PRINTED: 09/13/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	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		COMPI	LETED
		155826	B. WI	NG		08/22	/2022
							-
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					SEORGETOWN ROAD		
EVERGI	REEN CROSSING A	AND THE LOFTS		INDIAN	IAPOLIS, IN 46254		
(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 B CROSS-REFERENCED TO THE APPROPI	E RIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
		paredness Survey was	E 00	000	Preparation or execution of	this	
	-	ndiana Department of Health in			plan of correction does not		
	accordance with 42	2 CFR 483.73.			constitute admission or agre	ement	
					of Provider of the truth of the	e facts	
	Survey Date: 08/22	2/22			alleged or conclusions set for	orth on	
					the Statement of Deficiencie	s. The	
	Facility Number: 0	013280			Plan of Correction is prepare	ed and	
	Provider Number:	155826			executed solely because it is	S	
	AIM Number: 201	270670		ederal			
					and State Law. The Plan of		
	At this Emergency	Preparedness survey,			Correction is submitted in or	der to	
	Evergreen Crossing	g and the Lofts was found in			respond to the allegation of		
	not in compliance v	with Emergency Preparedness			noncompliance cited during	the	
	Requirements for N	Medicare and Medicaid			facility's Life Safety Code wi		
	_	ders and Suppliers, 42 CFR			Emergency Preparedness S		
	483.73.	••			Please accept this plan of	,	
					correction as the provider's		
	The facility has 105	5 certified beds. At the time of			credible allegation of compli	ance.	
	the survey, the cens				The provider respectfully red		
	,				a desk review with paper	10.0010	
	Ouality Review cor	mpleted on 08/24/22			compliance to be considered	d in	
		1			establishing that the provide		
					substantial compliance.	1 10 111	
E 0004	403.748(a), 416.5	54(a), 418,113(a),					
SS=C	1 ' '	(5(a), 483.475(a), 483.73(a),					
Bldg	484.102(a), 485.6						
3	1 ' '	920(a), 486.360(a),					
	491.12(a), 494.62						
	, ,	Review and Update					
	Annually	,					
	1	6.54(a), §418.113(a),					
		0.84(a), §482.15(a),					
	. , -	.475(a), §484.102(a),					
	, ,, ,	.625(a), \$485.727(a).					
	I VTUU.UUIAI. V400	.VEVIGI. VTVJ.1 ETIGI.			1		

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

§485.920(a), §486.360(a), §491.12(a),

§494.62(a).

TITLE (X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J5YA21 Facility ID: 013280 If continuation sheet Page 1 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIE			5404 GE	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Federal, State an preparedness recomprehensive exprogram that measurements and the following elements and updated at lements do all of the and updated at lements developments and updated at lements developments and updated at lements develop and main preparedness plas and updated at lements and updated a	lan. The [facility] must a tain an emergency in that must be [reviewed], ast every 2 years. The plan following: It §482.15 and CAHs at tergency Plan. The [hospital inply with all applicable and local emergency quirements. The [hospital or op and maintain a intergency preparedness ets the requirements of this an all-hazards approach. It §483.73(a):] The LTC facility must intain an emergency in that must be reviewed,					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 2 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CONSTRUCTION (X. A. BUILDING			COMPL	X3) DATE SURVEY COMPLETED 08/22/2022		
		OVIDER OR SUPPLIER EN CROSSING A		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) PREI TA	FIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)			TE	(X5) COMPLETION DATE
		Based on record reversitied to develop an oreparedness plan that least annually in a 483.73(a). This definencements. Findings include: Based on review of Preparedness Plan e Preparedness Plan e Preparedness and Roinder entitled "Hazon 08/22/22 betwee Maintenance Assist for an updated emergeviewed by the fact twelve-month period last documented revelopments as not had its emergeviewed by an Adranot currently have a exit conference with Manager and the Manag	riew and interview, the facility d maintain an emergency nat was reviewed and updated accordance with 42 CFR cient practice could affect all the facility's Emergency esponse Plan" and a second that Communication Program" in 1:36 p.m. to 2:19 a.m. with the ant present, documentation regency preparedness program ility within the most recent d was not available, with the riew date listed as 12/12/2019. The time of record review, assistant stated that the facility regency preparedness program ministrator because they did in Administrator. During the in the Divisional Facilities anintenance Assistant at 2:15 information or evidence could by to this deficient finding.	E 00		what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The Annual review done March 18th 2022 was found during for review of the facility Emergency preparedness Plan. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice. • what measures will be put implace and what systemic chan will be made to ensure that the deficient practice does not recomplished. The facility's Emergency Preparedness Plan will be reviewed at the facilities annual March QAPI meeting. The Emergency Preparedness Plan annual review will be added to facilities QAPI meeting agends occur in March of each preceding preceding will be put into place; what quality assurance program will be put into place; Maintenance Director received training on the emergency	nts y the h urther cy he cillity ed. this to ges e ur; al n the a to ding will f, and	09/06/2022

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

Event ID:

Facility ID: 013280

J5YA21

If continuation sheet Page 3 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u></u>	COMPL	
		155826	B. W	ING		08/22/	2022
NAME OF P	ROVIDER OR SUPPLIER	· L		1	ADDRESS, CITY, STATE, ZIP COD		
EVERGE	EEN CROSSING A	AND THE LOFTS		5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254			
EVENGN	EEN CROSSING P	———	_	INDIAN	AFOLIS, IN 40234		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
ING	REGUERTORT OR	LESC IDENTIFY TING IN ORIVERTION		ind	Preparedness Manual.		DATE
					Maintenance Director or desig	nee	
					will monitor the signature revie	•W	
					page of the Emergency		
					Preparedness Plan annually		
					ongoing report of progress will		
					forwarded to the QAPI commit	tee.	
					by what date the systemic		
					changes for each deficiency w	ill	
					be completed.		
					September 6, 2022		
E 0040	400 740(1) 440 5	4(1) 440 440(1)					
E 0013 SS=C	403.748(b), 416.5						
Bldg	, ,	5(b), 483.475(b), 483.73(b),					
Diug	484.102(b), 485.6 485.727(b), 485.9						
	491.12(b), 494.62						
		P Policies and Procedures					
		6.54(b), §418.113(b),					
	- , , -	0.84(b), §482.15(b),					
	- , , -	475(b), §484.102(b),					
	- ' ' -	625(b), §485.727(b),					
		6.360(b), §491.12(b),					
	§494.62(b).						
		rocedures. [Facilities] must					
	develop and imple						
		cies and procedures, based					
		plan set forth in paragraph					
	, ,	risk assessment at					
		of this section, and the an at paragraph (c) of this					
	•	cies and procedures must					
	-	updated at least every 2					
	years.	ipualou al Ibasi evely 2					
	, . 						
	_	s at §483.73(b):] Policies					
	and procedures. T	The LTC facility must					
	develop and imple	ement emergency					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 4 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	(X2) MUI A. BUII B. WIN	DING	NSTRUCTION	(X3) DATE COMPL 08/22 /	ETED		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Р.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
IAU	preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policy be reviewed and a *Additional Requires Facilities: *[For PACE at §4] procedures. The develop and imples preparedness pol on the emergency	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually. Tements for PACE and PACE organization must ement emergency icies and procedures, based plan set forth in paragraph		IAG			DATE		
	paragraph (a)(1) of communication plus ection. The policion address manager nonmedical emerglimited to: Fire; expending the policies and plus policies and plus communication plus paragraphs.	risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be lated at least every 2 years.							
	and procedures. develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) of communication pl section. The polic be reviewed and	ties at §494.62(b):] Policies The dialysis facility must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are							

