STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		624	EET ADDRESS, CITY, STATE, ZIP COD E 13TH ST NAMAC, IN 46996	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TION (X5) D BE COMPLETION OPRIATE DATE
E 0000	conducted by the In accordance with 42 Survey Date: 10/04 Facility Number: 00 Provider Number: 1 10/02 At this Emergency Health Care Center with Emergency Promotes and Mediand Suppliers, 42 Company The facility has 58 of the survey, the censility in the Intervence of the Interv	200553 255660 267430 Preparedness survey, Pulaski was found not in compliance eparedness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of	E 0000	The preparation and exect this Plan of Correction does constitute admission or agreement, by the provide alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies Plan of Correction is preparation of Every executed solely because is required by the provisions federal and state law. This maintains that the alleged deficiencies do not individ collectively jeopardize the and safety of its residents they of such character as this provider's capacity to adequate resident care. Furthermore, the operation licensure of the long-term facility and this Plan of Coin its entirety, constitutes the provider's credible allegatic compliance. Completion of provided for procedural put to comply with state and for regulations, and correlate most recent contemplated accomplished corrective at These dates do not necess correspond chronologicall date the provider is of the that is was in compliance requirements of participation.	es not er, of the e The ared and it is of s provider ually or health , nor are to limit render n and care prection this ion of lates are urposes ederal with the l or action. ssarily y to the opinion with the ion. sting a

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

(X6) DATE

TITLE

Thelma Jean Fort Administrator 10/31/2022

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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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155660	A. BU B. W	JILDING ING			LETED -/2022
		133000	Б. W.	_		10/04	12022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DIIIASK	I HEALTH CARE C	ENTER			3TH ST IAC, IN 46996		
	T TEALTH OAKE O	LIVILIX			, III 1 0090		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)	N	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
IAG	REGULATORT OF	K LSC IDENTIFT ING INFORMATION		IAG	proposed or implemented		DATE
					remedies that have been		
					presented to date.		
					•		
E 0041	482.15(e), 483.73	, ,					
SS=F		LTC Emergency Power					
Bldg	\ ,	tion for Participation:					
		nd standby power systems.					
		t implement emergency and stems based on the					
		set forth in paragraph (a) of					
	this section and ir	1 0 1 1 7					
		set forth in paragraphs (b)(1)					
	(i) and (ii) of this s	, ,					
	§483.73(e), §485						
		nd standby power systems.					
	-	and the CAH] must					
		ency and standby power n the emergency plan set					
	1 -	i (a) of this section.					
	lorur iii paragrapi	r (a) or this section.					
	§482.15(e)(1), §4	83.73(e)(1), §485.625(e)(1)					
	Emergency gener	rator location. The					
	generator must be	e located in accordance with					
		rements found in the Health					
		ode (NFPA 99 and Tentative					
		ents TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
	,	and Tentative Interim 12-1, TIA 12-2, TIA 12-3,					
		d NFPA 110, when a new					
		r when an existing					
	structure or buildi	<u> </u>					
	. , , , , ,	3.73(e)(2), §485.625(e)(2)					
		rator inspection and testing.					
		H and LTC facility] must					
	-	nergency power system					
I	I inspection, testing	g, and [maintenance]	I				1

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Event ID:

