents staff and visitors. The facility and visitors. The facility and visitors. The facility and visitors have the potential to be affected by the same deficient practice. The facility is emergency, The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all the deficient practice does not recur is that a mandatory				601 E RACE ST					
employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.  Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants.  Based on review of the Emergency/Disaster Preparedness Plan on 12/13/23 between 2:20 p.m. and 3:45 p.m. with the Assistant Administrator present, the facility's plan did not address the use of volunteers in an emergency.  This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.  The corrective action taken for the too have been affected by the deficient practice is that all thought no specific residents were identified during the survey, this deficient practice has the potential to affect all residents, staff and visitors.  The facility has now updated the facility's emergency.  The corrective action taken for the too have been affected by the deficient practice is that all residents were identified during the survey, this deficient practice has the open propreparedness plan to address the use of volunteers in the event of an emergency.  The corrective action taken for the too specific residents were identified during the survey, this deficient practice is that all residents, staff and visitors.  The facility has now updated the facility's emergency preparedness plan to address the use of volunteers in the event of an emergency.  The corrective action taken for the too specific residents were identified during the survey, this deficient practice is that all residents, were identified during the survey.	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
I difference of a source of the source of th		procedures. (4) Temployees in an emergency staffir process and role Federally designar professionals to a an emergency. Based on record refailed to ensure emand procedures incommended an emergency or of strategies, including integration of State care professionals to an emergency in active an emergency in active an emergency in active and 3:45 p.m. with present, the facility of volunteers in an interview at the time Administrator confaddress the use of with the finding was read and Assistant Administrator and the staff and the sistence of the staff and the	The use of hospice emergency and other of strategies, including the for integration of State and other health care of integration interview, the facility ergency preparedness policies dude the use of volunteers in their emergency staffing good the process and role for or Federally designated health to address surge needs during ecordance with 42 CFR deficient practice could affect on 12/13/23 between 2:20 p.m. the Assistant Administrator is plan did not address the use emergency. Based on the of review, the Assistant firmed the plan provided did not produnteers in an emergency.	E 00		those residents found to have been affected by the deficient practice is that although no specific residents were identificating the survey, this deficier practice has the potential to at all residents, staff and visitors. The facility has now updated to facility's emergency prepared plan to address the use of volunteers in the event of an emergency.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now updated the facility's emergency preparedness plan address the use of volunteers the event of an emergency.  The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service had been provided for all manager staff on the facility's emergency preparedness plan which	ed it ifect he he all ve this has in to in  put  ur is as ment cy ers in		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 4/2023		
	ROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562					
(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 I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
E 0034 SS=F Bldg	441.184(c)(7), 482.483.73(c)(7), 484.485.68(c)(5), 485.491.12(c)(5), 494. Information on Oc §403.748(c)(7), §4§441.184(c)(7), §4§483.73(c)(7), §48(6), §485.68(c)(5), (5), §485.625(c)(7) §491.12(c)(5),	cupancy/Needs 416.54(c)(7), §418.113(c)(7) 482.15(c)(7), §460.84(c)(7), 33.475(c)(7), §484.102(c) §485.68(c)(5), §485.727(c) ), §485.920(c)(7), 94.62(c)(7).  The state of the		the volunteers will full event of an emergency. The corrective action monitor to ensure the practice will not recur facility administration annually the policies a procedures related to emergency preparedrincluding the policy at related to the use of voluning an emergency the policies and proceduring an effective and procedure the facility's needs. The will be amended when warranted.	taken to e deficient r is that the will review and the facility's ness plan, nd procedure volunteers r to ensure edures pertinent to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE			ETED	
		155539	B. W	ING		12/14/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
(V4) ID	CLIMMADA	CTATEMENT OF DEFICIENCIE	1		T		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	DATE
1710	(7) [(5) or (6)] A m			1110			Ditte
	information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the						
	Incident Command Center, or designee.						
	*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs,						
		rovide assistance, to the					
		urisdiction, the Incident					
	Command Center	, or designee.					
	*[For Innational Lie	onice at \$419,112(a):1 (7) A					
		spice at §418.113(c):] (7) A g information about the					
	· ·	t occupancy, needs, and					
		le assistance, to the					
		urisdiction, the Incident					
	Command Center						
		view and interview, the facility	E 0	034	E 034		01/04/2024
		emergency preparedness			The corrective action taken for	r	
	communication pla	n includes a means of			those residents found to have		
	providing informati	on about the LTC facility's			been affected by the deficient		
		and its ability to provide			practice is that although no		
		thority having jurisdiction or			specific residents were identification		
		and Center, or designee in			during the survey, this deficier		
		CFR 483.73(c)(7). This			practice has the potential to af		
	deficient practice co	ould affect all occupants.			all residents, staff and visitors.		
	Findings include:				The facility has now developed	d an	
	rindings include:				emergency preparedness communication plan which		
	Based on review of	the Emergency/Disaster			includes a manner of providing	7	
		on 12/13/23 between 2:20 p.m.			information about the LTC faci	•	
	_	the Assistant Administrator			occupancy, needs and its abili	-	
	-	cation plan that included a			to provide assistance to the	-,	
	_	information about the LTC			authority having jurisdiction or	the	
	facility's occupancy, needs, and its ability to provide assistance, to the authority having				Incident Command Center, or		
					designee in accordance with tl	he	
	jurisdiction or the I	ncident Command Center, or			regulations in the event of an		
	designee in accorda	nce with 42 CFR 483.73(c)(7)			emergency.		
	was not available for	or review. Based on interview			The corrective action taken for	r the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP COD RACE ST I, IN 47562	
(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 APPROPR DEFICIENCY)	DATE
	conference, the Ass confirmed that the conclude the aforeme and ability to provide or designee.  This finding was re-	communication plan did not ntioned occupancy, needs, de assistance to the AHJ, IC, viewed with the Administrator nistrator during the exit		other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors he the potential to be affected by deficient practice. The facility now developed an emergency preparedness communication which includes a manner of providing information about the LTC facility's occupancy, need and its ability to provide assistance to the authority has jurisdiction or the Incident Command Center, or designed accordance with the regulation the event of an emergency. The measures that have been into place to ensure that the deficient practice does not rest that a mandatory in-service in been provided for all staff on facility's emergency prepared communication plan. The states been instructed on their in the manner of which they approvide information about the facility's occupancy, needs a ability to provide assistance that a mandatory in about the facility's occupancy, needs a ability to provide assistance that the designee in accordance with regulations in the event of an emergency.  The corrective action taken to monitor to ensure the deficient practice will not recur is that facility administration will reviannually the policies and procedures related to the facility	et all ave y this y has by has by has by has by has by has aving the eta cur is has the dness afferoles hare to be LTC and its of the brother the cur

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Event ID:

 $HGWV21 \quad \text{Facility ID:} \quad 000300$ 

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155539		A. BUILDING  B. WING	INSTRUCTION	COMPLETED 12/14/2023	
	PROVIDER OR SUPPLIER D GARTEN KETCHA	M MEMORIAL CENTER	601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				emergency preparedness communication plan to ensure it remains effective and pertine to the facility's needs. The powill be amended when and if warranted.	ent
E 0037 SS=F Bldg	441.184(d)(1), 482.1 483.73(d)(1), 484.10 485.68(d)(1), 485.72 486.360(d)(1), 491.1 EP Training Program \$403.748(d)(1), \$416 \$441.184(d)(1), \$460 \$483.73(d)(1), \$483. \$485.68(d)(1), \$485.(1), \$485.920(d)(1), \$491.12(d)(1).  *[For RNCHIs at \$40 Hospitals at \$482.15 HHAs at \$484.102, "\$485.727, OPOs at \$491.12:] (1) Training program all of the following: (i) Initial training in erpolicies and procedu existing staff, individu under arrangement, consistent with their (ii) Provide emergency at least every 2 years (iii) Maintain docume preparedness trainin (iv) Demonstrate staff emergency procedur	5.54(d)(1), §418.113(d)(1), 5.54(d)(1), §482.15(d)(1), 475(d)(1), §484.102(d)(1), 6.625(d)(1), §485.727(d) §486.360(d)(1), 3.748, ASCs at §416.54, ICF/IIDs at §483.475, Organizations" under 6486.360, RHC/FQHCs  a. The [facility] must do mergency preparedness res to all new and uals providing services and volunteers, expected roles. cy preparedness training s. ntation of all emergency g. ff knowledge of			

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 $HGWV21 \quad \text{Facility ID:} \quad 000300$ 

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155539		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY  MPLETED  14/2023	
	PROVIDER OR SUPPLIEI	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP RACE ST I, IN 47562	COD	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	·	re significantly updated, the duct training on the and procedures.				
	The hospice must (i) Initial training in policies and proce existing hospice of providing services consistent with the (ii) Demonstrate of emergency proce (iii) Provide emergency proce at least every 2 ye (iv) Periodically re emergency prepa employees (include with special emph the procedures no and others. (v) Maintain docu preparedness trai (vi) If the emerger and procedures a	dures. gency preparedness training ears. eview and rehearse its redness plan with hospice ding nonemployee staff), hasis placed on carrying out ecessary to protect patients mentation of all emergency ning. hey preparedness policies re significantly updated, the duct training on the				
	program. The PR following:  (i) Initial training in policies and proceexisting staff, indirectly under arrangement consistent with the	141.184(d):] (1) Training TF must do all of the n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ning, provide emergency				
	preparedness trai	ning every 2 years. staff knowledge of				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155539	B. W	ING		12/14	/2023
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					RACE ST		
BEKIHA	. D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	emergency proce	uries. Imentation of all emergency					
	preparedness trai						
		cy preparedness policies					
		re significantly updated, the					
	-	uct training on the updated					
	policies and proce						
	*IFor PACF at 840	60.84(d):] (1) The PACE					
		t do all of the following:					
		n emergency preparedness					
	, ,	edures to all new and					
	existing staff, individuals providing on-site						
	services under arrangement, contractors,						
	participants, and	volunteers, consistent with					
	their expected role	es.					
		ency preparedness training					
	at least every 2 ye						
	' '	staff knowledge of					
		dures, including informing					
		at to do, where to go, and					
		n case of an emergency.					
	` '	mentation of all training.					
		ncy preparedness policies					
	-	re significantly updated, the					
		uct training on the updated					
	policies and proce	eaures.					
	*[For LTC Facilitie	es at §483.73(d):] (1)					
	Training Program	. The LTC facility must do all					
	of the following:						
	, ,	n emergency preparedness					
		edures to all new and					
		viduals providing services					
	_	nt, and volunteers,					
	consistent with the						
		ency preparedness training					
	at least annually.						
	, ,	mentation of all emergency					
	preparedness trai	ning.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	ì	UILDING	NSTRUCTION	(X3) DATE COMPI 12/14			
	PROVIDER OR SUPPLIER D GARTEN KETC	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EAC)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	(iv) Demonstrate semergency proces	staff knowledge of dures.							
	CORF must do al  (i) Provide initial to preparedness polynew and existing a services under and consistent with the consistent	raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training ears. 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 ncy preparedness policies re significantly updated, the uct training on the updated edures.							
	program. The CAl following: (i) Initial training ir	35.625(d):] (1) Training H must do all of the n emergency preparedness							
	reporting and exti protection, and whof patients, person prevention, and contained disaster author existing staff, indivender arrangement	edures, including prompt inguishing of fires, mere necessary, evacuation innel, and guests, fire coperation with firefighting prities, to all new and viduals providing services int, and volunteers, eir expected roles.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE A. BUILDING B. WING					
	PROVIDER OR SUPPLIEI A D GARTEN KETC	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562				
(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  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	at least every 2 ye (iii) Maintain docu (iv) Demonstrate emergency proce (v) If the emerge and procedures a CAH must conduct policies and proce *[For CMHCs at § The CMHC must emergency preparated procedures to all individuals providical arrangement, and their expected role documentation of must demonstrate emergency proce CMHC must provide preparedness trail Based on record refailed to conduct ar Emergency Prepare LTC facility must of training in emergency procedures to all no individuals providicand volunteers, con roles; (ii) Provide et training at least and documentation of a training; (iv) Demo- emergency procedures con emergency proc	mentation of the training.  staff knowledge of dures.  check preparedness policies re significantly updated, the ct training on the updated edures.  485.920(d):] (1) Training. provide initial training in redness policies and new and existing staff, fing services under I volunteers, consistent with es, and maintain the training. The CMHC e staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. view and interview, the facility mual training for the edness Program (EPP). The do all of the following: (i) Initial five preparedness policies and ew and existing staff, fing services under arrangement, sistent with their expected mergency preparedness mually; (iii) Maintain ll emergency preparedness mustrate staff knowledge of fires in accordance with 42 CFR edeficient practice could affect	E 0037	E 037 The corrective action taken for those residents found to have been affected by the deficien practice is that although no specific residents were identiduring the survey, this deficien practice has the potential to all residents, staff and visitors. The facility has now conducted mandatory in-service for all sthe facility's emergency preparedness program. The has been re-educated on the respective responsibilities as outlined in the emergency preparedness program. The facility will continue to train a	fied ent affect s. ed a taff on staff		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	COMP	E SURVEY LETED 4/2023			
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562						
(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  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)					
	Preparedness Plan of and 3:45 p.m. with present, no docume preparedness training show staff could determine the emergency prepared review. Based on a record review, the acconfirmed there was emergency prepared documentation to silk knowledge of the emergency prepared documentation to silk howledge of the emergency prepared to the first how	viewed with the Administrator inistrator during the exit		employees on the faciliemergency preparedness upon hire and will also emergency preparedness at least annually. The corrective action to other residents that has potential to be affected same deficient practice. The now conducted a mand in-service for all staff of facility's emergency program. The staff has re-educated on their reresponsibilities as outliemergency preparedness program. The facility to train all new employ facility's emergency program upon hire and provide emergency pretraining at least annual. The measures that has into place to ensure the deficient practice does that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual schedule which include annual training on the emergency preparedness that the facility has devimplemented an annual training on the emergency preparedness that the facility has devimplemented an annual training on the emergency preparedness that the fa	ess program provide ess training  aken for the ve the d by the e is that all itors have cted by this e facility has datory on the eparedness s been espective ined in the ees on the eparedness d will also eparedness lly. ve been put at the inot recur is veloped and al in-service es at least facility's ess aken to deficient is that all vill now be ing that there				