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 5 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPI				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155826	A. BU B. WI			COMPL 08/22/	
		103020	D. W1			00/22/	2022
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS			IAPOLIS, IN 46254		
(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 DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		equipment or power ted emergencies, water					
		n, and natural disasters					
		he facility's geographic					
	area.	, , , , , ,					
		view and interview, the facility	E 00	013			09/06/2022
	_	nd implement emergency			what corrective action(s) will		
		es and procedures. The ures must be reviewed and			accomplished for those reside		
		nually in accordance with 42			found to have been affected by deficient practice;	y trie	
		is deficient practice could affect			The Annual review done Marc	h	
	all residents in the f	-			18th 2022 was found during fu		
			review of the facility Emergency		у		
	Findings include:				preparedness Plan		
	Preparedness Plan of Preparedness and R binder entitled "Haz on 08/22/22 between Maintenance Assist for updated policies the facility within the period was not avait documented review Based on interview the Maintenance Ashas not had its emereviewed by an Adnot currently have a exit conference with Manager and the M p.m., no additional	The facility's Emergency entitled "Emergency tesponse Plan" and a second zard Communication Program" en 1:36 p.m. to 2:19 a.m. with the tent present, documentation and procedures reviewed by the most recent twelve-month lable, with the last of date listed as 12/12/2019. The time of record review, sesistant stated that the facility regency preparedness program ministrator because they did an Administrator. During the the Divisional Facilities faintenance Assistant at 2:15 information or evidence could by to this deficient finding.	potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility have the potential to be affected by this alleged deficient practice. In what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what systemic does not recur; In the facilities and what corrective action(s) will be action(s) will be taken; All residents residing in the facility have the potential to be affected by this action(s) will be affected by the same deficient practice will be action(s) will be action(s) will be faction(s) will be action(s) will be action				
		,			annual review will be added to facilities QAPI meeting agends occur in March of each preced year.	the a to ing	

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/22/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(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			
E 0029 SS=C Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §466 §483.73(c), §485. §485.68(c), §485. §485.920(c), §486 §494.62(c). (c) The [facility] m an emergency preplan that complies local laws and mulat least every 2 year facilities]. Based on record rev	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),	E 0029	be monitored to ensure the deficient practice will not rective., what quality assurance program will be put into place. • Maintenance Director receive training on the emergency Preparedness Manual. Maintenance Director or desivill monitor the signature reversage of the Emergency Preparedness Plan annually ongoing report of progress we forwarded to the QAPI comments. • by what date the systemic changes for each deficiency be completed. September 6, 2022	gnee iew ill be iittee. will be 09/06/2022			

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 7 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/22/2022		
	PROVIDER OR SUPPLIEI		5404 G	ADDRESS, CITY, STATE, ZIP COD SEORGETOWN ROAD JAPOLIS, IN 46254		
EVERGI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Preparedness comm with Federal, State, with 42 CFR 483.7 could affect all occ Findings include: Based on review of Preparedness Plan of Preparedness and R binder entitled "Ha on 08/22/22 between Maintenance Assist for an updated com the facility within t period was not avait documented review Based on interview the Maintenance A has not had its eme	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Inunication plan that complies and local laws in accordance 3(c). This deficient practice upants. The facility's Emergency entitled "Emergency tesponse Plan" and a second zard Communication Program" en 1:36 p.m. to 2:19 a.m. with the tant present, documentation munication plan reviewed by the most recent twelve-month		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) found to have been affected deficient practice; The Annual review done Mar 18th 2022 was found during a review of the facility Emerger preparedness Plan • how other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice. • what measures will be put in place and what systemic chawill be made to ensure that the	by the ch further ncy the e e acility ted. y this	(X5) COMPLETION DATE
	not currently have a exit conference wit Manager and the M p.m., no additional	an Administrator. During the h the Divisional Facilities laintenance Assistant at 2:15 information or evidence could by to this deficient finding.		deficient practice does not re	ual an to the da to ding will ur,	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Maintenance Director or designee

Page 8 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPL	ETED
		155826	B. W	'ING		08/22	/2022
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS		INDIAN	IAPOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710	REGCE/ITORT OF	CESC IDENTIFY THAT IN ORDER THOSE		1710	will manitar the signature revi	011/	DATE
					will monitor the signature revi	CVV	
					page of the Emergency		
					Preparedness Plan annually		
					ongoing report of progress wi		
					forwarded to the QAPI comm	ittee.	
					by what date the systemic		
					changes for each deficiency	azill	
					be completed.	VIII	
					1		
					September 6, 2022		
E 0036	403.748(d), 416.5	M(d) M18 113(d)					
SS=C	` '	5(d), 483.475(d), 483.73(d),					
Bldg	` '						
Blug	484.102(d), 485.6						
	, ,	20(d), 486.360(d),					
	491.12(d), 494.62						
	EP Training and T	<u> </u>					
	§403.748(d), §416	6.54(d), §418.113(d),					
	§441.184(d), §460	0.84(d), §482.15(d),					
	§483.73(d), §483.	475(d), §484.102(d),					
	§485.68(d), §485.	625(d), §485.727(d),					
	§485.920(d), §486	6.360(d), §491.12(d),					
	§494.62(d).	(// 3					
	*[For RNCHIs at §	§403.748, ASCs at §416.54,					
		113, PRTFs at §441.184,					
		, Hospitals at §482.15,					
	-	2, CORFs at §485.68,					
	_	5, "Organizations" under					
	_	at §485.920, OPOs at					
		at §403.920, OFOs at IC/FHQs at §491.12:] (d)					
	_						
	_	ng. The [facility] must					
	1	tain an emergency					
	1 ' '	ning and testing program					
		ne emergency plan set forth					
	in paragraph (a) o	f this section, risk					
	assessment at pa	ragraph (a)(1) of this					
	section, policies a	nd procedures at paragraph					

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

(b) of this section, and the communication plan at paragraph (c) of this section. The