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155660	B. WING	_	10/04/2022
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF		624 E	13TH ST	
PULASK	I HEALTH CARE C	ENTER	WINAN	MAC, IN 46996	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP	RIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		nd in the Health Care			
		FPA 110, and Life Safety			
	Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3)				
	, , , , -	rator fuel. [Hospitals, CAHs			
		that maintain an onsite fuel			
	_	emergency generators must			
	· ·	w it will keep emergency			
		perational during the			
	emergency, unles	•			
	Simorgeney, armose it evacuates.				
	*[For hospitals at	§482.15(h), LTC at			
	§483.73(g), and CAHs §485.625(g):]				
	The standards inc	corporated by reference in			
	this section are ap	pproved for incorporation by			
	reference by the D	Director of the Office of the			
	Federal Register i	n accordance with 5 U.S.C.			
		l part 51. You may obtain			
		the sources listed below.			
		a copy at the CMS			
		urce Center, 7500 Security			
	· ·	ore, MD or at the National			
		ords Administration			
		mation on the availability of			
		ARA, call 202-741-6030, or			
	go to:	es.gov/federal register/code			
	· ·	ations/ibr_locations.html.			
		this edition of the Code are			
		eference, CMS will publish a			
		ederal Register to			
	announce the cha	<u> </u>			
		Protection Association, 1			
	Batterymarch Parl				
	Quincy, MA 02169				
	1.617.770.3000.	,			
		th Care Facilities Code,			
		ed August 11, 2011.			
		im amendment (TIA) 12-2 to			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155660	B. WING		10/04/2022
	PROVIDER OR SUPPLIER		624	ET ADDRESS, CITY, STATE, ZIP COD E 13TH ST AMAC, IN 46996	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(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 APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
140	NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S	August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012 gust 11, 2011. IFPA 101, issued August FPA 101, issued October FPA 101, issued October FPA 101, issued October FPA 101, issued October	TAG		DATE
	Standby Power Sy including TIAs to c 2009 Based on record revial failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). affect all occupants Findings include: Based on record revial Administrator on 10 documentation for a generator was not a record review found documentation of an additional street of the second review found documentation of an accordance of the second review found documentation of an accordance of the secondary sec	ystems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could	E 0041	1.) What corrective action(s be accomplished for those residents found to have been affected by the deficient pract A: Training scheduled for Oct 21, 2022 with Herman and G for new Maintenance Director assistant to learn how to conceast the 4 hour and 30 minute load test. On October 31, 2022, Herman and Goetz provided additional training to the Maintenance Director and assistant on the 30 minute load test and the proper document on the form. Maintenance Di or Assistant will continue to	tice? ober oetz and duct d

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155660	B. WING		10/04/2022
N. 1	NOTHER OF STATE		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	₹		13TH ST	
PULASK	I HEALTH CARE C	ENTER	WINAM	MAC, IN 46996	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	*	d on an interview at the time of		inspect the generator weekly,	
		facility Administrator stated		exercise under load for 30 mir	
		ty Code Consultant advised the		monthly and conduct 4hour lo	ad
	facility that they did not have to conduct monthly			test at least every 36 months.	
	-	year ago, and that was why			
	there was no documentation available as of the time of this survey.			2.) How other residents havi	~
				the potential to be affected by	
				same alleged deficient practic	e
				will be identified and what	0
				corrective action(s) will be take	
				A: All residents in facility have	ine
				potential to be affected.	o rh (
				Maintenance staff will be prop	- ·
				trained by Herman & Goetz ar	
				will conduct the 4 hour genera	iioi
				load tests per regulation. Maintenance will continue to	
					and
				inspect the generator weekly a will continue to inspect the	allu
				generator weekly, exercise un	der
				load for 30 minutes monthly a	
				conduct 4hour load test at least	
				every 36 months.	
				213.7 00	
				3.) What measures will be p	ut
				into place and what systemic	
				changes will be made to ensu	re
				that the alleged deficient pract	tice
				does not recur?	
				A: Herman & Goetz provided	
				training to the maintenance st	aff
				and will continue to provide	
				ongoing monthly training to er	
				maintenance staff are inspecti	~
				and testing generator properly	
				to ensure the documentation i	
				correct. Maintenance staff will	
				inspect the generator weekly,	
				exercise under load for 30 mir	nutes

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monthly and conduct 4hour load