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Event ID:

 $HGWV21 \quad \text{Facility ID:} \quad 000300$ 

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 12/14/2023		
	PROVIDER OR SUPPLIED A D GARTEN KETC	HAM MEMORIAL CENTER	<u> </u>	601 E R	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
140	REGULATORY	CLSC IDENTIFYING INFORMATION		140	employee's records to support that each of their employees h successfully completed annual training on the facility's emergency preparedness program.	ıas	BAIL
E 0039 SS=F Bldg	441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § (2), §491.12(d)(2) *[For ASCs at §4* OPO, "Organizati CMHCs at §485.9 §491.12, and ESF (2) Testing. The [i exercises to test to	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
	community-based (A) When a community accessible, confunctional exercis (B) If the [faction natural or man-material or material or	full-scale exercise that is levery 2 years; or munity-based exercise is onduct a facility-based e every 2 years; or ility] experiences an actual ade emergency that requires emergency plan, the [facility] egaging in its next required lor individual, facility-based					

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	ì	UILDING	NSTRUCTION	COMI	E SURVEY PLETED 4/2023	
	F PROVIDER OR SUPPLIED  HA D GARTEN KETC	R HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE	
	functional exercise actual event.  (ii) Conduct an actual every 2 years, oper or functional exercises (i) of this section include, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using clinically-relevant set of problem start messages, or presto challenge an econduct exercises, and enter the [facility's] emetale (2) Testing for hot the patient's home conduct exercises plan at least annual the following:  (i) Participate in accommunity based functional (B) If the hospice man-made emergency exempt from engascale community-	e following the onset of the diditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may illimited to the following: scale exercise that is dor individual, facility-based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop mergency events, and revise ergency plan, as needed.						

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539		UILDING	NSTRUCTION	(X3) DATE COMPI 12/14	LETED	
	DF PROVIDER OR SUPPLIEI HA D GARTEN KETC	R HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	years, opposite the functional exercise of this section is of include, but is not (A) A second full-community-based functional exercise (B) A mock disase (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an electron of the exercises to test the per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engate full-scale community functional exercise emergency event (ii) Conduct an authat may include, following: (A) A second full-	dditional exercise every 2 are year the full-scale or a under paragraph (d)(2)(i) conducted, that may limited to the following: -scale exercise that is a or a facility based a; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan.  spices that provide inpatient a hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or lency that requires activation plan, the hospice is aging in its next required nity based or facility-based are following the onset of the dditional annual exercise but is not limited to the  -scale exercise that is a or a facility based						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del>-</del>	COMPLETED	
		155539	B. WING		12/14/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
	D CARTEN VETO	LIAM MEMODIAL OFNITED		RACE ST		
BEKIHA	D GARTEN KETCI	HAM MEMORIAL CENTER	ODON	I, IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	· · · · · · · · · · · · · · · · · · ·		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP	RIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	(B) A mock disast					
	1 ' '	ercise or workshop led by a				
		udes a group discussion				
	using a narrated,	-				
		rio, and a set of problem				
		ed messages, or prepared				
	questions designe	ed to challenge an				
	emergency plan.	:				
	. , ,	ospice's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	l the hospice's eme	ergency plan, as needed.				
	*IFor PRFTs at 84	41.184(d), Hospitals at				
	§482.15(d), CAHs					
	. , ,	PRTF, Hospital, CAH] must				
		to test the emergency				
		r. The [PRTF, Hospital,				
	CAH] must do the					
	-	n annual full-scale exercise				
	that is community.					
	I -	nunity-based exercise is not				
	, ,	ct an annual individual,				
	facility-based fund					
	1	Hospital, CAH] experiences				
	an actual natural o	or man-made emergency				
	that requires activ	ation of the emergency				
	plan, the [facility] i	s exempt from engaging in				
	its next required fu	ull-scale community based				
	or individual, facili	ty-based functional exercise				
	following the onse	t of the emergency event.				
		an [additional] annual				
		at may include, but is not				
	limited to the follow	•				
	1 ' '	scale exercise that is				
	community-based					
	facility-based fund					
	, ,	ck disaster drill; or				
	(C) A tabletop	exercise or workshop that				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPI	ETED
		155539	B. W	ING		12/14	/2023
NAME OF I	DROVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	C		601 E F	RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE	JST BE PRECEDED BY FULL PREFIX GACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL			TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		or and includes a group					
	discussion, using						
	· ·	emergency scenario, and a					
	set of problem sta	pared questions designed					
	to challenge an er						
		he [facility's] response to					
	, ,	umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	3 3 71 7					
	*[For PACE at §46	60.84(d):]					
	(2) Testing. The P	ACE organization must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	<del>-</del>					
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund						
	, ,	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
		gaging in its next required nity based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		in additional exercise every					
	` '	he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to						
		scale exercise that is					
	' '	or individual, a facility					
	based functional e						
	(B) A mock disas						
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/14/2023			
		ROVIDER OR SUPPLIER  D GARTEN KETCH	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562					
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE		
		set of problem star messages, or prepto challenge an er (iii) Analyze the Problem star messages, or prepto challenge an er (iii) Analyze the Problem star messages, and em the PACE's emergence the emergency problem to the emergency problem the emergency problem to the emergency pro	emergency scenario, and a tements, directed pared questions designed mergency plan.  ACE's response to and station of all drills, tabletop mergency events and revise gency plan, as needed.  Is at §483.73(d):]  ty] must conduct exercises manounced staff drills using pocedures. The [LTC facility, the following: an annual full-scale exercise abased; or unity-based exercise is not ct an annual individual, tional exercise. Itity] facility experiences an man-made emergency that a of the emergency plan, the mpt from engaging its next le community-based or pased functional exercise to of the emergency event. Iditional annual exercise to of the emergency event. Iditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group an anrated, emergency scenario, and a						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/14/2023		
	PROVIDER OR SUPPLIEI	HAM MEMORIAL CENTER	•	601 E R	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  pared questions designed		TAG	DEFICIENCY)		DATE
	to challenge an e	mergency plan.					
		LTC facility] facility's naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, as needed.						
	*[For ICF/IIDs at §	§483.475(d)]:					
		CF/IID must conduct					
	exercises to test the emergency plan at least						
	twice per year. The ICF/IID must do the following:						
	(i) Participate in an annual full-scale exercise						
	that is community-based; or						
		nunity-based exercise is not					
		ıct an annual individual,					
		ctional exercise; or.					
		experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		ngaging in its next required nity-based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		Iditional annual exercise					
	` '	but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
	discussion, using	and includes a group					
		a narrated, emergency scenario, and a					
	set of problem sta						
	l '	pared questions designed					
	to challenge an e	•					
	_	CF/IID's response to and					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155539	B. WING		12/14/2023	
			STREET	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIEF	8		RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		, IN 47562		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	RIATE	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ntation of all drills, tabletop				
		nergency events, and revise				
	the ICF/IID's eme	rgency plan, as needed.				
	#F 1.0.40.4.40.03					
	*[For HHAs at §48					
		e HHA must conduct				
		he emergency plan at				
	following:	e HHA must do the				
		full-scale exercise that is				
	community-based					
	1	ommunity-based exercise				
is not accessible, conduct an annual						
individual, facility-based functional exercise						
	every 2 years; or.	badda fariotidriai dxorolod				
		A experiences an actual				
		ade emergency that requires				
		mergency plan, the HHA is				
		iging in its next required				
		nity-based or individual,				
		tional exercise following the				
	onset of the emer	_				
		ditional exercise every 2				
	1 ' '	e year the full-scale or				
	1	e under paragraph (d)(2)(i)				
	of this section is c					
		limited to the following:				
		full-scale exercise that is				
	community-based					
	facility-based fund	tional exercise; or				
	(B) A mock di	isaster drill; or				
	(C) A tabletor	exercise or workshop that				
	1	or and includes a group				
	discussion, using					
	I -	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	(iii) Analyze the H	HA's response to and				
	maintain documer	ntation of all drills, tabletop				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155539  A. BUILDING  B. WING		COMPLETED 12/14/2023				
	PROVIDER OR SUPPLIER  D GARTEN KETCI	HAM MEMORIAL CENTER	601 E R	DDRESS, CITY, STATE, ZIP COD ACE ST IN 47562		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		nergency events, and revise ency plan, as needed.				
	exercises to test to OPO must do the (i) Conduct a pape or workshop at lea exercise is led by group discussion, relevant emergency problem statement prepared question emergency plan. I actual natural or nor requires activation OPO is exempt from the emergency (ii) Analyze the Office maintain documer exercises, and emotion the [RNHCI's and needed.	e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset event. PO's response to and matation of all tabletop mergency events, and revise OPO's] emergency plan, as				
	exercises to test the RNHCl must do the (i) Conduct a paper at least annually.	he emergency plan. The				
	narrated, clinically scenario, and a se directed message designed to challe (ii) Analyze the RN maintain documer	ed by a facilitation, using a re-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan.  NHCl's response to and nation of all tabletop hergency events, and revise				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		155539	B. W	NG		12/14/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DEDTILA	D CARTEN KETO	IAMA MEMORIAL OFNITER			RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER		ODON,	IN 47562		
(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'	COMPLE	TION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	3
	the RNHCI's emer	gency plan, as needed.					
		view and interview, the facility	E 00	)39	E 039	01/04/2	2024
		ercises to test the emergency		,,,	The corrective action taken for		
	plan at least twice p				those residents found to have		
		drills using the emergency			been affected by the deficient		
		C facility must do the			practice is that although no		
	following:				specific residents were identific	-d	
	(i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual,				during the survey, this deficien		
					practice has the potential to af		
					all residents, staff and visitors.		
					The facility has now conducted	Lan	
	facility-based functi				additional exercise of the facili		
	1	y experiences an actual natural			emergency plan. The facility h	-	
		gency that requires activation			documentation of the completi		
	of the emergency plan, the LTC facility is exempt				of this exercise. The facility w		
		ext required full-scale in a			continue to conduct exercises		
		r individual, facility-based					
		exercise for 1 year following			its emergency plan at least twi	- E	
	the onset of the actu	-			a year.  The corrective action taken for	tho	
		itional exercise that may			other residents that have the	life	
		mited to the following:			potential to be affected by the		
	a. A second full-sca				same deficient practice is that		
		r an individual, facility-based			residents, staff and visitors ha		
	functional exercise.	•			the potential to be affected by		
	b. A mock disaster						
		se or workshop that is led by a			deficient practice. The facility has now conducted an additional	ias	
		des a group discussion, using			exercise of the facility's		
		y-relevant emergency scenario,				25	
	l	n statements, directed			emergency plan. The facility h		
	_	ed questions designed to			documentation of the completi of this exercise. The facility w		
		-			_		
	challenge an emerge	C facility's response to and			continue to conduct exercises		
	· · ·	ation of all drills, tabletop			its emergency plan at least twi	U <del>U</del>	
		gency events, and revise the			a year.	nut	
					The measures that have been	μιι	
		gency plan, as needed in			into place to ensure that the	i.a	
	accordance with 42				deficient practice does not rec		
		ice could affect all occupants			that a mandatory in-service ha	s	
	in the facility.				been provided for the facility		
	E. 1				administration on the regulatio		
	Findings include:				related to the required testing	of	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155539	B. WI	NG		12/14/	2023
				CTDEET A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEDTUA		HAM MEMORIAL CENTER			RACE ST		
DEKTHA	D GARTEN KETCI	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID	SUMMARY S	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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Preparedness Plan of and 3:45 p.m. with the present, the facility documentation of a 03/16/23 for the Rost of an actual event for 12/06/23, however, provide documentate performed during the main building and Rost confirmed by the Astrecord review.	table top exercise dated se House, and documentation or the main building dated the facility was unable to cion of a second exercise the past 12 month period for the Rose House. This was sesistant Administrator during wiewed with the Administrator nistrator during the exit			the facility emergency plan. Tentative plans were developed the required testing of the facility emergency plan. The corrective action taken to monitor to ensure the deficient practice will not recur is that the Quality Assurance team will review the documentation of the testing of the facility's emergen plan testing at the Quality Assurance meetings at least quarterly to ensure that there is timely documentation to support the testing of the emergency plan accordance with the regulation.	ity's  tee ne ncy s ort	
K 0000							
Bldg. 01							
	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 12/13  Facility Number: 00 Provider Number: 1002  At this Life Safety O Ketcham Memorial compliance with Re Medicare/Medicaid, Life Safety from Fin	00300 155539	K 0	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The fact requests the plan of correction considered our allegation of compliance effective January 2024 to the state findings of the Life Safety Code Recertification State Licensure Survey and Emergency Preparedness Surconducted on December 14, 2	ic of nese cility be 19, e	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ŕ	IULTIPLE CO UILDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155539	B. W	ING		12/14/	2023
	PROVIDER OR SUPPLIE	R HAM MEMORIAL CENTER	₹	601 E R	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FUI		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION LSC), Chapter 19, Existing	ON	TAG	DEFICIENCE		DATE
		ancies and 410 IAC 16.2.					
	Type V (000) cons sprinklered. A por determined to be to space above the may west nurses' station facility was determined to be to space above the may west nurses' station facility was determined to say the say fire alarm system of the say fire ala	lity was determined to be of truction and was fully tion of the facility was we story due to an occupied ain entrance, dining room and a areas, this portion of the ined to by of Type V (000) ally sprinklered. The facility stem with hard wired smoke ridors, spaces open to the resident sleeping rooms. The refacility has a capacity of 62 f 38 at the time of this survey. It is a capacity of 10 and had a time of this survey. It is a capacity of 72 and at the time of this survey.					
	Quality Review co	mpleted on 12/21/23					
K 0161 SS=F Bldg. 01	Building Construct 2012 EXISTING Building construct						
		ction Type (332), II (222)	nber				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	X3) DATE SURVEY COMPLETED 12/14/2023
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST , IN 47562	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
	of stories sprinklered	non-sprinklered and			
	2 II (111) non-sprinklered sprinklered	One story  Maximum 3 stories			
	3 II (000) non-sprinklered 4 III (211)	Not allowed  Maximum 2 stories			
	sprinklered 5 IV (2HH) 6 V (111)				
	7 III (200) non-sprinklered 8 V (000)	Not allowed  Maximum 1 story			
	sprinklered Sprinklered stories throughout by an a automatic system 9.7. (See 19.3.5) Give a brief descr construction, the r basements, floors located, location of dates of approval. small floor plan of	s must be sprinklered approved, supervised in accordance with section approved in accordance with section approved in accordance with section in REMARKS, of the number of stories, including on which patients are of smoke or fire barriers and accomplete sketch or attach the building as appropriate.			
	interview; the facili construction type of requirements of a to building, and be of deficient practice of	riew, observation and ty failed to ensure the if the facility meets the wo story, fully sprinklered at least Type V (111). This ould affect all residents, staff, in the Dining Room of the Main	K 0161	K 161 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors in the main dir room of the facility have the potential to be affected by this	ed