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 9 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826	 JILDING	NSTRUCTION	COMPL 08/22/	ETED
	PROVIDER OR SUPPLIER		5404 GE	.DDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	_	g program must be ated at least every 2 years.				
	and testing. The land maintain an etraining and testin the emergency plate of this section, risk (a)(1) of this section at paragraph (b) communication plate section. The train must be reviewed annually.	s at §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least				
	testing. The ICF/II maintain an emergand testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication playsection. The train must be reviewed 2 years. The ICF/II	D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every				
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of	ties at §494.62(d):] and orientation. The lest develop and maintain an redness training, testing ation program that is based replan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section,				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 10 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLI	
		155826	B. W	ING		08/22/	2022
NAME OF I	PROVIDER OR SUPPLIER	?			ADDRESS, CITY, STATE, ZIP COD		
					EORGETOWN ROAD		
EVERGE	REEN CROSSING A	AND THE LOFTS		INDIAN	IAPOLIS, IN 46254		
(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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		cation plan at paragraph (c)					
		ne training, testing and					
	orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility						
			E 0	036			09/21/2022
		nd maintain an emergency		050	what corrective action(s) will	be	09/21/2022
		ng and testing program that			accomplished for those reside		
	was reviewed and u	updated at least annually in			found to have been affected b		
	accordance with 42	CFR 483.73(d). This deficient			deficient practice;		
	practice could affect	et all occupants.			Employee emergency		
					preparedness program training	-	
	Findings include:				be implemented and reviewed		
	Based on review of	the facility's Emergency			how other residents having t	he	
	_	entitled "Emergency			potential to be affected by the		
	_	esponse Plan" and a second			same deficient practice will be		
		zard Communication Program"			identified and what corrective		
		en 1:36 p.m. to 2:19 a.m. with the			action(s) will be taken;		
		tant present, documentation			The facility's Emergency		
	_	ing and testing program sility within the most recent			Preparedness Plan will be		
		od was not available, with the			reviewed at the facilities annu- March QAPI meeting. The	aı	
	-	view date listed as 12/12/2019.			Emergency Preparedness Pla	n	
		at the time of record review,			annual review will be added to		
		ssistant stated that the facility			facilities QAPI meeting agend		
		rgency preparedness program			occur in March of each preced		
		ministrator because they did			year.		
	not currently have a	an Administrator. During the					
	exit conference with	h the Divisional Facilities			what measures will be put in	to	
	_	faintenance Assistant at 2:15			place and what systemic chan	-	
	•	information or evidence could			will be made to ensure that the		
	be provided contrar	ry to this deficient finding.			deficient practice does not rec		
					Maintenance Director has reco	eived	
					training on developing and		
					maintaining the Emergency preparedness training and tes	ting	
					program. The facility's Emerge	_	
					Preparedness Plan will be	J. IOy	
					reviewed at the facilities annu-	_{al}	
					March QAPI meeting the		

PRINTED: 09/13/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (VI) PROVIDER/SUDDITED/CLIA (V2) MULTIPLE CONSTRUCTION						B NO. 0938-039
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIE		5404 0	ADDRESS, CITY, STATE, ZIP COD SEORGETOWN ROAD		
EVERGF	REEN CROSSING	AND THE LOFTS	INDIAN	NAPOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
				Emergency Preparedness Plan annual review will be added to facilities QAPI meeting.		
				how the corrective action(s) we be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place; Maintenance Director or design will monitor the training and testing of the Emergency Preparedness Plan annually. Ongoing report of training and testing will be forwarded to the QAPI committee until compliant has been achieved for three consecutive reviews and plant be adjusted accordingly. • by what date the systemic changes for each deficiency will be completed. September 21, 2022	and nee	
E 0037 SS=F Bldg	441.184(d)(1), 48 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 49 EP Training Prog §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4 §485.68(d)(1), §4					

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§491.12(d)(1).

*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 12 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIE		5404 G	ADDRESS, CITY, STATE, ZIP COE EORGETOWN ROAD APOLIS, IN 46254)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	CTION JLD BE BODDIATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	ROFRIATE	DATE
TAG	HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training progall of the following (i) Initial training in policies and proceed existing staff, indivender arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain documpreparedness training in policies at least every 2 ye (iii) Maintain documpreparedness training in procedures at [facility] must consupdated policies at the hospice must (i) Initial training in policies and proceed existing hospice exis	2, "Organizations" under at §486.360, RHC/FQHCs ram. The [facility] must do g: n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. Hency preparedness training ears. In mentation of all emergency ning. It is staff knowledge of dures. He duct training on the land procedures. §418.113(d):] (1) Training. It do all of the following: n emergency preparedness edures to all new and employees, and individuals is under arrangement, eir expected roles. It is staff knowledge of dures. It is gency preparedness training enemy preparedness edures to all new and employees, and individuals is under arrangement, eir expected roles. It is staff knowledge of dures. It is gency preparedness training enemy preparedness enemy preparedness training enemy preparedness enemy prepa	TAG	DEFICIENCY)		DATE
	(v) Maintain docu	(v) Maintain documentation of all emergency				

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

preparedness training.

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 13 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155826	B. W	ING		08/22/	/2022
NAME OF I	DROVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF			5404 G	EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS		INDIAN	APOLIS, IN 46254		
(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
	, ,	ncy preparedness policies					
	and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.						
	-	441.184(d):] (1) Training					
		TF must do all of the					
	following: (i) Initial training in	n emergency preparedness					
		edures to all new and					
		viduals providing services					
	under arrangement, and volunteers,						
	consistent with the	eir expected roles.					
	' '	ning, provide emergency					
		ning every 2 years.					
	, ,	staff knowledge of					
	emergency proce	unes. mentation of all emergency					
	preparedness trai						
		cy preparedness policies					
		re significantly updated, the					
	PRTF must condu	uct training on the updated					
	policies and proce	edures.					
	*[For PACE at 846	60.84(d):] (1) The PACE					
	-	do all of the following:					
		n emergency preparedness					
	policies and proce	edures to all new and					
	_	viduals providing on-site					
		rangement, contractors,					
		volunteers, consistent with					
	their expected role						
	, ,	ency preparedness training					
	at least every 2 years. (iii) Demonstrate staff knowledge of						
	emergency procedures, including informing						
		at to do, where to go, and					
		n case of an emergency.					
		mentation of all training.					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 14 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826	 UILDING	NSTRUCTION	COMPL 08/22	ETED
	PROVIDER OR SUPPLIER		5404 GF	DDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
EVERGR	CEEN CROSSING F	THE LOFTS	 INDIAN	AFOLIS, IN 40234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	(v) If the emerger and procedures and procedures and PACE must condupolicies and procedures and	re significantly updated, the act training on the updated edures. It is at §483.73(d):] (1) The LTC facility must do all the emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected role. Hency preparedness training ementation of all emergency pring. It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the following: It is a facility must do all emergency in the facility	TAG			DATE
	(v) If the emerge	ncy preparedness policies				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 15 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826	A. BUILDING B. WING		COMPL 08/22	LETED
	PROVIDER OR SUPPLIER		5404	TADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD NAPOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	RUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		re significantly updated, the uct training on the updated edures.				
	program. The CAI following: (i) Initial training ir policies and procereporting and exting protection, and who for patients, persong prevention, and coand disaster authors staff, indivender arrangement consistent with the (ii) Provide emergat least every 2 years.	nere necessary, evacuation nnel, and guests, fire poperation with firefighting prities, to all new and viduals providing services nt, and volunteers, peir expected roles. ency preparedness training pears.				
	emergency proced (v) If the emerge and procedures at CAH must conduct policies and proced *[For CMHCs at §	dures. ncy preparedness policies re significantly updated, the et training on the updated edures. 485.920(d):] (1) Training.				
	emergency preparation procedures to all randividuals providing arrangement, and their expected role documentation of must demonstrate emergency proceded the composition of must proving preparedness train	volunteers, consistent with es, and maintain the training. The CMHC staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years.				
	Based on record rev	view and interview, the facility	E 0037			09/06/2022