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	OF CORRECTION	IDENTIFICATION NUMBER 155660	A. BUILDING B. WING		COMPLETED 10/04/2022
	PROVIDER OR SUPPLIER		624 E ²	ADDRESS, CITY, STATE, ZIP COD 13TH ST 1AC, IN 46996	
(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
				4.) How the corrective action will be monitored to ensure the alleged deficient practice will recur; what quality assurance program will be put into place? A: Maintenance will provide Administrator a copy of the log sheets each month to be revie in the monthly Quality Assuran Meeting. The QA Committee ware and make revisions as warranted on the basis of compliance. 5.) By what date the system changes will be completed? A: October 31, 2022	e not ?? g ewed noce will
K 0000 Bldg. 01					
	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/04 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety 0	00553 55660 67430 Code survey, Pulaski Health and not in compliance with	K 0000	The preparation and execution this Plan of Correction does not constitute admission or agreement, by the provider, of alleged deficiencies, or the conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared executed solely because it is required by the provisions of federal and state law. This promaintains that the alleged deficiencies do not individually collectively jeopardize the hear	ot f the and ovider

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/04/2022
	ROVIDER OR SUPPLIER		624 E 1	ADDRESS, CITY, STATE, ZIP COD 13TH ST 1AC, IN 46996	
(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
	Life Safety from Fin National Fire Protect Life Safety Code (L Care Occupancies a This one-story facil building and a later building since both V (111) constructio The facility has a fin smoke detection in the corridors, and rewing. All other residuatery powered sin The facility has the census of 39 at the tensus of 39 at th	ity, consisting of the original addition was surveyed as one were determined to be of Type in and was fully sprinklered. The alarm system with hard wired the corridors, spaces open to esident rooms in the northeast dent rooms are equipped with gle station smoke detectors. Capacity for 58 and had a		and safety of its residents, nor they of such character as to lift this provider's capacity to rend adequate resident care. Furthermore, the operation and licensure of the long-term care facility and this Plan of Correct in its entirety, constitutes this provider's credible allegation of compliance. Completion dates provided for procedural purpose to comply with state and feder regulations, and correlate with most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to date the provider is of the opin that is was in compliance with requirements of participation. We are respectfully requesting desk review to clear any and a proposed or implemented remedies that have been presented to date.	mit der d d e tion of s are ses ral the n. dy the nion the
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observation failed to ensure 1 of tested annually for 9	ng g of at least 1-1/2-hour ed automatically in	K 0291	What corrective action(s) be accomplished for those residents found to have been affected by the deficient practi	
	periods of power ou	stages and a written record of and tests was provided.		A: Maintenance Director or designee will complete the an	

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Event ID:

J53J21

Facility ID: 000553

3

If continuation sheet Pa

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155660	B. W	ING		10/04/	2022
		l	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			3TH ST		
DIIIVON	I HEALTH CARE C	ENTER			IAC, IN 46996		
IULASK	· · · LALIII CARE C	LIVILIN		VVIINAVIVI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	,) requires functional testing			90 minute test on the emerger	псу	
		monthly, with a minimum of 3			generator lighting. Test was		
		num of 5 weeks between tests,			completed on 10/10/22.		
		seconds, (3) Functional					
	_	ducted annually for a minimum			2.) How other residents havi	-	
	of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.				the potential to be affected by	the	
					same alleged deficient practic	е	
					will be identified and what		
					corrective action(s) will be take		
					A: All residents in facility have	the	
	residents in the faci	lity.			potential to be affected.		
					Maintenance staff will continue		
	Findings include:				complete the annual 90 minute		
					test on the generator lighting t		
		view with the facility			ensure the emergency lighting		
		0/05/22 at 11:26 a.m., the			functional and immediately co	rrect	
		mergency Light Test Log for			any issues.		
		battery operated light located					
		gency generator location and			3.) What measures will be p	ut	
		d tests conducted monthly			into place and what systemic		
	· ·	f 2021 to the present. No			changes will be made to ensu		
		ld be provided regarding a			that the alleged deficient pract	ice	
		e battery-operated emergency			does not recur?		
	~	ervations during a tour of the			A: Maintenance staff will comp		
		ility Administrator, there was a			the annual 90 minute test on t		
		nergency light located at the			emergency generator lighting		
		or. The lack of annual			will record results on the log s	heet	
		f the battery-operated exit light			titled "Emergency Generator		
	_	facility Administrator at the			Lighting."		
	time of record revie	ew.					
	TEI (* 1)	1 1 1 1 1 1 1 1 1 1				, ,	
		e reviewed with the facility			4.) How the corrective action	` '	
	Administrator at the	e exil conference.			will be monitored to ensure the	_	
	2.1.10(1-)				alleged deficient practice will r	iot	
	3.1-19(b)				recur; what quality assurance	,	
					program will be put into place?	<i>!</i>	
					A: Maintenance will provide		
					Administrator a copy of the log		
					sheet each month to be review		
			1		in the monthly Quality Assurar	nce	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155660 B. WING 10/04/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 624 E 13TH ST PULASKI HEALTH CARE CENTER WINAMAC, IN 46996 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Meeting. The QA Committee will review and make revisions as warranted on the basis of compliance. 5.) By what date the systemic changes will be completed? A: October 10, 2022 K 0355 **NFPA 101** SS=E Portable Fire Extinguishers Bldg. 01 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility K 0355 1.) What corrective action(s) will 10/10/2022 failed to ensure 1 of 1 portable fire extinguishers in be accomplished for those the laundry room was installed in accordance with residents found to have been NFPA 10, Standard for Portable Fire Extinguishers, affected by the deficient practice? 2010 Edition. Section 6.1.3.4 states portable fire A: Maintenance assistant extinguishers other than wheeled extinguishers mounted the fire extinguisher in shall be installed using any of the following the laundry room immediately on means. (1) Securely on a hanger intended for the 10/5/22. extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket 2.) How other residents having approved for such purpose. (3) In a cabinet or wall the potential to be affected by the recess. This deficient practice could affect as same alleged deficient practice many as 3 staff. will be identified and what corrective action(s) will be taken? Findings include: A: All residents in facility have the potential to be affected.

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Based on observations made during a tour of the

facility with the with the Administrator on

10/05/22 at 1:29 p.m., the ABC portable fire

extinguisher located in the laundry room was

observation, the facility Administrator

sitting on a floor. Based on interview at the time of

acknowledged the portable fire extinguisher was

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Administrator walked through

fire extinguishers were stored

immediately mounted the fire

facility with surveyor and no other

improperly. Maintenance assistant

extinguisher in the laundry room.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVE COMPLETED 10/04/2022	Ý	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 624 E 13TH ST WINAMAC, IN 46996				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF sitting on the floor a adding that they had in the laundry room opportunity to mout the Maintenance ma	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and not mounted on the wall d just moved some equipment and had not yet had the nt it back on the wall because an was currently out sick. e again reviewed with the or at the exit conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SECROSS-REFERENCED TO THE ADEFICIENCY) 3.) What measures we into place and what system changes will be made to that the alleged deficient does not recur? A: Maintenance staff we an audit of all fire extingensure proper storage	COMI DILLO BE PPROPRIATE COMI DI	(X5) PLETION ATE	
14 0045	3.1-19(b)			weeks then monthly x and will log results on tool named "Fire Extinstorage Audit" and consisues immediately. 4.) How the corrective will be monitored to ensalleged deficient practice recur; what quality assiprogram will be put into A: Maintenance will propose Administrator a copy of sheet each month to be in the monthly Quality and Meeting. The QA Compression of the basis compliance. 5.) By what date the schanges will be completed. October 10, 2022	the audit guisher rect any rect and rec		
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenal The generator or source and assoc	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the					