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	JILDING	nstruction <u>01</u>	(X3) DATE : COMPL 12/14/	ETED
	ROVIDER OR SUPPLIER D GARTEN KETCI	HAM MEMORIAL CENTER	601 E R	ADDRESS, CITY, STATE, ZIP COD AACE ST IN 47562		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	a.m. and 3:45 p.m. Supervisor present, facility for the Mair be Type V (000). The Maintenance Super review. Based on o and 6:30 p.m. durin Maintenance Super portion of the facilitarea, main dining rowas an occupied spattorage of many file totes, plastic, paper, general storage. Bat Maintenance Super space/floor on a reg	viewed with the Administrator nistrator during the exit		deficient practice. The identificatorage items, such as file cabinets, cardboard boxes, tot plastic, paper, mattresses, PP and other general storage items stored in the attic have now be removed from the attic. The identified attic area will no long be utilized for storage of any tyof materials.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors in the main dining area have the potential to be affected by this deficient practice.  The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service has been provided for the maintensupervisor on the regulation related to building construction. The maintenance supervisor has been instructed that the attic is longer to be utilized for storage any type of materials. The maintenance supervisor was a instructed on their responsibility check the attic area monthly to ensure no items have been taken to this area for storage as part the facility's preventative maintenance program.  The corrective action taken to monitor to ensure the deficient practice will not recur is that the administrator and/or assistant	es, E is seen ger ype all he ential put ur is sance is so of ilso by to of seen of	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPI A. BUILDIN B. WING	ee construction G <u>01</u>	COMP	E SURVEY PLETED 4/2023
	ROVIDER OR SUPPLIER D GARTEN KETCI	HAM MEMORIAL CENTER	601	EET ADDRESS, CITY, STATE, ZIF E RACE ST ON, IN 47562	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO TH	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
				administrator will rev preventative mainten documentation mont that monthly checks storage area have be and verified that no items/materials are be the attic.	nance program hly to ensure of the een completed	
K 0291 SS=C Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on record revialled to ensure their documentation for the backup light that we seconds during the requires emergency accordance with Serequires functional monthly, with a min maximum of 5 week than 30 seconds, (3) conducted annually if the emergency light powered and (5) Weinspections and test for inspection by the jurisdiction. This directions include:	g of at least 1-1/2-hour and automatically in 1.9.  Tiew and interview, the facility re was complete the testing of 1 of 1 battery as tested monthly for 30 past 12 months. LSC 19.2.9.1 lighting shall be provided in action 7.9. Section 7.9.3.1.1 (1) testing shall be conducted himum of 3 weeks and a ks between tests, for not less of Functional testing shall be for a minimum of 1 1/2 hours attended to the state of the st	K 0291	K 291 The corrective action those residents found been affected by the practice is that althous specific residents we during the survey, all staff and visitors have to be affected by this practice. There is not documentation to support to be affected by the practice. There is not documentation to support to be affected by this practice. There is not documentation to support the seconds, including the seconds, including the sackup light located generator. The facilic consistently test all battery-operated backup light and docume components of the test including the 30 seconds.	d to have deficient ugh no ere identified I residents, te the potential deficient ow pport that all the postential the potential deficient ow pport that all the postential deficient ow pport that all the postential deficient ow pport that all the postential deficient ow provide the postential deficient ow the	01/04/2024
	Based on record rev	riew on 12/13/23 between 9:00		The corrective action	taken for the	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	LETED
		155539	B. W	ING		12/14	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER			IN 47562		
(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
	_	with the Maintenance			other residents that have the		
		the facility did have a			potential to be affected by the		
	-	enance (PM) report that the			same deficient practice is that	all	
		ergency light set at the			residents, staff and visitors ha	ve	
	-	d monthly, however, the			the potential to be affected by	this	
	-	ot complete. The monthly test			deficient practice. There is no		
	indicated the battery powered emergency light set was only tested for 15 seconds, furthermore, there were no monthly tests performed during March, September, and November of 2023. Based on an				documentation to support that		
					battery-operated backup lights		
					have been tested for at least t	-	
					seconds, including the battery	•	
	interview at the time of record review, the Maintenance Supervisor agreed the PM form for the battery powered emergency light set was not				backup light located at the		
					generator. The facility will now	N	
					consistently test all		
	•	rmed there were three months			battery-operated backup lights		
	where the light set v	was not tested.			monthly and document all req	uired	
					components of the testing		
	_	viewed with the Administrator			including the 30 second testin	g	
		nistrator during the exit			period.		
	conference on 12/14	4/23.			The measures that have been	put	
					into place to ensure that the		
	3.1-19(b)				deficient practice does not rec		
					that a mandatory in-service ha		
					been provided for the mainten		
					supervisor on their responsibil	-	
					ensure that monthly testing of		
					battery-operated backup lights		
					being conducted and docume		
					in accordance with the regulat		
					The documentation shall inclu	de	
					the 30 second testing period.		
					The corrective action taken to		
					monitor to ensure the deficien	•	
					practice will not recur is that the		
					administrator and/or assistant		
					administrator will now review		
					monthly the preventative		
					maintenance documentation of		
					the testing of the battery-opera		
					backup lights to ensure that all	II	
					documentation has been		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	CONSTRUCTION (X3) DATE SURVEY		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155539	B. W	ING		12/14/	2023
NAME OF I	DROLUDER OR GURRI IFI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF E	PROVIDER OR SUPPLIEF	· ·		601 E F	RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					completed accurately and in		
					accordance with the regulation		
					Any concerns identified will be promptly reviewed with the	;	
					maintenance supervisor so that	at	
					immediate corrective action ca		
					be taken.	ai i	
					Do tanon.		
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas	- Enclosure					
		are protected by a fire					
	_	our fire resistance rating					
	,	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
	-	e areas shall be separated					
	-	s by smoke resisting ors in accordance with 8.4.					
	Doors shall be se						
		and permitted to have					
	_	applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
	hazardous areas	that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	N/A					
	a. Boiler and Fuel	-Fired Heater Rooms					
	, -	er than 100 square feet)					
	•	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)						
	e. Trash Collectio						
	(exceeding 64 gal	llons)					

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETI	
		155539	B. WI	NG		12/14/20	23
			_	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	· ·		601 E F	RACE ST		
BERTHA	A D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	, IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		orage Rooms/Spaces					
	(over 50 square fe	classified as Severe					
	Hazard - see K32						
		on and interview, the facility	K 03	321	The corrective action taken fo	$r \mid_{0}$	1/12/2024
		f over 10 hazardous area doors,	1 100	21	those residents found to have		11/12/2021
		oom door, was provided with a			been affected by the deficient		
	_	This deficient practice could			practice is that although no		
	affect up to 10 resid	dents and staff while in the			specific residents were identif	ied	
	Physical Therapy C	Sym.			all residents and staff in the		
					physical therapy gym have the	е	
	Findings include:				potential to be affected by this		
			deficient practice. A self-closing		-		
		ons on 12/13/23 between 4:50			device has now been placed of		
		during a tour of the facility with			the physical therapy storage r		
		apervisor, the Physical			door and is functioning proper	-	
		om was over 50 square feet in			The corrective action taken fo	r the	
		at least 30 cardboard boxes,			other residents that have the		
		astic items, along with Physical			potential to be affected by the		
		The door to this room was not f closing device. This was			same deficient practice is that		
	_	faintenance Supervisor at the			residents and staff in the phys therapy gym have the potentia		
	time of observation	-			be affected by this deficient	ai 10	
	time of observation				practice. A self-closing device	_	
	This finding was re	viewed with the Administrator			has now been placed on the	-	
	_	inistrator during the exit			physical therapy storage room	1	
	conference on 12/1	_			door and is functioning proper		
					The measures that have been	-	
	3.1-19(b)				into place to ensure that the		
					deficient practice does not red	cur is	
					that a mandatory in-service ha	as	
					been provided for the mainter	ance	
					supervisor on the regulation		
					related to the requirements of		
					hazardous storage areas. The	e	
			maintenance supervisor was				
					instructed that it is their		
					responsibility to ensure that the		
					regulations are being followed		
	1		1		ensure the proper safety/secu	IIIV I	

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	OF CORRECTION	IDENTIFICATION NUMBER  155539	A. BUILDING B. WING	01	COMPLETED 12/14/2023
	ROVIDER OR SUPPLIER  D GARTEN KETCH	HAM MEMORIAL CENTER	601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0324 SS=F Bldg. 01	Ventilation Control Commercial Cooking * residential cooking appliances such as toasters) are used cooking in accordang 19.3.2.5.2 * cooking facilities smoke compartment patients comply with 18.3.2.5.3, 19.3.2.	and Fire Protection of and Fire Protection of and Operations, unless: and equipment (i.e., small as microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, appen to the corridor in ants with 30 or fewer the conditions under 5.3, or in smoke compartments		is maintained in the hazardou storage areas.  The corrective action taken to monitor to ensure the deficient practice will not recur is that a housewide audit of all areas of facility has been conducted to identify each hazardous storal room to ensure that these areare being maintained in accordance with the regulation including self-closing devices the doors. These doors will be monitored in accordance with regulation as part of the facility preventative maintenance proto ensure that the self-closing device is in place and function properly.	of the of the one on the one of the of the one one of the