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 16 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIER		5404 (ADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD NAPOLIS, IN 46254	
(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	
PREFIX TAG	failed to maintain demergency prepared employees. The Lorall of the following: preparedness policicand existing staff, in under arrangement, with their expected preparedness training Maintain document preparedness training knowledge of emergacordance with 42 deficient practice consistency of Preparedness Plan of Preparedness and Resident proparedness and Resident employees was an interview at the Maintenance Assist for an emergency proparedness and Resident employees was an interview at the Maintenance Assist documentation for the program should be provided, and if it was where it was. During Divisional Facilities Maintenance Assist Maintenance Maintenance Maintenance Maintenance Maintenance Maintenance Assist Maintenance Maintena	cumentation of the dness training program for ng-Term Care facility must do (i) Initial training in emergency and procedures to all new ndividuals providing services and volunteers, consistent roles; (ii) Provide emergency at least annually; (iii) ation of all emergency ag; (iv) Demonstrate staff gency procedures in CFR 483.73(d)(1). This hald affect all occupants. the facility's Emergency esponse Plan" and a second card Communication Program" in 1:36 p.m. to 2:19 a.m. with the ant present, documentation reparedness training program not available for review. Based time of record review, the ant stated that he was told all the Emergency Preparedness located within the binders was not there, he had no idea g the exit conference with the sant at 2:15 p.m., no additional ence could be provided	PREFIX TAG	what corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Employee emergency preparedness program training be implemented and reviewed. how other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility's Emergency Preparedness Plan will be reviewed at the facilities annual March QAPI meeting. The Emergency Preparedness Planual review will be added to facilities QAPI meeting agend occur in March of each precessive and what systemic charwill be made to ensure that the deficient practice does not reall staff will be in-serviced and on Emergency Preparedness Plan. how the corrective action(s) be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place. Maintenance Director has received training on developing maintaining the Emergency	al an o the a to ding ato nges e cur; nually will r, ; and ng and
				preparedness training and tes	sting

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155826	B. W	NG		08/22/	/2022
	ROVIDER OR SUPPLIER			5404 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(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
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requires \$416.54(d)(2), \$4\$460.84(d)(2), \$4\$483.475(d)(2), \$4\$485.625(d)(2), \$4\$(2), \$491.12(d)(2) *[For ASCs at \$41 OPO, "Organization CMHCs at \$485.9 \$491.12, and ESF (2) Testing. The [fexercises to test to the state of t	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)			program. The facility's Emerger Preparedness Plan will be reviewed at the facilities annual March QAPI meeting the Emergency Preparedness Pla annual review will be added to facilities QAPI committee for annual review. • by what date the systemic changes for each deficiency who be completed. September 6, 2022	al in o the	

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(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 18 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155826	 UILDING	nstruction 	COMPL 08/22	ETED
	F PROVIDER OR SUPPLIER		5404 GF	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD		
EVER	GREEN CROSSING A	AND THE LOFTS	 INDIAN	APOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	functional exercise (B) If the [fact natural or man-material activation of the exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, opeof functional exercise (i) of this section in include, but is not (A) A second full-accommunity-based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an erection of the [facility's] emedically for hother patient's home conduct exercises plan at least annual the following: (i) Participate in accommunity based (A) When a community based (A)	er 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 nation of all drills, tabletop nergency events, and revise ergency plan, as needed. 418.113(d):] espices that provide care in each the emergency example in the stotest the emergency example. The hospice must do a full-scale exercise that is				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 19 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	N OF CORRECTION	IDENTIFICATION NUMBER 155826		UILDING	NSTRUCTION	COMPL 08/22	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(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 APPROPR		(X5) COMPLETION DATE	
	(B) If the hospice man-made emerg of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preport to challenge an error (3) Testing for hose care directly. The exercises to test the per year. The hose (i) Participate in a that is community (A) When a commaccessible, conducted facility-based functions (B) If the hospice man-made emergency exempt from engage full-scale community (A) when a commaccessible, conducted facility-based functions (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made emergency exempt from engage full-scale community (B) If the hospice man-made eme	dditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a etements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise based; or nunity-based exercise is not ict an annual individual						

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 20 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826		UILDING	NSTRUCTION	COMPL 08/22/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		TE	(X5) COMPLETION DATE	
IAU	emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercises (B) A mock disass (C) A tabletop exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emother the hospice's emergency seements. *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [For the conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community. (A) When a community cacessible, conduct facility-based functions in the conduct exercises plan twice per year cacessible, conducted in a that is community. (A) When a community caces is the property of the prope	ditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a cudes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an ospice's response to and nation of all drills, tabletop pergency events and revise ergency plan, as needed. 41.184(d), Hospitals at eat §485.625(d):] PRTF, Hospital, CAH] must et to test the emergency exercise is not ct an annual individual,		IAU			DATE	
	its next required fu or individual, facili following the onse	ull-scale community based ty-based functional exercise t of the emergency event. an [additional] annual						

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 21 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826	A. B	UILDING VING	nstruction 	COMPI 08/22	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS			APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		at may include, but is not		1710			DITTE
	limited to the follo						
		scale exercise that is					
	community-based or individual, a						
	facility-based fund	tional exercise; or					
	, ,	ock disaster drill; or					
	, ,	exercise or workshop that					
	•	or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to						
		umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	emily of emergency plant, as					
	*[For PACE at §46	60.84(d):]					
	_	PACE organization must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	do the following:					
		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	•					
		n additional exercise every					
	` '	he year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted that may include,					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 22 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155826	A. B	UILDING VING	NSTRUCTION	COMPL 08/22/	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD		
EVERGE	REEN CROSSING A	AND THE LOFTS			APOLIS, IN 46254		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVIDER TO THE APPROVIDE TO THE APPROVIDER TO THE APPROVIDER TO THE APPROVIDER TO THE APP		.TE	(X5) COMPLETION
TAG		a the following:		TAG	DEFICIENCE		DATE
	but is not limited to (A) A second full-	scale exercise that is					
	, ,	or individual, a facility					
	based functional e						
	(B) A mock disas						
	' '	ercise or workshop that is					
		and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an emergency plan. (iii) Analyze the PACE's response to and						
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emero	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	_	ity] must conduct exercises					
		ency plan at least twice per					
	_	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	he following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund						
	(B) If the [LTC fac	ility] facility experiences an					
		nan-made emergency that					
	-	n of the emergency plan, the					
		mpt from engaging its next					
	-	lle community-based or					
	-	based functional exercise					
	_	et of the emergency event.					
	' '	dditional annual exercise					
		but is not limited to the					
	following:						
	, ,	scale exercise that is					
	community-based	or an individual, facility					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 23 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155826	A. BUILDING B. WING	construction 	COMP	E SURVEY PLETED 2/2022		
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	O BE	(X5) COMPLETION DATE		
	led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the [response to and rall drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at § (2) Testing. The leaver cises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID of the is exempt from er full-scale community facility-based functions of the emer (ii) Conduct an activation of the emer (iii) Conduct an activation of the emer (iii	ster drill; or sercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the emergency plan at least the ICF/IID must do the enanual full-scale exercise rebased; or munity-based exercise is not act an annual individual, ctional exercise; or. experiences an actual adde emergency plan, the ICF/IID magaging in its next required and exercise following the gency event. Iditional annual exercise but is not limited to the escale exercise; or						