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If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155660	B. WING		10/04/2022
****	DD OT THE .	<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP COD	1
NAME OF F	PROVIDER OR SUPPLIE	К		E 13TH ST	
	I HEALTH CARE C	ENTER	WIN	AMAC, IN 46996	· · · · · · · · · · · · · · · · · · ·
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
		on is not met during the			
		ocess shall be provided to			
	annually confirm this capability for the life safety and critical branches. Maintenance				
		generator and transfer			
	_	_			
	switches are performed in accordance with NFPA 110.				
		re inspected weekly,			
		oad 30 minutes 12 times a			
		intervals, and exercised			
		onths for 4 continuous hours.			
		nder load conditions include			
	a complete simula	ated cold start and			
		ual transfer of all EES			
	loads, and are co	nducted by competent			
	personnel. Mainte	enance and testing of stored			
	energy power sou	ırces (Type 3 EES) are in			
	accordance with I	NFPA 111. Main and feeder			
	circuit breakers a	re inspected annually, and a			
		dically exercising the			
		stablished according to			
		uirements. Written records			
		nd testing are maintained			
	· ·	ble. EES electrical panels			
		narked, readily identifiable,			
		n normal power circuits.			
		essibility of damage of the			
		r source is a design			
	consideration for				
		(NFPA 99), NFPA 110,			
	NFPA 111, 700.1	U (NFPA 70) view and interview, the facility	V 0010	1) What corrective setime	(c) will 10/21/2022
		or complete written record of	K 0918	What corrective action be accomplished for those	(s) will $10/31/2022$
		load testing for 12 of the last 12		residents found to have bee	n
		4.4.1.1.4(a) of 2012 NFPA 99		affected by the deficient pra	
		esting of the generator serving		A: Training scheduled for O	
		etrical system to be in		21, 2022 with Herman and 0	
		FPA 110, the Standard for		for new Maintenance Direct	•
		andby Powers Systems, Chapter		assistant to learn how to cor	
		requires diesel generator sets in		the 4 hour and 30 minute loa	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155660	B. W	ING		10/04/	2022
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DIII A OI		ENTER			3TH ST		
PULASK	I HEALTH CARE C	ENTER		WINAM	IAC, IN 46996		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S 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'		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	service to be exerci	sed at least once monthly, for a			test. On October 31, 2022,		
		nutes. Chapter 6.4.4.2 of NFPA			Herman and Goetz provided a	n	
		n record of inspection,			additional training to the		
	-	ising period, and repairs for the			Maintenance Director and		
	_	larly maintained and available			assistant on the 30 minute loa	d	
	for inspection by th	-			test and the proper documenta		
		eficient practice could affect all			on the form. Maintenance Dire		
	occupants.	1			or Assistant will continue to		
					inspect the generator weekly,		
	Findings include:				exercise under load for 30 min	utes	
	8				monthly and conduct 4hour loa		
	Based on record review with the facility Administrator on 10/05/22 at 11:30 a.m.,				test at least every 36 months.		
		nonthly testing of the facilities			2.) How other residents havi	na	
		vailable for review. Further			the potential to be affected by	-	
	-	I that the facility had no			same alleged deficient practice		
		ny monthly generator testing			will be identified and what		
		within the last 12-month			corrective action(s) will be take	en?	
		interview at the time of record			A: All residents in facility have		
	_	Administrator stated that their			potential to be affected.		
		onsultant advised the facility			Maintenance staff will be prop	erlv	
		ve to conduct monthly testing			trained by Herman & Goetz ar	-	
		o, and that was why there was			will conduct the 4 hour genera		
		vailable as of the time of this			load tests per regulation.		
	survey.				Maintenance will continue to		
					inspect the generator weekly a	and	
	These findings were	e again reviewed with the			will continue to inspect the		
	_	or at the exit conference.			generator weekly, exercise un	der	
					load for 30 minutes monthly ar		
	3.1-19(b)				conduct 4hour load test at least		
					every 36 months.		
					3.) What measures will be p	ıt	
					into place and what systemic		
					changes will be made to ensur	·e l	
					that the alleged deficient pract		
					does not recur?		
					A: Herman & Goetz provided		
					training to the maintenance sta	aff	
					and will continue to provide		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/04/2022	
	ROVIDER OR SUPPLIEF		624 E	ADDRESS, CITY, STATE, ZIP COD 13TH ST MAC, IN 46996		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLE DATE	TION