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PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  conditions under 18.3.2.5.4, 19.3.2.5.4.  Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	STATEME AND PLA	VEY D 3
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all		
conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.  18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all	PREFIX	(X5) MPLETION
Findings include:  Based on observations on 12/13/23 between 4:50 p.m. and 6:30 p.m. during a tour of the facility with the Maintenance Supervisor, the kitchen was provided with a UL 300 hood system. Based on interview with three kitchen staff, when asked what they would do if there was a fire underneath the hood. All three said they didn't really know. Kitchen staff #1 finally said she would go pull the  suppression system as part of their job specific orientation.  The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that all kitchen staff, residents and visitors in the main dining room have the potential to be affected by this deficient practice. All dietary staff have now been instructed on the		/04/2024
pull station near the exit door from the dining room. No one said they would pull the range hood fire suppression system pull station. This was acknowledged by the Maintenance Supervisor at the time of observation and interview with the three kitchen staff. The  proper use of the UL300 hood fire suppression system in the kitchen. All new dietary staff will also be instructed on the proper use of the UL300 hood fire suppression system as part of		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			01	COMPLETED		
155539			B. W	B. WING 12/14/2023			/2023	
NAME OF PROVIDER OR SUPPLIER BERTHA D GARTEN KETCHAM MEMORIAL CENTER				STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE		
	Maintenance Supervisor said more training for kitchen staff would be a priority.  This finding was reviewed with the Administrator and Assistant Administrator during the exit conference on 12/14/23.  3.1-19(b)				their job specific orientation.			
					The measures that have been put			
					into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff on the proper use of the UL300 hood fire suppression system in the kitchen. In addition,			
					instruction on the proper use of the UL300hood fire suppression system in the kitchen has now	on		
					become a part of the dietary s job specific orientation. In			
					addition, instruction on the pro	per		
					use of the UL300 hood fire suppression system has now			
					been added to the dietary staf annual in-service schedule.	f's		
					The corrective action taken to			
					monitor to ensure the deficient practice will not recur is that a			
					dietary staff's personnel files v			
					be audited annually to ensure there is documentation to sup	nort		
					that they have been instructed on			
					the UL300 hood fire suppressi system in the kitchen.	ion		
					-			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and							
	Maintenance A fire alarm syste	m is tested and maintained						
	complying with the National Electric (	h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY  COMPLETED  12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP COD RACE ST I, IN 47562	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
TAG	Records of system and testing are readed. 1.3, 9.6.1.5, N Based on observation failed to maintain that it had accurate accordance with the 2012 edition, Section 2010 edition 2010 edition 2010 edition, Section 2010 edition 2010 edition 2010 edition 2010 edition 201	n acceptance, maintenance adily available. FPA 70, NFPA 72 on and interview, the facility are fire alarm system to assure time and date information in requirements of NFPA 101- ons 19.3.4 and 9.6 and NFPA 72 ions 14.1, 14.1.1. This deficient that all residents, staff and ation and interview during a with the Maintenance alarm control panel was lay on the main fire alarm that the time to be 5:14 p.m. the on the panel showed it to be the correct date of 12/13/2023. The time of observation, the visor indicated he was not beaucy and would speak with ection company to get the time by.  Viewed with the Administrator inistrator during the exit	K 0345		for 01/04/2024 re nt office onts, as be ctice. The ethat least at all of the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by . The ethat least at the tial to wo on all so riew by .

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILI	DING	ONSTRUCTION (X3		(3) DATE SURVEY COMPLETED	
		155539	B. WING	<del>-</del>		12/14/	2023	
	OF PROVIDER OR SUPPLIE	R CHAM MEMORIAL CENTER	6	601 E R	DDRESS, CITY, STATE, ZIP COD ACE ST IN 47562			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
					into place to ensure that the deficient practice does not recthat a mandatory in-service had been provided for the maintensupervisor on the regulation related to the sensitivity testing requirements of smoke detector. The maintenance supervisor winstructed on their responsibilitiensure the smoke detector sensitivity testing is completed every 24 months and documentation of this testing retained on file for review by the authorities in accordance with regulation.  The corrective action taken to monitor to ensure the deficient practice will not recur is that the administrator will now be revied the documentation on the sensitivity testing of the smoked detectors in the Rose House of 24 months to ensure that the documentation has been completed timely. Any concertidentified will be promptly discussed with the maintenance supervisor for immediate correlation.	ance g ors. vas ty to l ne the wing e overy		

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039		
STATEME	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>01</u>	COMPL	LETED		
		155539	B. WI	NG		12/14	/2023		
NAME OF I	PROVIDER OR SUPPLIER	)		STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF	FROVIDER OR SUFFLIER			601 E RACE ST					
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE COMPLETION			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX					
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
K 0351	NFPA 101								
SS=F	Sprinkler System								
Bldg. 01	Spinkler System - 2012 EXISTING	Installation							
		nd hospitals where required							
	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler								
	Systems.	·							
	In Type I and II co	onstruction, alternative							
	protection measur	res are permitted to be							
	substituted for spi	inkler protection in specific							
	areas where state	or local regulations prohibit							
	sprinklers.								
	In hospitals, sprin	klers are not required in							
	clothes closets of	patient sleeping rooms							
		the closet does not exceed							
	1	sprinkler coverage covers							
	-	t as required by NFPA 13,							
		ıllation of Sprinkler							
	Systems.								
		, 19.3.5.3, 19.3.5.4,							
	i e	19.3.5.10, 9.7, 9.7.1.1(1)	17.0	2.5.1			01/04/0004		
		on and interview, the facility	K 0:	351	The corrective action taken fo		01/04/2024		
		sprinkler system piping was			those residents found to have				
	1	1 of 1 attic area. NFPA 13,			been affected by the deficient				
		llation of Sprinkler Systems, es Sprigs 4 feet or longer shall			practice is that although no	iad			
		st lateral movement. This			specific residents were identified uring the survey, all residents				
	1	ould affect all residents, staff,			during the survey, all residents				
	and visitors in the M				staff and visitors have the potential to be affected by this deficient				
	and visitors in the r	Tum Dunuing.			practice. All the identified				
	Findings include:				sprinkler pipe sprigs in the atti	ic			
	I manago morado.				space have now been	•			
	Based on observation	ons on 12/13/23 between 4:50			secured/restrained against lat	eral			
		during a tour of the facility with			movement in accordance with				
	_	spervisor, there were at least 40			regulation.				

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or more sprinkler pipe sprigs in the attic space that

were not restrained against lateral movement. The

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The corrective action taken for the

other residents that have the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	_	LETED L/2023		
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 E RACE ST ODON, IN 47562					
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PROPRIATE	(X5) COMPLETION DATE		
	and mostly located west corridors. Thi Maintenance Super observations.  This finding was re	viewed with the Administrator inistrator during the exit		potential to be affected same deficient practice residents staff and visite the potential to be affect deficient practice. All spipe sprigs in the attic so now been secured/restragainst lateral movement accordance with the regard that a mandatory in-service does not that a mandatory in-service deep provided for the mosupervisor on the regular related to ensuring that sprinkler system piping properly secured/restrain against lateral movement maintenance supervisor educated on their responsant to ensure the depractice will not recur is part of the facility preversion of the sprinkler system will be conducted that each sprinkler system inspection of the sprinkler system spring is secured/restrain lateral movement. The inspections will be docut the preventative maintenance that required.	is that all ors have ted by this orinkler pace have rained in the pulation. The recur is vice has raintenance ration the sprigs are rined int. The recur is vice has raintenance ration the sprigs are rined int. The recur is vice has raintenance recurs in the recurs in			

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i '		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155539	·			12/14/	
		10000	D. ((1)		PRESIDENCE CONTROL CON	12/14/	2020
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
BERTHA	D GARTEN KETCH	HAM MEMORIAL CENTER			IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAF coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record facility failed to ens piping system was i accordance with NF the Inspection, Test Water-Based Fire P Edition, Section 14. piping and branch li conducted every 5 y connection at the en removing a sprinkle line for the purpose of foreign organic a Alternative nondest	supply source  RKS information on non-required or partial r system.	K 03	53	1.) The corrective action taken those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors have the pote to be affected by this deficient practice. The facility has now the automatic sprinkler piping system inspected and there is documentation on file for reviet the authorities of this inspectic 2.) The corrective action taken those residents found to have	ed s, ential had ew by on.	01/19/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155539	B. W	ING		12/14/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
DEDTILA	D CARTEN KETO	LIANA MENAODIAL OFNITED			RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER		ODON,	IN 47562		
(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	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	required to be inspe	ected internally. Section 4.3.1			been affected by the deficient		
	states records shall	be made for all inspections,			<i>practice is that</i> although no		
		nce of the system and its			specific residents were identifi	ed	
		all be made available to the			during the survey, all residents		
	-	risdiction upon request. This			the west unit, as well as west		
		ffects all residents, staff and			staff and visitors have the pote		
	visitors in the Main				to be affected by this deficient		
					practice. The ceiling in the we		
	Findings include:				unit nurses station med room		
	i mamga maraati				now been repaired and a new		
	Based on record rev	view on 12/13/23 between 9:00			escutcheon ring has been place		
		with the Maintenance			on the sprinkler head allowing		
	_	documentation of an internal			sprinkler head to function to its		
		ain Building sprinkler system			capacity.	5 IUII	
	•	ne most recent five year period			3.) The corrective action taker	for	
	-	or review. Documentation for			those residents found to have		
		rnal pipe inspection performed			been affected by the deficient		
		. Based on interview at the			practice is that although no		
		ew, the Maintenance Supervisor			specific residents were identifi	od	
		ntation of an internal inspection			during the survey, all residents		
		tem within the most recent five			staff and visitors on the east u		
		available for review.			have the potential to be affect		
	year period was not	available for fevicw.			by the deficient practice. The	eu	
	This finding was re	viewed with the Administrator			1 -		
	-	nistrator during the exit			sprinkler head covered with corrosion identified at the east		
	conference on 12/14					L	
	conference on 12/12	+/23.			back exit overhang has been		
	2.1.10/1-)				replaced.	41	
	3.1-19(b)				The corrective action taken for	r tne	
	2 D 1 1				other residents that have the		
		ration and interview, the			potential to be affected by the		
		sure the ceiling in 1 of 6			same deficient practice is that		
	*	compartments was maintained			residents, staff and visitors ha		
		eads to function to their full			the potential to be affected by		
		ficient practice could affect all			deficient practice. The facility		
		visitors while in the main			now had the automatic sprinkl		
		was adjacent to the west			piping system inspected and t		
	nurses' station.				is documentation on file for re-	view	
					by the authorities of this		
	Findings include:				inspection. A housewide audi		
					all ceiling areas around sprink	ler	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X.		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155539	B. W	ING		12/14	2023	
				OTDEET :	ADDRESS CITY STATE TIP COP			
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
DEDTILA	D OADTEN KETO	LIAMAMENAODIAL OENTED			RACE ST			
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562			
(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)		DATE	
	Based on observation	ons on 12/13/23 between 4:50			heads has been conducted to			
	p.m. and 6:30 p.m.	during a tour of the facility with			ensure that there are no holes	or		
	the Maintenance Su	pervisor, the sprinkler head in			obstruction that would prevent	t the		
	the west nurses' stat	tion med room was missing its			sprinkler head from functioning	g to		
	escutcheon ring wh	ich left a half inch gap around			their full capacity. No other			
	the sprinkler head to	o the attic space. Based on			compromised ceiling areas are	ound		
	interview at the tim	e of observation, the			the sprinkler heads were			
	Maintenance Super	visor acknowledged the half			identified. A housewide audit	of all		
	inch gap around the	west nurses' station med			sprinkler heads has been			
	room sprinkler head	that penetrated the ceiling			completed to ensure that they	are		
	and said he would o	correct the issue as soon as			free from corrosion. No other			
	possible.				corroded sprinkler heads were	)		
					identified.			
	This finding was re	viewed with the Administrator			The measures that have been	put		
	and Assistant Admi	inistrator during the exit			into place to ensure that the			
	conference on 12/14	4/23.			deficient practice does not rec	ur is		
					that a mandatory in-service ha	as		
	3.1-19(b)				been provided for the mainten	ance		
					supervisor on the regulation			
	<ol><li>Based on observ</li></ol>	ration and interview, the			regarding the maintenance an	d		
	facility failed to ens	sure sprinkler heads in 1 of 6			testing of the sprinkler system			
	smoke compartmen	ts covered with corrosion was			The maintenance supervisor v	vas		
	1 -	5, 2011 edition, at 5.2.1.1.1			educated on their responsibilit	y for		
	_	show signs of leakage; shall			ensuring that all inspections,			
	be free of corrosion	, foreign materials, paint, and			testing and maintenance of the	е		
		nd shall be installed in the			sprinkler system in accordanc	е		
		(e.g., up-right, pendent, or			with the regulation is their			
		nore, at 5.2.1.1.2 any sprinkler			responsibility, as well as ensu	ring		
	_	any of the following shall be			that the required supportive			
		age (2) Corrosion (3) Physical			documentation of all inspectio	ns,		
		f fluid in the glass bulb heat			testing and maintenance must			
	_	(5) Loading (6) Painting			maintained by the supervisor t	for		
		ne sprinkler manufacturer.			review by the authorities.			
		ice could affect up to 20			The corrective action taken to			
	· · · · · · · · · · · · · · · · · · ·	staff and visitors in the east			monitor to ensure the deficien	t		
	corridor.				practice will not recur is that the			
					administrator and/or assistant			
	Findings include:				administrator will now review			
					monthly the maintenance			
	Based on observation	ons on 12/13/23 between 4:50	1		supervisor's supportive			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155539	B. W	B. WING 12/14/2023			/2023
				CTREET /	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
DEDTUA	D CARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
DENTHA	D GARTEN KETC	HAW WEWORIAL CENTER		ODON,	IN 47 502		
(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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	p.m. and 6:30 p.m.	during a tour of the facility with			documentation on the inspecti	ons,	
	the Maintenance Su	pervisor, there was a sprinkler			testing and maintenance of the	е	
	head under the east	back exit overhang covered			facility's sprinkler system to		
		sed on interview at the time of			ensure compliance with the		
		intenance Supervisor agreed			regulation. Any concerns		
	-	inder the east back exit			identified by administration wil	l be	
	overhang was cover	red with corrosion and should			promptly addressed with and		
	be replaced.				corrected by the maintenance		
					supervisor.		
		viewed with the Administrator					
		nistrator during the exit					
	conference on 12/1	4/23.					
	3.1-19(b)						
14.0544							
K 0511	NFPA 101						
SS=D	Utilities - Gas and						
Bldg. 01	Utilities - Gas and						
		gas or related gas piping					
		PA 54, National Fuel Gas					
		iring and equipment					
		PA 70, National Electric					
	-	tallations can continue in					
	service provided r						
	18.5.1.1, 19.5.1.1	on and interview, the facility	17.0	<i>5</i> 1 1	The corrective action taken to		01/10/2024
		f over 10 wet locations, was	K 0	311	The corrective action taken for those residents found to have		01/19/2024
		nd fault circuit interrupter			been affected by the deficient		
		against electric shock. NFPA			practice is that although no		
		ion at 210.8 Ground-Fault			specific residents were identifi	iod	
		Protection for Personnel,			during the survey, nursing state		
	_	circuit-interruption for			the east nurses' station have t		
	_	provided as required in			potential to be affected by this		
		C). The ground-fault			deficient practice. The identifi		
	` ' ' ` '	hall be installed in a readily			electrical receptacle in the eas		
	accessible location.	_			nurses' station med room has		
		: See 215.9 for ground-fault					
		rotection for personnel on			been replaced and provides g fault circuit interrupter protection		
	feeders.	roccion for personner on				UII	
		alling Units All 125 volt			against shock.	r tha	
	(D) Omer Than DW	elling Units. All 125-volt,			The corrective action taken for	ı irre	I