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 24 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	AN OF CORRECTION	IDENTIFICATION NUMBER 155826	A. BUILDIN B. WING	rice construction NG		COMPLETED 08/22/2022
	OF PROVIDER OR SUPPLIED GREEN CROSSING A		54	REET ADDRESS, CITY, S 04 GEORGETOWN DIANAPOLIS, IN 46	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	IX (EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the IC maintain docume exercises, and en the ICF/IID's eme *[For HHAs at §44 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the HH natural or man-materivation of the exempt from engate full-scale community facility based fund onset of the emer (ii) Conduct an accommunity-based functional exercises of this section is community-based facility-based functional exercises of this section is community-based facility-based functional exercises of this section is community-based facility-based functional exercises facility-based functional exercises of the section is community-based fun	emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed. 84.102] e HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is the conduct an annual chased functional exercise conduct an annual chased functional exercise that is the emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the gency event. Iditional exercise every 2 the year the full-scale or e under paragraph (d)(2)(i) conducted, that may tilimited to the following: full-scale exercise that is				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 25 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155826		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G =-	COM	E SURVEY PLETED 2/2022			
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF T		(X5) COMPLETION DATE		
	set of problem star messages, or preto challenge an eto challenge an eto challenge and eto challenge and eto challenge and eto challenge and eto challenge are the HHA's emerged *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor workshop at lee exercise is led by group discussion, relevant emergency plan. actual natural or requires activation OPO is exempt for required testing eto fithe emergency (ii) Analyze the Omaintain docume exercises, and enthe [RNHCI's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCI must do to (i) Conduct a papar at least annually.	temergency scenario, and a atements, directed apared questions designed amergency plan. HAA's response to and antation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] The OPO must conduct the emergency plan. The afollowing: The afollowing: The afollowing: The afollowing: The afollowing a narrated, clinically not scenario, and a set of a facilitator and includes a gray and a set of a facilitator and a set of ants, directed messages, or ans designed to challenge an an annual emergency plan, the form engaging in its next exercise following the onset of event. The OPO's response to and antation of all tabletop mergency events, and revise at OPO's] emergency plan, as						

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 26 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022		
		ROVIDER OR SUPPLIER			5404 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD IAPOLIS, IN 46254		
	(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
		scenario, and a sedirected message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversiled to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based function of the emergency plant of	drills using the emergency C facility must do the annual full-scale exercise that l; or ity-based exercise is not an annual individual, ional exercise. y experiences an actual natural gency that requires activation an, the LTC facility is exempt ext required full-scale r individual, facility-based l exercise for 1 year following hal event. itional exercise that may mited to the following: le exercise that is r an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using y relevant emergency scenario, in statements, directed ed questions designed to	E 0	039	what corrective action(s) will accomplished for those reside found to have been affected by deficient practice; The facility will conduct one to top and one community based disaster drill. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice. what measures will be put in place and what systemic chann will be made to ensure that the deficient practice does not received training on developing maintaining the Emergency preparedness training and test program. The facility's Emergency Preparedness Plan will be reviewed at the facilities QAPI meeting to insure an monitor compliance.	nts y the ble l he cility ed. this to ges e ur; g and ting ency	09/21/2022

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 27 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 08/22/2022			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		gency events, and revise the			• how the corrective action(s)	will	
	LTC facility's emergency plan, as needed in				be monitored to ensure the		
	accordance with 42 CFR 483.73(d)(2). This				deficient practice will not recu	,	
	deficient practice could affect all occupants.				i.e., what quality assurance		
	Findings include:				program will be put into place; and Maintenance Director or designee will monitor training Program of the		
	Based on review of	the facility's Emergency			Emergency Preparedness Pla		
	Preparedness Plan	entitled "Emergency			annually. Ongoing report of		
	_	esponse Plan" and a second			progress will be forwarded to t		
		zard Communication Program"			QAPI committee for annual re	view.	
	on 08/22/22 between 1:36 p.m. to 2:19 a.m. with the Maintenance Assistant present,				by what date the systemic		
		n annual full-scale exercise			changes for each deficiency w	rill	
		pased, an annual individual,			be completed.		
		ional exercise, an actual natural			September 21, 2022		
		gency that requires activation			,		
	of the emergency p	lan was not available for					
	review. Furthermor	e, there was no documentation					
	of a second full-sca	le exercise that is					
	community-based of	or an individual, facility-based					
		a mock disaster drill, or a					
		workshop that is led by a					
		des a group discussion, using					
		y relevant emergency scenario,					
		n statements, directed					
		red questions designed to					
		ency plan. Based on interview d review, the Maintenance					
	Assistant stated that						
		the Emergency Preparedness					
		located within the binders					
		vas not there, he had no idea					
	1 ~	g the exit conference with the					
	Divisional Facilities						
		ant at 2:15 p.m., no additional					
	information or evid	ence could be provided					
	contrary to this defi	cient finding.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 28 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826			UILDING	NSTRUCTION	COMPL 08/22/	ETED	
	ROVIDER OR SUPPLIER			5404 GI	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
EVERGR	EEN CROSSING A	IND THE LOFTS		INDIAN	AFOLIS, IN 40254		
(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
TAG E 0041 SS=F Bldg	482.15(e), 483.73(e) Hospital CAH and §482.15(e) Conditive (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (i) and (ii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan set (ii) and (iii) of this section and in procedures plan section require Care Facilities Cool Interim Amendment Table and Table Tab	(e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. In the CAH] must ency and standby power the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) externolocation. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new of when an existing		TAG			DATE
			1				l

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 29 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155826	B. WI	NG		08/22	/2022
NAME OF F	PROVIDER OR SUPPLIER	}	•		ADDRESS, CITY, STATE, ZIP COD		
					EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS		INDIAN.	APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		3.73(e)(3), §485.625(e)(3)					
		ator fuel. [Hospitals, CAHs					
	_	that maintain an onsite fuel					
	-	mergency generators must					
	-	w it will keep emergency					
		perational during the					
	emergency, unles	s it evacuates.					
	*[For hospitals at	§482.15(h), LTC at					
		CAHs §485.625(g):]					
	The standards inc	corporated by reference in					
	this section are ap	proved for incorporation by					
	reference by the D	Director of the Office of the					
	Federal Register i	n accordance with 5 U.S.C.					
	552(a) and 1 CFR	l part 51. You may obtain					
	the material from t	the sources listed below.					
	You may inspect a	a copy at the CMS					
	Information Resou	urce Center, 7500 Security					
	Boulevard, Baltim	ore, MD or at the National					
	Archives and Rec	ords Administration					
	(NARA). For inform	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
	http://www.archive	es.gov/federal_register/code					
		ations/ibr_locations.html.					
	If any changes in	this edition of the Code are					
	incorporated by re	eference, CMS will publish a					
		ederal Register to					
	announce the cha	inges.					
		Protection Association, 1					
	Batterymarch Parl	k,					
	Quincy, MA 02169						
	1.617.770.3000.						
	(i) NFPA 99, Heal	th Care Facilities Code,					
		ed August 11, 2011.					
	(ii) Technical interim amendment (TIA) 12-2 to						
	NFPA 99, issued August 11, 2011.						
		FPA 99, issued August 9,					
	2012.	, 3					
		FPA 99 issued March 7					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 30 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155826	B. W	NG	_	08/22/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
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)	16	DATE
TAG	2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Li 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. (xii) NFPA 110, S Standby Power Stincluding TIAs to 2009. Based on record revialed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). affect all occupants Findings include: Based on review of testing logs entitled Logbook Documen testing logs entitled Logbook Documen Maintenance Assist testing documentary review. Based on in review.	PA 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 TPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, View and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA by Code in accordance with 42 This deficient practice could	E 00		what corrective action(s) will accomplished for those reside found to have been affected by deficient practice; The facility will conduct load an load generator PM testing. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice. what measures will be put integrated and what systemic chan	be nts y the nd ne cility ed. this	09/15/2022
		ant and that he could not			will be made to ensure that the	-	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 31 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. BUILDING B. WING		COMPLETED 08/22/2022	
	REEN CROSSING A		5404	ADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD NAPOLIS, IN 46254	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		(X5) COMPLETION DATE
	or phone to locate the documentation. Dur the Divisional Facili Maintenance Assista	ing the exit conference with ities Manager and the ant at 2:15 p.m., no additional ence could be provided		deficient practice does not rec The maintenance direct has be educated on maintaining load no load PM on the generator. Generator monthly loads and weekly exercise are added to a TELS PNM Program to insure timely completion. • how the corrective action(s) to be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Executive Director or designs monitor TELS generator pm for continued compliance. • by what date the systemic changes for each deficiency w be completed. September 15, 2022	een and the will and will or
K 0000					
Bldg. 01	A T 10 G 2	D 46 4 12			
	Licensure Survey w Department of Healt 483.90(a). Survey Date: 08/22 Facility Number: 0 Provider Number: 1 AIM Number: 2012 At this Life Safety C Crossing and the Lo	13280 155826 270670 Code survey, Evergreen	K 0000	Preparation or execution of thi plan of correction does not constitute admission or agreer of Provider of the truth of the falleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fedand State Law. The Plan of Correction is submitted in orderespond to the allegation of noncompliance cited during the facility's Life Safety Code with	ment acts h on The and deral er to