				ongoing monthly training to maintenance staff are inspand testing generator propto ensure the documentatic correct. Maintenance staff inspect the generator wee exercise under load for 30 monthly and conduct 4houtest at least every 36 monto dest	perting perly and on is will kly, minutes ir load ths. ction(s) e the will not nce ace? e e log eviewed urance ee will s as	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qualifications.	ent - Power Cords and ent - Power Cords and catient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/04/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 624 E 13TH ST WINAMAC, IN 46996			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	S SHOULD BE COMPLETION EAPPROPRIATE	
	non-PCREE (e.g., except in long-term do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care mother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.30 Based on observation failed to ensure in 1 cords were not used wiring. LSC 9.1.2 mequipment shall be National Electrical Article 400.8 requir permitted, flexible cused as a substitute This deficient pract staff. Findings include: Based on observation facility with the wit 10/05/22 at 1:37 p.m. record review was be salt-water fish tank electronic devices: at thermostat, were placed to the salt-water placed thermostat, were placed to the salt-water fish tank electronic devices: at thermostat, were placed to the salt-water fish tank electronic devices: at the salt-water placed the salt-water placed the salt-water fish tank electronic devices: at the salt-water placed the salt-water fish tank electronic devices: at the salt-water placed the salt-water placed the salt-water placed the salt-water fish tank electronic devices: at the salt-water fish tank electronic devices at the salt	cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE of UL 60601-1. Power strips the patient care rooms meet UL 1363. In cooms, power strips meet is. All power strips are precautions. Extension does a substitute for fixed for extension cords used moved immediately upon purpose for which it was to the conditions of 10.2.4. 20), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 for and interview, the facility of 1 conference room, flexible is as a substitute for fixed equires electrical wiring and in accordance with NFPA 70, Code. NFPA 70, 2011 Edition, resident that, unless specifically cords and cables shall not be for fixed wiring of a structure. Side could affect as many as 8 for smade during a tour of the hold the Administrator on more than the conference room where for fixed wiring of a structure. Side could affect as many as 8 for smade during a tour of the hold and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it. The man aerator, a water filter, and a located within it.	K 0920	1.) What corrective action(s be accomplished for those residents found to have been affected by the deficient pract A: Maintenance Assistant immediately went to store and purchased an approved power and replaced the power strip to was being used in the employ conference room which is a non-resident area. Education provided to staff on not utilizing power strips in resident areas 2.) How other residents have the potential to be affected by same alleged deficient practic will be identified and what corrective action(s) will be tak A: The power strip was tempor being utilized in a non-resider area. An approved Tripp Lite Safe-IT Medical Grade UL 13:	ice? I r strip hat ee was eg . ing the ee en? erarily at	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155660	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2022		
			STREET ADDRESS, CITY, STATE, ZIP COD 624 E 13TH ST WINAMAC, IN 46996				
PULASK (X4) ID PREFIX TAG	DF PROVIDER OR SUPPLIER SKI HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) power strip was purchased an replaced the one being used. 3.) What measures will be printo place and what systemic changes will be made to ensure that the alleged deficient pract does not recur? A: Maintenance staff will compa walk-through of all resident areas to ensure that no extensions cords are being utilized weekly weeks then monthly x 4 month and will log results on the audit tool named "Extension Cord A and correct any issues immediately. 4.) How the corrective action will be monitored to ensure the alleged deficient practice will recur; what quality assurance program will be put into place? A: Maintenance will provide Administrator a copy of the autor form each month to be reviewed the monthly Quality Assurance Meeting. The QA Committee will provide and the provide of the p	d ut re cice blete sion y x 8 ns it udit" n(s) e not c dit ed in e		
				review and make revisions as warranted on the basis of compliance. 5.) By what date the systemichanges will be completed? A: October 10, 2022	ic		

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