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STATEMEN	NT OF DEFICIENCIES	DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) M		(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLE			ETED
		155539	B. WI	NG		12/14/	2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DEDTILA	D OADTEN KETO	LIANA MENODIAL CENTED			RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562		
(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
	single-phase, 15- ar	nd 20-ampere receptacles			other residents that have the		
	installed in the loca	tions specified in 210.8(B)(1)			potential to be affected by the		
	through (8) shall ha				same deficient practice is that		
		protection for personnel.			residents, staff and visitors ha		
	(1) Bathrooms	•			the potential to be affected by		
	(2) Kitchens				deficient practice. A housewid		
	(3) Rooftops				audit of all wet locations has b		
	(4) Outdoors				conducted to ensure that elec		
	` /	(3) and (4): Receptacles that are			receptacles in the wet location		
	_	ole and are supplied by a			have the appropriate ground for		
	-	cated to electric snow-melting,			circuit interrupter protection to		
		and vessel heating equipment			prevent electric shock. No oth		
	U	o be installed in accordance			electrical receptacles were		
	with 426.28 or 427.				identified.		
		(4): In industrial establishments			The measures that have been	nut	
	_	nditions of maintenance and			into place to ensure that the	Par	
		that only qualified personnel			deficient practice does not rec	ur is	
	_	sured equipment grounding			that a mandatory in-service ha		
		as specified in 590.6(B)(2)			been provided for the mainten		
		or only those receptacle			supervisor on the regulation	unoo	
	_	bly equipment that would			related to wet location electric		
		ard if power is interrupted or			receptacles. The maintenance		
		t is not compatible with GFCI			supervisor was educated on the		
	protection.	on not companied with or or			responsibility for ensuring that		
	•	eceptacles are installed within			location electric receptacles ha		
		outside edge of the sink.			the proper ground fault circuit		
		(5): In industrial laboratories,			interrupter protection against		
		supply equipment where			shock.		
	_	vould introduce a greater			The corrective action taken to		
	_	nitted to be installed without			monitor to ensure the deficien		
	GFCI protection.				practice will not recur is that a	-	
	_	(5): For receptacles located in			part of the on-going preventati		
	_	as of general care or critical			maintenance program, the		
	_	care facilities other than those			maintenance supervisor will		
	covered under	The same same than those			monitor to ensure that all wet		
		protection shall not be required.			locations have the proper elec	tric	
	(6) Indoor wet loca				receptacles properly installed		
	` '	vith associated showering			protection against shock.	VVILII	
	facilities	Tim associated showering			protection against shock.		
		e bays, and similar areas where					
	(o) Garages, service	oays, and similal aleas where	I		1		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	 UILDING	onstruction  01	(X3) DATE COMPL 12/14/	ETED		
	ROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562					
,			 <u> </u>	114 47 002				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION		
TAG	electrical	LSC IDENTIFYING INFORMATION	TAG	BEIGERGI		DATE		
		nt, electrical hand tools.						
		Vet Locations, requires all						
	·	ed equipment within the area of						
	_	nave ground-fault circuit						
	interrupter (GFCI) j	protection. Note: Moisture can						
	reduce the contact r	esistance of the body, and						
		is more subject to failure.						
	-	ice could affect mostly nursing						
	staff.							
	Findings include:							
	Based on observation	ons on 12/13/23 between 4:50						
	p.m. and 6:30 p.m.	during a tour of the facility with						
	the Maintenance Su	pervisor, there were three						
	electric receptacles	within three feet of the sink in						
		on Med Room. The						
	_	ft was provided with a GFCI						
	_	ther two were piggy backed to						
		ed with a GFCI testing device						
		ptacle was properly wired,						
		cally circuit was not of the three receptacles.						
	1	ne test button on the first						
		rically circuit was interrupted						
	_	cles. Based on interview at the						
	•	, the Maintenance Supervisor						
		ceptacles in the east nurses's						
		were functioning properly and						
	he would replace th	em as soon as possible.						
		viewed with the Administrator						
	and Assistant Admi conference on 12/14	nistrator during the exit						
	conference on 12/14	<del>1</del> /23.						
	3.1-19(b)							
K 0711	NFPA 101							
SS=F	Evacuation and R	elocation Plan						

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)					(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPL	ETED	
		155539	B. WI	NG		12/14/	2023
	ROVIDER OR SUPPLIER	HAM MEMORIAL CENTER		601 E R	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562		
(X4) ID	SUMMARY S	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
Bldg. 01	Evacuation and R						
		plan for the protection of all					
	·	eir evacuation in the event					
	of an emergency.						
		riodically instructed and					
	-	their duties under the plan,					
		plan is readily available					
		erator or with security. The e basic response required					
	•	7.2.1.2 and provides for all					
	-	lan components per					
	18/19.2.2.	сотретене рег					
		8.7.1.3, 18.7.2.1.2,					
	_	, 19.7.1.1 through 19.7.1.3,					
	19.7.2.1.2, 19.7.2.	2, 19.7.2.3					
		view and interview, the facility	K 0	711	The corrective action taken for	r	01/05/2024
	_	complete facility specific			those residents found to have		
		lan for the protection of 38 of			been affected by the deficient		
		Main Building to accurately			<i>practice is that</i> although no		
		ty systems, plus a system			specific residents were identifi		
		required by NFPA 101, 2012			during the survey all residents		
		7.2.2. LSC 19.7.2.2 requires a occupancy fire safety plan that			staff and visitors have the pote		
	shall provide for the				to be affected by this deficient		
	(1) Use of alarms	onowing.			practice. The facility fire safet plan has now been amended t	-	
		alarm to fire department			include the location of the smo		
		ne call to fire department			barriers within the facility.		
	(4) Response to alar				The corrective action taken for	r the	
	(5) Isolation of fire				other residents that have the		
	(6) Evacuation of in	nmediate area			potential to be affected by the		
	(7) Evacuation of sr				same deficient practice is that	all	
		loors and building for			residents, staff and visitors ha		
	evacuation				the potential to be affected by		
	(9) Extinguishment				deficient practice. The facility	fire	
		states any required aisle or			safety plan has now been		
		e less than 48 inches in clear			amended to include the location	on ot	
	_	g as means of egress from ms. Projections into the			the smoke barriers within the		
		be permitted for wheeled			facility.  The measures that have been	nut	
		the relocation of wheeled			into place to ensure that the	ραι	
	equipment provided	. and relocation of wheeled			The place to elisale that the		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>01</u>	COMPLETED	
		155539	B. WING	_	12/14/2023	
			CTDE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8				
DEDTILA	D CARTEN KETO	LIAM MEMORIAL CENTER		E RACE ST		
BERTHA	D GARTEN KETCI	HAM MEMORIAL CENTER	ODO	ON, IN 47562		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DATE	
	equipment during a	fire or similar emergency is		deficient practice does not re	cur is	
	addressed in the wr	itten fire safety plan and		that a mandatory in-service h	I	
		r the facility. The wheeled		been provided for administration		
	equipment is limited			and the maintenance supervi		
	i. Equipment in use			on the regulation related to the		
		ncy equipment not in use		requirements of a fire safety,		
	iii. Patient lift and to			evacuation and relocation pla	in	
		ice could affect all occupants		Administration and the		
	in the event of an er			maintenance supervisor were	ž	
				educated on their responsibil		
	Findings include:			ensuring that all components	-	
	i mamga maraati			the regulation are outlined in		
	Based on a review o	of the facility's "Fire Plan" on		facility's fire safety plan.		
		2:00 a.m. and 3:45 p.m. with the		The corrective action taken to	,	
	Maintenance Super	-		monitor to ensure the deficien		
	_	ent, the plan did address		practice will not recur is that		
	_	noke compartment, however,		facility's fire safety plan will b	I	
		ntify where the smoke barriers		reviewed by the Quality Assu		
	-	facility. Based on interview at		committee at least bi- annual		
		eview, the Maintenance		ensure that all components o	•	
		istant Administrator			i ille	
	-			regulation are outlined in the		
		agreed that the Fire Plan did		facility's fire safety plan.		
	-	the smoke barriers were located		Modifications to the fire safet	- I	
	in the facility.			plan will be made when warra	anted	
	Tl.:- C 1'	adiana di adia di Adia 1999 di		or required by regulation.		
	-	viewed with the Administrator				
		inistrator during the exit				
	conference on 12/14	4/25.				
	2.1.10(1)					
	3.1-19(b)					
K 0764						
K 0761						
SS=F						
Bldg. 01	   D					
		view, observation, and	K 0761	The corrective action taken for	01/01/2021	
		ty failed to ensure a complete		those residents found to have		
	-	nd testing of 1 of 1 stairway		been affected by the deficien	t	
		and 1 of 1 oxygen transfilling		practice is that although no		
		y was completed in accordance		specific residents were identi		
	with LSC 19.1.1.4.1	1.1. Communicating openings in		during the survey all resident	S,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155539	B. W	ING		12/14/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
RERTHA	D GARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
DLITTIA		HAW MEMORIAL CENTER		ODON,	111 47 302		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	rs required by 19.1.1.4.1 shall be			staff and visitors have the pot		
		orridors and shall be protected			to be affected by this deficient	İ	
	by approved self-closing fire door assemblies.				practice. The form utilized to		
	(See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table				document the annual inspecti		
	_				and testing of smoke barrier a		
	8.3.4.2 shall be protected by approved, listed,				fire rated doors has been ame		
		labeled fire door assemblies and fire window			and now contains documenta	tion	
		r accompanying hardware,			for the inspection of the door		
	_	s, closing devices, anchorage,			assemblies. All smoke barrie		
		nce with the requirements of			and fire rated doors have now	been	
	NFPA 80, Standard for Fire Doors and Other				inspected/tested and there is		
	Opening Protectives, except as otherwise				documentation to support the	se	
	specified in this Code. NFPA 80 5.2.1 states fire				inspections/testing including	_	
		all be inspected and tested not			documentation of the inspecti	on of	
		and a written record of the			the door assemblies. These		
	_	signed and kept for inspection		inspections also included the			
		. 80, 5.2.4.1 states fire door			stairway fire door and the doo	r to	
		visually inspected from both			the oxygen transferring room.		
		overall condition of door			The corrective action taken fo	r the	
	assembly.				other residents that have the		
	NED 4 00 5 2 4 2				potential to be affected by the		
		tates as a minimum, the			same deficient practice is that		
	following items sha				residents, staff and visitors ha		
		or breaks exist in surfaces of			the potential to be affected by	this	
	either the door or fr				deficient practice. All smoke		
		light frames, and glazing beads			barrier and fire rated doors ha		
		ely fastened in place, if so			now been inspected/tested ar		
	equipped.	1. 1 1			there is documentation to sup	-	
		e, hinges, hardware, and			these inspections/testing inclu	•	
		eshold are secured, aligned,			documentation of the inspecti	on of	
		er with no visible signs of			the door assemblies. These		
	damage.	saina an hualtan			inspections also included the	4	
	(4) No parts are mis	-			stairway fire door and the doo	r to	
	` '	do not exceed clearances			the oxygen transferring room.	4	
	listed in 4.8.4 and 6.3.1.7.				The measures that have been	ı put	
	(6) The self-closing device is operational; that is, the active door completely closes when operated				into place to ensure that the		
					deficient practice does not red		
	from the full open p				that a mandatory in-service ha		
		is installed, the inactive leaf			been provided for the mainter	ance	
	closes before the active leaf.				supervisor on the regulation		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155539	B. W	NG		12/14/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	3			RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
(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'	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		are operates and secures the			related to the maintenance,		
	door when it is in the	-			inspection and testing of smok		
		vare items that interfere or			barrier and fire rated doors. T	he	
		are not installed on the door or			maintenance supervisor was		
	frame.	Sactions to the deep assembly			educated on the required		
		fications to the door assembly			documentation that must be	in	
	have been performed that void the label. (11) Gasketing and edge seals, where required, are				included with each inspection		
	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.				accordance with the regulation  The corrective action taken to	1.	
	inspected to verify their presence and integrity.  This deficient practice could affect all residents,				monitor to ensure the deficient	•	
	as well as staff, and visitors.				practice will not recur is that th		
	as well as staff, and visitors.				administrator and/or assistant		
	Findings include:				administrator will now be revie	wina	
	I mango morado.				annually the documentation or	•	
	Based on record review on 12/13/23 between 9:00				maintenance, inspection and		
	a.m. and 3:45 p.m.	with the Maintenance			testing of smoke barrier and fi	·e	
	Supervisor present,	the facility did provide			rated doors. Administration w		
	documentation of a	form used for the annual			ensure that the documentation	1	
	inspection of all of	the facility's smoke barrier and			includes the inspection of the	door	
	fire rated door asser	mblies, however, the			assemblies in accordance with	the	
	-	vided was not filled out to			regulation.		
		assemblies were inspected.					
		at the time of record review,					
	the Maintenance Su	-					
		vided was the only inspection					
		ntation available for the					
	•	esting of the facility's fire door					
		on observations during a tour					
		the Maintenance Supervisor					
	-	and 6:30 p.m., there was 1 ssembly and 1 oxygen					
	-	re door assembly noted in the					
	facility.	te door assembly noted in the					
	iacinity.						
	This finding was re	viewed with the Administrator					
		inistrator during the exit					
	conference.						
	3.1-19(b)						