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 32 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIER		5404 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD IAPOLIS, IN 46254	
(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
IAG	Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This two-story facil Type V (111) constraction in the correction in the corrections, and hard-resident sleeping rocapacity of 105 and of this visit. All areas where resident services were sprinkled and service	the and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. The arm system with smoke etidors, spaces open to the wired smoke detectors in all toms. The facility has a had a census of 77 at the time dents have customary access all areas providing facility steed except for two portable or P. O. D. S. trailers that were used for facility storage.		Emergency Preparedness Sur Please accept this plan of correction as the provider's credible allegation of compliar The provider respectfully requ a desk review with paper compliance to be considered i establishing that the provider is substantial compliance.	nce. lests
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation facility failed to ma from obstructions in facility. LSC 19.2.3 required width shall	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The three drawer PPE cabine immediately removed from the	ents by the t was

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 33 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155826	B. W	ING		08/22/	2022
VI. 1 =	OD OLUBER OR STATE	`		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEI	<			EORGETOWN ROAD		
EVERGF	REEN CROSSING A	AND THE LOFTS		INDIANAPOLIS, IN 46254			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions are met:				hallway.		
		uipment does not reduce the					
		corridor width to less than 60			how other residents having th		
	in. (1525 mm.)				potential to be affected by the		
		occupancy fire safety plan and			same deficient practice will be		
	training program address the relocation of the				identified and what corrective		
	wheeled equipment during a fire or similar				action(s) will be taken;		
	emergency.				Facility hallways were assess		
	(c) The wheeled equipment is limited to the				for the same issue and any is	sues	
	following:				were immediately corrected.		
	i. Equipment in use						
	ii. Medical emergency equipment not in use				what measures will be put into		
	iii. Patient lift and transport equipment				place and what systemic cha		
	•	ice could affect approximately			will be made to ensure that th		
	18 residents, 4 staff	f and 2 visitors.			deficient practice does not red		
					Daily rounds will be made by		
	Findings include:				facility management and any		
					issues immediately corrected		
	Based on observation						
		tant during a tour of the			how the corrective action(s) w		
	I	2 at 1:05 a.m., there was a small			monitored to ensure the defic		
	_	r dresser located immediately			practice will not recur, i.e., wh		
		om #212. This dressed			quality assurance program wi	ll be	
		did not have wheels on it.			put into place; and		
		with the Maintenance			Executive Director or designe	d will	
		e of the observation, he			make spot rounds weekly to		
	_	dresser was stored in the			insure compliance.		
		ot on wheels. This item was					
		nt room taking care of the			by what date the systemic		
		Divisional Facilities Manager at			changes for each deficiency v	vill	
	the time it was obse	erved removing the deficiency.			be completed.		
					September 6, 2022		
	3.1-19(b)						
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
	Doors in a required means of egress shall not						
		a latch or a lock that					
		of a tool or key from the					

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155826	B. W	ING		08/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			EORGETOWN ROAD		
EVERGE	REEN CROSSING A	AND THE LOFTS			APOLIS, IN 46254		
LVLINOI		THE LOT TO		INDIAN	Al OLIO, IIV 40234		
(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	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s using one of the following					
	special locking ar	•					
		S OR SECURITY THREAT					
	LOCKING						
		king arrangements for the					
		eeds of the patient are					
	•	cking device shall be					
		door and provisions shall					
		apid removal of occupants					
	I -	l of locks; keying of all					
		ied by staff at all times; or e means available to the					
	staff at all times.	e means available to the					
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	.2.2.0, 19.2.2.2.3.1,					
	SPECIAL NEEDS	I OCKING					
	ARRANGEMENT						
		king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					
	-	at fail safely so as to					
		of power to the device; the					
	•	ed by a supervised					
		er system and the locked					
	-	d by a complete smoke					
	detection system	(or is constantly monitored					
	at an attended loc	cation within the locked					
	space); and both	the sprinkler and detection					
	systems are arrar	nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
		lelayed-egress locking					
	1 -	in accordance with					
		permitted on door					
		g low and ordinary hazard					
		ngs protected throughout by					
	an approved, sup	ervised automatic fire					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 35 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155826	B. WING		08/22/2022
		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP COD	<u>.l</u>
NAME OF I	PROVIDER OR SUPPLIEI	R		GEORGETOWN ROAD	
EVERGF	REEN CROSSING A	AND THE LOFTS		ANAPOLIS, IN 46254	
	T			, 	(VI)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG		or an approved, supervised	IAG		DATE
	automatic sprinkle				
	18.2.2.2.4, 19.2.2				
		ROLLED EGRESS			
	LOCKING ARRAI				
		d Egress Door assemblies			
		dance with 7.2.1.6.2 shall			
	be permitted.	anioc with 7.2.1.0.2 Shall			
	18.2.2.2.4, 19.2.2	24			
		BY EXIT ACCESS			
	LOCKING ARRAI				
		it access door locking in			
	-	7.2.1.6.3 shall be permitted			
		es in buildings protected			
		approved, supervised			
	-	ection system and an			
		ised automatic sprinkler			
	system.	•			
	18.2.2.2.4, 19.2.2	.2.4			
		on and interview, the facility	K 0222	what corrective action(s) will	be 09/06/2022
	failed to ensure the	means of egress through 1 of		accomplished for those reside	I
	1 main entrance/ ex	it were readily accessible for		found to have been affected be	I
	residents without a	clinical diagnosis requiring		deficient practice;	
	specialized security	measures. Doors within a		Door key pad code was place	ed at
	_	egress shall not be equipped		the door during survey.	
	with a latch or lock	that requires the use of a tool			
		ess side unless otherwise		how other residents having th	ie
		19.2.2.2.4. Door-locking		potential to be affected by the	;
		be permitted in accordance		same deficient practice will be	e
		This deficient practice could		identified and what corrective	
		ents, 12 staff, and 4 visitors if		action(s) will be taken;	
	needing to exit the	facility.		All residents residing in the fa	•
				have the potential to be affec	I
	Findings include:			No residents were affected by	y this
				alleged deficient practice.	
	Based on observation			what measures will be put int	
		tant during a tour of the		place and what systemic cha	nges
	facility on 08/22/22 at 9:42 a.m., the main entrance /			will be made to ensure that the	
		vas marked as a facility exit, was		deficient practice does not re-	cur;
magnetically locked, and could be opened by		I	The four-digit code was poste	-dat I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	COMPLETED	
		155826	B. WI	NG		08/22/	2022	
	ROVIDER OR SUPPLIER			5404 GI	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID I				(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE	
	entering a four-digit posted. Based on an Maintenance Assist employee, it was de to the facility autom then unlock at 7:00 Maintenance Assist employee that durin exit the facility wou the main entry door with the Divisional Maintenance Assist	t code but the code was not interview with the ant and a front desk termined that the front doors natically lock at 6:00 p.m. and a.m. It was agreed by both the ant and the front desk g that time, anyone needing to ald need the door code to exit s. During the exit conference Facilities Manager and the ant at 2:15 p.m., no additional ence could be provided			the main entrance / exit door during survey. how the corrective action(s) wi monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place; and The Maintenance Director is to monitor the front entrance / ex door for code posting daily, an issues will be immediately corrected by what date the systemic changes for each deficiency who be completed. September 6, 2022	ent be be it y		
K 0232 SS=E Bldg. 01	unobstructed) servat least 4 feet and convenient remove on stretchers, exception 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on observation clear width requirem 19.2.3.4(1) for 1 of 19.2.3.4(1) requires adjunct areas not intreatment, or use of than 44 inches in clear	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by	K 02	232	what corrective action(s) will be accomplished for those resides found to have been affected by deficient practice; Two wheeled cart and PPE storage were immediately rem from the conference room area during survey.	nts / the oved	09/06/2022	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 37 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ЛLDING	01	COMPL	
		155826	B. W	ING		08/22/	2022
	PROVIDER OR SUPPLIE			5404 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD IAPOLIS, IN 46254		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	Based on observati Maintenance Assis facility on 08/22/22 corridor containing Services office, the MDS Coordinators had a two-wheeled Personal Protective inch wide by 17-incof foam cups stored and the boxes obstrall to approximate interview at the tim Maintenance Assis emergency situation stored within the cotthe area dangerous with the Divisional Maintenance Assis	tant during a tour of the 2 at 9:42 a.m., the Administration 3: The Director of Clinical 4: Executive Directors office, the 5 office, and a conference room 6 cart with 12 boxes of assorted 6: Equipment (PPE), and two 17- 7 ch long by 28-inch-high boxes 7 d there. This two-wheeled cart 7 cucted the clear width of the 7 cly 24 inches. Based on an 7 ne of the observation, the 7 tant agreed that in an 7 n, the aforementioned items 7 borridor would make evacuation 8 During the exit conference 9 Facilities Manager and the 7 tant at 2:15 p.m., no additional 8 dence could be provided		TAG	how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Administrative areas were assert for storage and any issues were immediately addressed. What measures will be put into place and what systemic charm will be made to ensure that the deficient practice does not receive action from the place and what systemic charm will be made to ensure that the deficient practice does not receive action from the place and what systemic charm will be made to ensure that the deficient practice does not receive action from the place and be action from the corrective action from the deficient practice will not recur, i.e., who quality assurance program will put into place; and the practice of t	sed ere onges e cur; e e inges ill be ient at ill be	DATE
K 0271 SS=E Bldg. 01	7.7, provides a le				by what date the systemic changes for each deficiency vbe completed. September 6, 2022	vill	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 38 of 56