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

Event ID: HGWV21 Facility ID: 000300

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PRINTED: 01/25/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (VI.) PROVIDED (SURBLIED (CL.))			OMB NO. 0938-0			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155539	B. WING		12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST , IN 47562		
(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 APPROPRIAT	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
K 0914	NFPA 101					
SS=F	Electrical Systems	s - Maintenance and				
Bldg. 01	Testing					
	_	s - Maintenance and				
	Testing					
	•	ceptacles at patient bed				
		ere deep sedation or general				
		ninistered, are tested after				
		replacement or servicing.				
		is performed at intervals				
	_	ented performance data.				
	I	sted as hospital-grade at				
these locations are tested at intervals not						
	exceeding 12 months. Line isolation monitors					
	_	are tested at intervals of				
	' '	to 1 month by actuating				
	· ·	h per 6.3.2.6.3.6, which				
		ual and audible alarm. For				
		utomated self-testing, this				
		formed at intervals less				
	· ·	2 months. LIM circuits are				
		.2 after any repair or				
	•	electric distribution system.				
		tained of required tests and				
	associated repairs					
		oom or area tested, and				
	results.					
	6.3.4 (NFPA 99)					
	. ,	on, record review and	K 0914	The corrective action taken for	01/05/2024	
		ty failed to ensure complete	IK O) I I	those residents found to have	01/03/2021	
	documentation was	-		been affected by the deficient		
		electrical receptacles in all		practice is that although no		
		ions tested at least annually.		specific residents were identifie	<sub>2d</sub>	
		Care Facilities Code 2012 Edition,		during the survey, all residents		
		ates receptacles not listed as		staff and visitors have the pote		
		atient bed locations and in		to be affected by this deficient		
		ep sedation or general		practice. The facility has now		
		istered, shall be tested at		conducted testing on all		
		ling 12 months. Additionally,		nonhospital-grade electrical		
		ceptacle Testing in Patient Care		receptacles in all resident roon	_	
	Section 0.3.3.2, Ref	ceptacie resumg in rationi Care	I	Lievehranies in all resident 10011	.1	

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

Event ID:

 $HGWV21 \quad \text{Facility ID:} \quad 000300$ 

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PRINTED: 01/25/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER		601 E F	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562		
			1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		physical integrity of each			locations. No issues were		
		confirmed by visual inspection.			identified. The facility will con		
	The continuity of the grounding circuit in each				to conduct annual testing of a	I	
		e shall be verified. Correct			nonhospital-grade electrical		
		and neutral connections in			receptacles in resident rooms		
	· ·	ptacle shall be confirmed; and			document the results of the te	sts	
	retention force of the grounding blade of each				for review by the authorities.	41	
	electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4				The corrective action taken fo	rine	
	* ′	Ψ ,			other residents that have the		
	residents.	ient practice could affect all			potential to be affected by the		
	residents.				same deficient practice is that		
	Findings include:				residents, staff and visitors ha the potential to be affected by		
	I mangs metade.				deficient practice. The facility		
	Based on record review on 12/13/23 between 9:00				now conducted testing on all	IIas	
	a.m. and 3:45 p.m. with the Maintenance				nonhospital-grade electrical		
	_	there was no documentation			receptacles in all resident roor	m	
		ual resident room receptacle			locations. No issues were	"	
		l-grade receptacles for the			identified. The facility will con	tinua	
	_	od or prior. Based on interview			to conduct annual testing of a		
		d review, the Maintenance			nonhospital-grade electrical	•	
		ctrical receptacles in resident			receptacles in resident rooms	and	
	_	spital-grade receptacles as far			document the results of the te		
		ther said he could not find			for review by the authorities.		
		how that annual testing per			The measures that have been	put	
		cle Testing requirements was			into place to ensure that the	•	
	met with all pertine	ent information within the past			deficient practice does not red	ur is	
	_	Based on observations on			that a mandatory in-service ha		
	12/13/23 between 4	:50 p.m. and 6:30 p.m. during a			been provided for the mainten	ance	
	tour of the facility v	with the Maintenance			supervisor on the regulation		
	Supervisor, there w	ere at least four to six electrical			related to the testing of		
	receptacles in each	resident room.			nonhospital-grade electrical		
					receptacles. The maintenanc		
		viewed with the Administrator			supervisor has been educated		
		inistrator during the exit			their responsibility to ensure the		
	conference on 12/1	4/23.			this annual test is performed a		
					the findings documented for re	eview	
	3.1-19(b)				by the authorities.		
					The corrective action taken to		
					monitor to ensure the deficien	t	

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Event ID:

HGWV21 Facility ID: 000300

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155539	B. WI	NG		12/14/	2023
			<u> </u>	CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEDTUA	D CARTEN KETCL	LAM MEMORIAL CENTER					
DERTHA	D GARTEN KETCH	HAM MEMORIAL CENTER	ODON, IN 47562		IN 47562		
(X4) ID	SUMMARY S	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 APPROPRIATE CO		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					practice will not recur is that th	ne	
					administrator and/or assistant		
					administrator will now be revie	wing	
					annually the documentation of	the	
					testing of the nonhospital-grad	le	
					electrical receptacles in reside	ent	
					rooms to ensure that the tests	are	
					performed in accordance with	the	
					regulation. Any concerns		
					identified will be promptly		
				discussed with the maintenance supervisor for immediate		ce	
			correction.		correction.		
K 0000							
Bldg. 03							
	•	Recertification and State	K 00	000	By submitting the enclosed		
	_	as conducted by the Indiana			materials, we are not admitting	g the	
	Department of Heal	th in accordance with 42 CFR			truth or accuracy of any specif	ic	
	483.90(a).				findings or allegations. We		
					reserve the right to contest the		
	Survey Date: 12/13	3/23 and 12/14/23			findings or allegations as part		
					any proceedings and submit th	nese	
	Facility Number: 0				responses pursuant to our		
	Provider Number:				regulatory obligations. The fa	-	
	AIM Number: 1002	287340			requests the plan of correction	ı be	
					considered our allegation of		
	-	Code survey, the small house			compliance effective January		
	-	rtha D Garten Ketcham			2024 to the state findings of th		
		as found not in compliance			Life Safety Code Recertification	n	
	with Requirements	•			State Licensure Survey and		
		, 42 CFR Subpart 483.90(a),			Emergency Preparedness Sur	•	
	-	re and the 2012 edition of the			conducted on December 14, 2	2023.	
	National Fire Protec	etion Association (NFPA) 101,					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPLETED	
		155539	B. WI	NG		12/14/	2023
	ROVIDER OR SUPPLIER	HAM MEMORIAL CENTER		601 E R	ADDRESS, CITY, STATE, ZIP COD RACE ST IN 47562		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Life Safety Code (L Care Occupancies.	SC), Chapter 18, New Health					
K 0291 SS=C	Type V (111) constricts sprinklered. The fact with hard wired smooth spaces open to the considerable sleeping rooms. The certified beds and he of this survey. The main building of 62 and had a census survey. Combined, 72 and had a census survey.  Quality Review considerable survey.  NFPA 101  Emergency Lighting	ng					
Bldg. 03	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on record rev failed to ensure ther documentation for t backup light that was seconds during the prequires emergency accordance with Secrequires functional to monthly, with a mir	g of at least 1-1/2 hour ed automatically in 1.9.  Tiew and interview, the facility re was complete the testing of 1 of 1 battery as tested monthly for 30 past 12 months. LSC 18.2.9.1 lighting shall be provided in ction 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a	K 02	291	K 291 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors have the pote to be affected by this deficient	ed s, ential	01/04/2024
	than 30 seconds, (3) conducted annually if the emergency lig	ks between tests, for not less Functional testing shall be for a minimum of 1 1/2 hours thing system is battery ritten records of visual			practice. There is now documentation to support that battery-operated backup lights have been tested for at least t seconds, including the battery	all s hirty	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155539	B. W	ING		12/14/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER	_		IN 47562		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ts shall be kept by the owner			backup light located at the		
	for inspection by th				generator. The facility will nov	V	
	jurisdiction. This deficient practice could affect all				consistently test all		
	residents, as well as staff and visitors in the				battery-operated backup lights		
	facility.				monthly and document all requ	uired	
					components of the testing		
	Findings include:				including the 30 second testing	g	
	D1 1				period.	- 41	
		view on 12/13/23 between 9:00			The corrective action taken for	rthe	
	-	with the Maintenance			other residents that have the		
		the facility did have a			potential to be affected by the	-11	
	preventative maintenance (PM) report that the				same deficient practice is that		
	battery powered emergency light set at the generator was tested monthly, however, the				residents, staff and visitors ha		
	_	ot complete. The monthly test			the potential to be affected by		
		y powered emergency light set			deficient practice. There is now		
		15 seconds, furthermore, there			documentation to support that battery-operated backup lights		
		ests performed during March,			have been tested for at least the		
	-	vember of 2023. Based on an			seconds, including the battery	iii ty	
	-	ne of record review, the			backup light located at the		
		visor agreed the PM form for			generator. The facility will nov	v	
	-	d emergency light set was not			consistently test all	•	
		rmed there were three months			battery-operated backup lights		
	where the light set				monthly and document all requ		
	6				components of the testing	. = =	
	This finding was re	eviewed with the Administrator			including the 30 second testing	q	
	_	inistrator during the exit			period.		
	conference on 12/14	_			The measures that have been	put	
					into place to ensure that the		
	3.1-19(b)				deficient practice does not rec	ur is	
					that a mandatory in-service ha	ıs	
					been provided for the mainten	ance	
					supervisor on their responsibil	ity to	
					ensure that monthly testing of	all	
					battery-operated backup lights		
					being conducted and docume		
					in accordance with the regulat		
					The documentation shall inclu	de	
					the 30 second testing period.		
					The corrective action taken to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155539	B. W	ING		12/14/	2023
<b>N</b>				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			RACE ST		
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					monitor to ensure the deficient practice will not recur is that t		
					administrator and/or assistant		
					administrator will now review	•	
					monthly the preventative		
					maintenance documentation	on	
					the testing of the battery-oper		
					backup lights to ensure that a		
					documentation has been		
					completed accurately and in		
					accordance with the regulatio		
					Any concerns identified will be	9	
					promptly reviewed with the	-4	
					maintenance supervisor so th		
					immediate corrective action control be taken.	all	
					be taken.		
IX 0004	NEDA 464						
K 0321 SS=F	NFPA 101	Frankrauma					
Bldg. 03	Hazardous Areas						
Diag. 03	Hazardous Areas 2012 New	- Endosule					
		are protected in accordance					
		e areas shall be enclosed					
		rated barrier, with a 3/4-hour					
	fire-rated door wit						
		8.7.1.1). Doors shall be					
	self-closing or au	tomatic-closing in					
		7.2.1.8. Hazardous areas					
		a sprinkler system in					
		9.7, 18.3.2.1, and 8.4.					
		r and zone locations of					
		that are deficient in					
	REMARKS. 18.3.2.1, 7.2.1.8,	8.4. 8.7. 9.7					
	10.0.2.1, 1.2.1.0,						
	Area	Automatic Sprinkler					
	Separation						
		I-Fired Heater Rooms					
	I b. Laundries (lard	er than 100 square feet)	I		1		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	LETED
		155539	B. W	ING		12/14	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			RACE ST		
REDTHA	D CARTEN KETC	HAM MEMORIAL CENTER			IN 47562		
DEIXIIIA	D GARTEN RETO	TAW WEWORIAL CENTER		ODON,	111 47 302		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection Rooms						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	l '	than 100 square feet)					1
	I -	torage Rooms/Spaces					
	(over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322)						
		on and interview, the facility	K 0	321	The corrective action taken for		01/04/2024
	failed to ensure 1 of 2 rooms with fuel fired				those residents found to have		
		tected with a complete 1-hour			been affected by the deficient		
		This deficient practice could			practice is that although no		
		staff, and visitors in the Rose			specific residents were identified		
	House.				all residents and staff in the		
	E' 1' ' 1 1				physical therapy gym have the		
	Findings include:				potential to be affected by this		
	D4	12/12/22 h-+ 2.45			deficient practice. A self-closi	-	
		ons on 12/13/23 between 3:45 during a tour of the facility with			device has now been placed of		
		apervisor, there was a room in			the physical therapy storage re		
		ned two fuel fired furnaces.			door and is functioning proper  The corrective action taken for	-	
		om were protected with a			other residents that have the	ıııe	
		arrier, except, the east wall that			potential to be affected by the		
		ce room from the remainder of			same deficient practice is that		
		ere was no drywall on the back			residents and staff in the phys		
		nd there was only one 5/8 inch			therapy gym have the potentia		1
		the furnace side of this wall,			be affected by this deficient	41 10	
	1 -	et the 1-hour fire-rating barrier			practice. A self-closing device	į	
		d on interview at the time of			has now been placed on the	-	
	_	aintenance Supervisor			physical therapy storage room	1	
		lack of a 1-hour fire-rated wall			door and is functioning proper		
		attic fuel fired furnace room.			The measures that have been	•	
					into place to ensure that the	r	
	This finding was re	eviewed with the Administrator			deficient practice does not rec	ur is	
		inistrator during the exit			that a mandatory in-service ha		
	conference on 12/1				been provided for the mainten		
					supervisor on the regulation	•	