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPL	ETED	
		155826	B. W	NG		08/22/	2022	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			EORGETOWN ROAD			
EVERGF	REEN CROSSING A	AND THE LOFTS			IAPOLIS, IN 46254			
	T		1		T			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE	
	-	ion and shall be maintained						
		ns. Additionally, the exit						
	_	e a hard packed all-weather						
	travel surface.							
	18.2.7, 19.2.7	on and interview, the facility	IZ O	271	what corrective action(a) will be	_	00/20/2022	
		means of egress through 1 of	K 0	2/1	what corrective action(s) will be		08/29/2022	
		cks was readily accessible for			accomplished for those reside found to have been affected b			
		and visitors. LSC 7.2.1.6.1.1			deficient practice;	y trie		
		cking Systems allows			Your Automatic door company	,		
		elayed-egress locks shall be			was called in to adjust stairwe			
		alled on door assemblies			door egress on 8.29.22	11		
	_	linary hazard contents in			1 door egress on 0.23.22			
		throughout by an approved,			how other residents having the	۵		
		ic fire detection system			potential to be affected by the	•		
	_	nce with Section 9.6, or an			same deficient practice will be			
		ed automatic sprinkler system			identified and what corrective			
		nce with Section 9.7, and			action(s) will be taken;			
		Chapters 11 through 43,			All residents residing in the fac	cility		
	provided:	1 2 /			have the potential to be affected	-		
	•	shall unlock in the direction of			No residents were affected by			
		ion of one of the following:			alleged deficient practice.			
		rvised automatic sprinkler						
		accordance with Section 9.7			what measures will be put into	ı		
		one heat detector of an			place and what systemic chan			
	approved, supervise	ed automatic fire detections			will be made to ensure that the			
	system in accordan	ce with section 9.6			deficient practice does not rec	ur;		
	(c) Not more than t	wo smoke detectors of an			Maintenance Director was			
	approved, supervise	ed automatic fire detection			educated on the importance o	f		
	system in accordan	ce with Section 9.6			proper egree of stairwell doors	3.		
	(2) The door leaves	shall unlock in the direction of			Door agrees has been added	to		
	egress upon loss of	power controlling the lock or			the facilities Tels PM program			
	locking mechanism							
		process shall release the lock in			how the corrective action(s) w	ill be		
	_	ess within 15 seconds, or 30			monitored to ensure the defici-	ent		
		roved by the authority having			practice will not recur, i.e., who	at		
		pplication of a force to the			quality assurance program wil	be		
		ired in 7.2.1.5.10 under all of			put into place; and			
	the following condi				Executive Director or designed	e will		
	(a) The force shall i	not be required to exceed 15 lbf			monitor facility Tels program			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLI	ETED
		155826	B. W	'ING	_	08/22/2	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS			APOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	Ī	(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
	(67 N).				during monthly QAPI for		
	(b) The force shall 1	not be required to be			compliance.		
	continuously applie	d for more than 3 seconds.					
	(c) The initiation of	the release process shall			by what date the systemic		
	activate an audible	signal in the vicinity of the			changes for each deficiency w	/ill	
	door opening.				be completed.		
	(d) Once the door lo	ock has been released by the			August 29, 2022		
	application of force	to the releasing device,					
	relocking shall be b	y manual means only.					
	(4) A readily visible	e, durable sign in letters not					
	less than 1 in. (25m	m) high and at least 1/8 in.					
	(3.2mm) in stroke v	vidth on a contrasting					
	background that rea	ds as follows shall be located					
	on the door leaf adj	acent to the release device in					
	the direction of egre						
	"PUSH UNTIL AL	ARM SOUNDS.					
	DOOR CAN BE O	PENED IN 15 SECONDS".					
	(5) The egress side	of the doors equipped with					
		s shall be provided with					
		in accordance with 7.9.					
		ice could affect as many as 18					
	residents, 4 staff and	d 2 visitors.					
	Findings include:						
	Based on observation	ons made with the					
	Maintenance Assist	ant during a tour of the					
	facility on 08/22/22	at 9:59 a.m., the stairwell exit					
	door nearest to resid	dent room #107 was provided					
	with delayed egress	locks and was provided with					
	the proper signage i	ndicating the doors can be					
	opened in 15 second	ds by pushing on the door,					
		door was tested, the					
	irreversible process	to release the lock was not					
	initiated. The 15 sec	cond delayed egress door not					
	functioning when to	ested was acknowledged by					
	the Maintenance As	ssistant at the aforementioned					
	time who added tha	t he would have to call the					
	vendor and have it a	adjusted. During the exit					
	conference with the	Divisional Facilities Manager					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 40 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DAT			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155826	B. W.	ING		08/22	/2022
			_	STREET .	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOFTS		INDIAN	IAPOLIS, IN 46254		
(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
		ee Assistant at 2:15 p.m., no ion or evidence could be					
		o this deficient finding.					
	provided contrary to	o this deficient finding.					
	3.1-19(b)						
K 0291	NFPA 101						
SS=F	Emergency Lightin	na					
Bldg. 01	Emergency Lightin	_					
		ig of at least 1-1/2-hour					
	duration is provide	ed automatically in					
	accordance with 7	7.9.					
	18.2.9.1, 19.2.9.1						
		on and interview, the facility	K 0	291	what corrective action(s) will b		09/21/2022
		f 3 battery backup lights were			accomplished for those reside		
	-	annually for 90 minutes over			found to have been affected b	y the	
		ure the light would provide			deficient practice;		
		ods of power outages, and a			Emergency 30 second battery	1	
		sual inspections and tests was			light test completed on		
	_	2.9.1 requires emergency			09.01.2022. The annual 90 mi		
		ovided in accordance with 17.9.3.1.1 (1) requires			emergency battery light test w	111	
		hall be conducted monthly,			be completed by 09.21.2022.		
		3 weeks and a maximum of 5			how other residents having the	•	
		s, for not less than 30			potential to be affected by the		
		onal testing shall be			same deficient practice will be		
		for a minimum of 1 1/2 hours			identified and what corrective		
		ghting system is battery			action(s) will be taken;		
		ritten records of visual			All residents residing in the fac	cility	1
		s shall be kept by the owner			have the potential to be affect	•	
	for inspection by th				No residents were affected by		
	jurisdiction. This de	eficient practice could affect all			alleged deficient practice.		
	residents in the faci	lity.					
					what measures will be put into)	
	Findings include:				place and what systemic chan	iges	
					will be made to ensure that the		
		view with the Maintenance			deficient practice does not rec	:ur;	
		22 at 9:59 a.m., the Battery-			Maintenance director was		
	-	ey Light Test Log for 2022			educated on importance of		
	indicated three batte	ery operated lights located			emergency battery light testing	g.	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 41 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLI	
		155826	B. W			08/22/	2022
NAME OF P	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
		AND THE LOFTS			EORGETOWN ROAD		
EVERGR	REEN CROSSING A	AND THE LOCIO		INDIAN	APOLIS, IN 46254		
(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)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION ity. Based on an interview at		TAG	Emergency battery light testin	<u> </u>	DATE
		eview, the Maintenance			has been added to facility Tels	-	
		the facility has some			program.	3 1 IVI	
		nergency lights in the facility			- program		
		on both a monthly and annual			how the corrective action(s) w	rill be	
	basis. Further record	d review indicated missing			monitored to ensure the defici		
	documentation as fo	ollows:			practice will not recur, i.e., wh	at	
		y testing for all three facility			quality assurance program wil	l be	
		nergency lights for September			put into place; and		
	of 2021				Executive Director or designed		
		testing for all three facility			monitor Tels PM during facility	/	
	battery-operated em	nergency lights for October of			monthly QAPI		
		testing for all three facility			by what data the avetomic		
		nergency lights for November			by what date the systemic changes for each deficiency w	,ill	
	of 2021	lergency lights for tvovember			be completed.	VIII	
		y testing for all three facility			September 21, 2022		
		nergency lights for February of			Coptombol 21, 2022		
	2022						
	E) Missing monthly	testing for all three facility					
	battery-operated em	nergency lights for April of					
	2022						
		testing for all three facility					
		nergency lights for June of					
	2022						
	1	ented 90-minute annual testing					
		d be located was dated					
		20, and was well over 12					
	months.	y and annual teatin					
	·	y and annual testing of the ed exit lights was verified by					
		ssistant at the time of record					
		exit conference with the					
	Divisional Facilities						
		ant at 2:15 p.m., no additional					
		ence could be provided					
	contrary to this defi	-					
	_	-					
	3.1-19(b)						