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	OF CORRECTION	IDENTIFICATION NUMBER  155539	A. BUILDING B. WING	03	COMI	PLETED 4/2023
	PROVIDER OR SUPPLIER  D GARTEN KETCH	HAM MEMORIAL CENTER	601 E F	address, city, state, zi RACE ST , IN 47562	P 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	3.1-19(b)			related to the require hazardous storage a maintenance supervinstructed that it is the responsibility to ensure gulations are being ensure the proper sais maintained in the storage areas.  The corrective action monitor to ensure the practice will not recurbousewide audit of a facility has been considentify each hazard room to ensure that are being maintained accordance with the including self-closing the doors. These do monitored in accordance regulation as part of preventative maintened to ensure that the sed device is in place an properly.	areas. The risor was neir ure that the g followed to afety/security hazardous an taken to be deficient ur is that a all areas of the aducted to lous storage these areas d in a regulation g devices on cors will be ance with the interest the facility's mance program elf-closing	
K 0345 SS=F Bldg. 03	in accordance with complying with the National Electric C	-				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE C A. BUILDING B. WING	construction 03	(X3) DATE SURVEY  COMPLETED  12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP COD RACE ST I, IN 47562	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	and testing are rea 9.6.1.3, 9.6.1.5, N Based on record rev failed to ensure doc show that all smoke tested within the pa 72, National Fire A Section 14.4.5.3.1 s be checked within 1 alternate year there required calibration indicate that the det listed and marked st time between calibration to be extended to a frequency is extend nuisance alarms and alarms shall be main where nuisance alar previous year, calib To ensure that each listed and marked st tested using any of (1) Calibrated test in (2) Manufacturer's dinstrument.  (3) Listed control expurpose.  (4) Smoke detector/arrangement wherel at the control unit wits listed sensitivity (5) Other calibrated to the authority hav Detectors found to listed and marked so cleaned and recalibrated to the detector sensiti measured using any	adily available. FPA 70, NFPA 72 riew and interview, the facility umentation was available to detectors were sensitivity st 24 months or prior. NFPA larm Code, 2010 Edition, tates detector sensitivity shall year of installation, and every after. After the second test, if sensitivity tests ector has remained within its ensitivity range, the length of ation tests shall be permitted maximum of 5 years. If the ed, records of detector caused d subsequent trends of these intained. In zones or areas ms show an increase over the ration tests shall be performed. smoke detector is within its ensitivity range, it shall be the methods: method. calibrated sensitivity test quipment arranged for the fire alarm control unit by the detector causes a signal where its sensitivity is outside range. sensitivity method acceptable ing jurisdiction. mave sensitivity outside the ensitivity range shall be	K 0345		or 01/04/2024 et t fied ts, pe etice. ed te fied ts fied ts, pe etice. ed te fied ts f

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155539		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 12/14/2023	
	ROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E	ADDRESS, CITY, STATE, ZIP COD RACE ST , IN 47562	
(X4) ID PREFIX TAG	detector. This defice residents, staff, and Findings include:  Based on record revalum, and 3:45 p.m. Supervisor present, produce a smoke detectors duror prior. Based on review, the Mainter thought the fire alar a smoke detector sensitivity available.  This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION cient practice could affect all visitors in the Rose House.  View on 12/13/23 between 9:00 with the Maintenance the facility was unable to etector sensitivity report for all ring the past 24 month period interview at the time of record nance Supervisor said he em system vendor did perform ensitivity test in the Rose ed there was no smoke testing documentation  viewed with the Administrator mistrator during the exit 4/23.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPREDEFICIENCY)  deficient practice does not rethat a mandatory in-service in been provided for the mainted supervisor on the regulation related to the sensitivity testing requirements of smoke detect. The maintenance supervisor instructed on their responsible ensure the smoke detector sensitivity testing is completed every 24 months and documentation of this testing retained on file for review by authorities in accordance with regulation.  The corrective action taken to monitor to ensure the deficie practice will not recur is that administrator and/or assistant administrator will now be revered the documentation on the sensitivity testing of the smool detectors in the Rose House 24 months to ensure that the documentation has been completed timely. Any conceindentified will be promptly discussed with the maintenant supervisor for immediate correction.	ecur is nas nas nance  ng ctors. was illity to ed  the the h the o nt the it iewing  ke every erns nce

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155539		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 03	(X3) DATE COMPI 12/14		
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	601 E	ET ADDRESS, CITY, STATE, ZIP COE E RACE ST N, IN 47562	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
K 0373 SS=F Bldg. 03	smoke barriers to the total number of compartments.  18.3.7.5.1, 18.3.7 Based on observation failed to ensure span of the smoke barrier the total number of compartment. 18.3 feet per resident shat aggregate area of contract treatment rooms, lo low hazard areas on barrier. This deficit residents, staff, and Findings include:  Based on observation p.m. and 4:40 p.m. the Maintenance Suprovided with three compartments, how compartments did in 18.3.7.5.1. One sm west side of the houlaundry equipment was not provided wother smoke compartments was also on the west garage was full of contract the total number of the east was cardboard boxes, to	Iding Spaces - Ice ovided on each side of adequately accommodate of occupants in adjoining 15.2, 19.3.7.5.1, 19.3.7.5.2 on and interview, the facility occupants from the adjoining 17.5.1 states not less than 30 net all be provided within the orridors, resident rooms, unge or dining areas, and other a each side of the smoke ent practice could affect all 10 visitors in the Rose House.	K 0373	The corrective action take those residents found to been affected by the definanctice is that although specific residents were induring the survey, all resistaff and visitors have the to be affected by this definanctice. The smoke compartment identified a located on the west side house that contains complaundry equipment with frequipment is not utilized evacuation route. The sincompartment identified a garage has now been clean all items removed. If garage is not and will not utilized as a storage area the corrective action take other residents that have potential to be affected be same deficient practice is residents staff and visitor the potential to be affected deficient practice. The sicompartment identified a located on the west side house that contains compartments.	have icient no dentified dentified didents de potential ficient des being of the mercial ficel fired des an moke des the deaned out The t be dea. dentified des the de	01/06/2024

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, ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	03	COMPLETED	
		155539	B. W	ING		12/14/	2023
	PROVIDER OR SUPPLIER  D GARTEN KETCI	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  601 E RACE ST  ODON, IN 47562				
	SUMMARY (EACH DEFICIEN REGULATORY OR wall, cardboard box other house hold ge the garage were tab interview at the tim Maintenance Super considered a smoke used for storage pur chairs were not norn garage, but they had residents recently. Vehicle parked in the This finding was re-	HAM MEMORIAL CENTER  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Les, totes, old furniture, and neral storage. In the middle of les and chairs. Based on e of observation, the visor said the garage was compartment, but was also rposes. He said the tables and mally in the middle of the d had a Christmas party for the He also said there was never a e garage.  viewed with the Administrator nistrator during the exit		601 E R	RACE ST	put fur is as ance ang y to y of by s ye re nis visor	(X5) COMPLETION DATE
					monitor to ensure the deficient practice will not recur is that the administrator and/or assistant administrator will monitor the documentation monthly of the audits conducted to ensure no items are being stored in the garage area.	ne	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>03</u>		03	COMPLETED	
		155539	B. WI	NG		12/14/2023	
	PROVIDER OR SUPPLIER	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 E RACE ST ODON, IN 47562				
(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 0711 SS=F Bldg. 03	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. The fire safety per 18/19.2.2.  18.7.1.1 through 18.7.2.3, 19.7.2.1.2, 19.7.2.1.2, 19.7.2.1.2, 19.7.2.1.2 Based on record reversialled to provide a comparison of the fire safety per 38 residents in the fire safety per safet	elocation Plan plan for the protection of all eir evacuation in the event  riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per  8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 riew and interview, the facility complete facility specific lan for the protection of 38 of Main Building to accurately ry systems, plus a system required by NFPA 101, 2012 7.2.2. LSC 18.7.2.2 requires a recupancy fire safety plan that e following:  Talarm to fire department the call to fire department me call to fire department me call to fire department me call to fire department mos and building for	K 0'	711	The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey all residents staff and visitors have the potential to be affected by this deficient practice. The facility fire safet plan has now been amended include the location of the smoth barriers within the facility. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility safety plan has now been amended to include the location the smoke barriers within the facility.	ied ; ential ; y to bke r the ve this fire	01/05/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	03	COMPLETED	
		155539	B. W	B. WING		12/14/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			RACE ST		
BERTHA	D GARTEN KETCH	HAM MEMORIAL CENTER			IN 47562		
			ı		 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		l be permitted for wheeled I the relocation of wheeled			The measures that have been	i put	
	• • •	fire or similar emergency is			into place to ensure that the	ur io	
		itten fire safety plan and			deficient practice does not red that a mandatory in-service ha		
		r the facility. The wheeled			been provided for administrati		
	equipment is limited				and the maintenance supervis		
	i. Equipment in use				on the regulation related to th		
		ncy equipment not in use			requirements of a fire safety,	C	
	iii. Patient lift and to				evacuation and relocation pla	n	
		ice could affect all occupants			Administration and the		
	in the event of an er				maintenance supervisor were		
		5 ,			educated on their responsibili		
	Findings include:				ensuring that all components	-	
					the regulation are outlined in		
	Based on a review of	of the facility's "Fire Plan" on			facility's fire safety plan.		
	12/13/23 between 9	:00 a.m. and 3:45 p.m. with the			The corrective action taken to		
	Maintenance Super	visor and Assistant			monitor to ensure the deficien	t	
	Administrator prese	ent, the plan did address			practice will not recur is that t	he	
	evacuation of the sn	noke compartment, however,			facility's fire safety plan will be	)	
	-	ntify where the smoke barriers			reviewed by the Quality Assur	ance	
		facility. Based on interview at			committee at least bi- annuall	y to	
		eview, the Maintenance			ensure that all components of	the	
	_	istant Administrator			regulation are outlined in the		
	_	agreed that the Fire Plan did			facility's fire safety plan.		
	_	he smoke barriers were located			Modifications to the fire safety		
	in the facility.				plan will be made when warra	nted	
					or required by regulation.		
		viewed with the Administrator					
		nistrator during the exit					
	conference on 12/14	4/23.					
	2 1 10(b)						
	3.1-19(b)						
K 0712	NFPA 101						
SS=C	Fire Drills						
Bldg. 03	Fire Drills						
2.59.00		the transmission of a fire					
		simulation of emergency fire					
	-	ills are held at expected					
	i conditions, rife at						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	03	COMPLETED		
		155539	B. W	ING		12/14/2023		
				CTREET	ADDRESS CITY STATE ZIR COD			
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD			
DEDTUA		HAM MEMORIAL CENTER						
DERITA	D GARTEN KETC	HAW WEWORIAL CENTER		ODON,	IN 47562			
(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	TF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	conditions, at leas	st quarterly on each shift.						
	The staff is familia	ar with procedures and is						
		re part of established						
		rills are conducted between						
	9:00 PM and 6:00	AM, a coded						
	announcement ma	ay be used instead of						
	audible alarms.							
	18.7.1.4 through 1	18.7.1.7						
	Based on record rev	view and interview, the facility	K 0	712	The corrective action taken fo	r	01/05/2024	
	failed to ensure fire	drills were held at varied times			those residents found to have			
	for 1 of 3 employee	shifts during 3 of 4 quarters.			been affected by the deficient			
	This deficient pract	ice could affect all residents in			practice is that although no			
	the facility.				specific residents were identif	ied		
					during the survey all residents	<b>3</b> ,		
	Findings include:				staff and visitors have the potential	ential		
					to be affected by this deficient	İ		
	Based on review of	the facility's fire drill reports			practice. The facility has now			
	on 12/13/23 betwee	en 9:00 a.m. and 3:45 p.m. with			conducted fire drills on each s	hift		
	the Maintenance Su	pervisor present, 3 of 4			at times that are varied by at I	east		
	second shift (evening	ng) fire drills were performed			two hours of the prior fire drill			
	between 7:03 p.m.	and 7:51 p.m. Based on			being conducted.			
	interview at the tim	e of record review, the			The corrective action taken fo	r the		
	_	visor acknowledged the times			other residents that have the			
		e drills were performed and			potential to be affected by the			
	agreed the times we	ere not varied enough.			same deficient practice is that	' all		
					residents, staff and visitors ha	ve		
		viewed with the Administrator			the potential to be affected by		1	
		inistrator during the exit			deficient practice. The facility			
	conference on 12/1	4/23.			now conducted fire drills on ea			
					shift at times that are varied b	-		
	3.1-19(b)				least two hours of the prior fire	e drill		
	3.1-51(c)				being conducted.			
					The measures that have been	put		
					into place to ensure that the			
					deficient practice does not red			
					that a mandatory in-service ha			
					been provided for the mainter	ance		
					supervisor on the regulation			
					related to conducting fire drills		1	
					varied times. The maintenand	ce		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155539	A. BUILDING B. WING		03	COMPLETED 12/14/2023	
		10000	J	_		12/11/	
NAME OF I	PROVIDER OR SUPPLIE	R		l	ADDRESS, CITY, STATE, ZIP COD		
BERTHA	D GARTEN KETO	HAM MEMORIAL CENTER			IN 47562		
(X4) ID		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					supervisor was instructed that drill must be conducted at staggered hours with at least two-hour time difference from previous fire drill that was conducted on that shift.  The corrective action taken to monitor to ensure the deficient practice will not recur is that fit drill reports will now be review by the administrator and/or assistant administrator month ensure that the time frame of fire drill is staggered by at least two hours from the time the previous fire drill that was conducted on that shift. Any concerns identified will be discussed with the maintenan supervisor so that immediate action can be taken to correct	a the treed ly to each st	
K 0761 SS=F Bldg. 03							
	interview; the facil annual inspection a fire door assembly room door assemb with LSC 18.1.1.4 dividing fire barrie permitted only in c by approved self-c (See also Section 8 required to have a 8.3.4.2 shall be pro-	view, observation, and ity failed to ensure a complete and testing of 1 of 1 stairway, and 1 of 1 oxygen transfilling ly was completed in accordance 1.1. Communicating openings in rs required by 18.1.1.4.1 shall be orridors and shall be protected losing fire door assemblies.  3.3. LSC 8.3.3.1 Openings fire protection rating by Table steeted by approved, listed, assemblies and fire window	K 0	761	The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey all residents staff and visitors have the potent to be affected by this deficient practice. The form utilized to document the annual inspection and testing of smoke barrier affire rated doors has been ame and now contains documentated.	ied s, ential s on end	01/04/2024

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPLETED		
		155539	B. W	ING		12/14/2023		
		<u> </u>	_	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	3						
BERTHA	D GARTEN KETC	HAM MEMORIAL CENTER		601 E RACE ST ODON, IN 47562				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE	
	assemblies and their accompanying hardware,				for the inspection of the door			
	including all frames	s, closing devices, anchorage,			assemblies. All smoke barrier	-		
	and sills in accorda	nce with the requirements of			and fire rated doors have now	been		
	NFPA 80, Standard	l for Fire Doors and Other			inspected/tested and there is			
	Opening Protective	s, except as otherwise			documentation to support thes	se		
	specified in this Co	de. NFPA 80 5.2.1 states fire			inspections/testing including			
	door assemblies sha	all be inspected and tested not			documentation of the inspection	on of		
	less than annually,	and a written record of the			the door assemblies. These			
	inspection shall be	signed and kept for inspection			inspections also included the			
	by the AHJ. NFPA	80, 5.2.4.1 states fire door			stairway fire door and the doo	r to		
	assemblies shall be	visually inspected from both			the oxygen transferring room.			
	sides to assess the overall condition of door				The corrective action taken fo	r the		
	assembly.				other residents that have the			
					potential to be affected by the			
	NFPA 80, 5.2.4.2 s	tates as a minimum, the			same deficient practice is that	all		
	following items sha	all be verified:			residents, staff and visitors ha	ve		
	(1) No open holes of	or breaks exist in surfaces of			the potential to be affected by	this		
	either the door or fr	rame.			deficient practice. All smoke			
	(2) Glazing, vision	light frames, and glazing beads			barrier and fire rated doors ha	ve		
	are intact and secur	rely fastened in place, if so			now been inspected/tested an	d		
	equipped.				there is documentation to sup	port		
	(3) The door, frame	e, hinges, hardware, and			these inspections/testing inclu	ding		
	noncombustible thr	reshold are secured, aligned,			documentation of the inspection	on of		
	and in working orde	er with no visible signs of			the door assemblies. These			
	damage.				inspections also included the			
	(4) No parts are mis				stairway fire door and the doo	r to		
	* *	s do not exceed clearances			the oxygen transferring room.			
	listed in 4.8.4 and 6				The measures that have been	put		
		g device is operational; that is,			into place to ensure that the			
		npletely closes when operated			deficient practice does not rec			
	from the full open p				that a mandatory in-service ha			
	* *	is installed, the inactive leaf			been provided for the mainten	ance		
	closes before the ac				supervisor on the regulation			
		are operates and secures the			related to the maintenance,			
	door when it is in the	-			inspection and testing of smol			
		vare items that interfere or			barrier and fire rated doors. T	he		
	prohibit operation a	are not installed on the door or			maintenance supervisor was			
	frame.				educated on the required			
		fications to the door assembly			documentation that must be			
	I have been performe	ed that void the label.			included with each inspection	in		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>03</u>			COMPLETED	
		155539	B. WING			12/14/2023	
				CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEDTILA	D CARTEN KETO	IAMAMENAODIAL OENTED			RACE ST		
BERTHA	D GARTEN KETCH	HAM MEMORIAL CENTER		ODON,	IN 47562		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			I C	DATE	
	(11) Gasketing and edge seals, where required, are				accordance with the regulation	1.	
		their presence and integrity.			The corrective action taken to		
	-	ice could affect all residents,			monitor to ensure the deficient		
	as well as staff, and				practice will not recur is that th		
	us wen us starr, and	Visitors.			administrator and/or assistant	C	
	Findings include:				administrator will now be revie	wing	
	Tillulings illelude.					•	
	Rosed on magaind mary	riew on 12/13/23 between 9:00			annually the documentation or maintenance, inspection and	ıııe	
		with the Maintenance			•	_	
	•	the facility did provide			testing of smoke barrier and fir		
					rated doors. Administration wi		
		form used for the annual			ensure that the documentation		
	_	the facility's smoke barrier and			includes the inspection of the		
		mblies, however, the			assemblies in accordance with	the	
	•	rided was not filled out to			regulation.		
	_	assemblies were inspected.					
		at the time of record review,					
	the Maintenance Su	-					
	_	rided was the only inspection					
	_	ntation available for the					
	_	esting of the facility's fire door					
		on observations during a tour					
		he Maintenance Supervisor					
	_	and 4:40 p.m., there were 2					
	stairway fire door as	ssemblies noted in the facility.					
	_	viewed with the Administrator					
		nistrator during the exit					
	conference.						
	3.1-19(b)						
K 0914	NFPA 101						
SS=F	Electrical Systems	s - Maintenance and					
Bldg. 03	Testing						
	Electrical Systems	s - Maintenance and					
	Testing						
	Hospital-grade red	ceptacles at patient bed					
		re deep sedation or general					
		inistered, are tested after					
		replacement or servicing.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 12/14/2023	
	PROVIDER OR SUPPLIER  D GARTEN KETCI	HAM MEMORIAL CENTER	601 E	ET ADDRESS, CITY, STATE, ZIP COD E RACE ST N, IN 47562	
(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 APPROPE DEFICIENCY)	E COMPLETION
	defined by docum Receptacles not li these locations are exceeding 12 mor (LIM), if installed, less than or equal the LIM test switch activates both visu LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3 renovation to the of Records are main associated repairs containing date, ro results. 6.3.4 (NFPA 99) Based on observation interview; the facility documentation was nonhospital-grade of resident room location NFPA 99, Health Co Section 6.3.4.1.3 state hospital-grade, at pal locations where dee anesthesia is admin intervals not exceed Section 6.3.3.2, Rec Rooms requires the receptacle shall be of The continuity of the electrical receptacle polarity of the hot a each electrical receptacle retention force of the electrical receptacle retention force of the electrical receptacle	oom or area tested, and on, record review and ty failed to ensure complete	K 0914	The corrective action taken is those residents found to have been affected by the deficient practice is that although no specific residents were idented during the survey, all resident staff and visitors have the poto be affected by this deficient practice. The facility has not conducted testing on all nonhospital-grade electrical receptacles in all resident rollocations. No issues were identified. The facility will contour to conduct annual testing of nonhospital-grade electrical receptacles in resident room document the results of the for review by the authorities. The corrective action taken in other residents that have the	tified onts otential ont om ontinue all as and tests

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155539		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY  COMPLETED  12/14/2023			
	PROVIDER OR SUPPLIER  D GARTEN KETC	HAM MEMORIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 E RACE ST ODON, IN 47562				
(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			
TAG		ent practice could affect all	TAG	potential to be affected by the same deficient practice is tha	l l		
	Findings include:			residents, staff and visitors hat the potential to be affected by	ave this		
		view on 12/13/23 between 9:00 with the Maintenance		deficient practice. The facility now conducted testing on all nonhospital-grade electrical	nas		
	Supervisor present, available of an annu	there was no documentation all resident room receptacle		receptacles in all resident roo locations. No issues were			
	past 12 month perio	d. The most recent lable was dated 02/15/22.		identified. The facility will cor to conduct annual testing of a			
	Based on interview	at the time of record review, pervisor said electrical		nonhospital-grade electrical receptacles in resident rooms document the results of the te			
	receptacles in reside hospital-grade recep	ent rooms were not otacles as far as he knew. He		for review by the authorities.  The measures that have been			
	show that annual te	d not find documentation to sting per NFPA 99, Receptacle ts was met with all pertinent		into place to ensure that the deficient practice does not retain that a mandatory in-service h			
	information within	the past 12 month period. ons on 12/13/23 between 3:45		been provided for the mainter supervisor on the regulation			
	the Maintenance Su	during a tour of the facility with pervisor, there were at least		related to the testing of nonhospital-grade electrical			
	room.	l receptacles in each resident		receptacles. The maintenand supervisor has been educated their responsibility to ensure to	d on		
	and Assistant Admi	viewed with the Administrator nistrator during the exit		this annual test is performed the findings documented for r	and		
	3.1-19(b)	4/23.		by the authorities.  The corrective action taken to monitor to ensure the deficier			
	3.1 15(6)			practice will not recur is that the administrator and/or assistant	he		
				administrator will now be revi- annually the documentation of	f the		
				testing of the nonhospital-gra electrical receptacles in resid- rooms to ensure that the tests	ent		
				performed in accordance with regulation. Any concerns	the street		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155539	` ′	JILDING	ONSTRUCTION 03	(X3) DATE COMPL 12/14,	ETED
NAME OF PROVIDER OR SUPPLIER BERTHA D GARTEN KETCHAM MEMORIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 601 E RACE ST ODON, IN 47562				
(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
					identified will be promptly discussed with the maintenand supervisor for immediate correction.	ce	

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