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 42 of 56

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/22/2022				ETED
	PROVIDER OR SUPPLIER			5404 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(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)	ГЕ	(X5) COMPLETION DATE
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, al by construction tyl throughout by an a sprinkler system in 13, Standard for th Systems. In Type I and II co protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure the system met the requ 13, Standard for the Systems, 2010 Edit sprinkler wrench as manufacturer shall the each type of sprinkl removal and installat system. Annex A is not a pa included for inform A.6.2.9.6 states one be appropriate for in	- Installation Installation nd hospitals where required	K 0:		what corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; No residents were affected by alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice.	nts y the this	09/21/2022

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

Event ID:

J5YA21 Facility ID: 013280 If continuation sheet Page 43 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	r í	ILDING	onstruction 01	(X3) DATE COMPL 08/22/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	within the facility Findings include: Based on observation Maintenance Assist facility on 08/22/22 cabinet located in the contain a sprinkler the time of observat Assistant confirmed wrench could not be survey adding that Assistant and he wo Director where it whim. During the exi Facilities Manager Assistant at 2:15 p.	ons made with the ant during a tour of the at 9:59 a.m., the spare sprinkler he sprinkler riser room did not wrench. Based on interview at tion, the Maintenance has specialized sprinkler e located as of the time of this he was just the Maintenance has located the next time he saw t conference with the Divisional and the Maintenance m., no additional information or provided contrary to this			what measures will be put interplace and what systemic charwill be made to ensure that the deficient practice does not reconstruct the sprinkler wrench and maintain the sprinkler riser. how the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., where quality assurance program with put into place; and Results will be brought to the monthly QAPI until compliance achieved. by what date the systemic changes for each deficiency with the completed. September 21, 2022	nges ecur; n at vill be ient nat ll be	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a nd readily available. system last checked					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155826	B. W	NG		08/22	/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		ICY 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)	IE	DATE
	c) Water system	supply source					
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record revaled to ensure 1 or systems was examinate where conditions exobstructed piping as	, and NFPA 25 view and interview, the facility f 1 automatic sprinkler piping ned for internal obstructions xist that could cause s required by NFPA 25, 2011	K 0	353	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; An internal sprinkler pipe	nts	09/21/2022
	obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This			inspection will be conducted certified sprinkler contractor how other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; All residents residing in the have the potential to be affected.		e cility ed.	
	visitors. Findings include:	ffects all residents, staff, and			No residents were affected by alleged deficient practice. what measures will be put into		
	Based on record rev Assistant on 08/22/documentation of a investigation docun review. Based on an Maintenance Assist review, he stated th documentation was he had no idea when the exit conference Manager and the M p.m., no additional	view with the Maintenance 22 at 12:02 p.m., sprinkler system internal pipe ment was not available for in interview with the stant at the time of record at if the aforementioned not in the logbook provided, re it would be located. During with the Divisional Facilities faintenance Assistant at 2:15 information or evidence could by to this deficient finding.			place and what systemic chan will be made to ensure that the deficient practice does not rec Main Director was education the importance of 5 year internal prinspections. Internal sprinkler inspections have been added the facility Tels PM program. how the corrective action(s) with monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place; and Executive Director or designed monitor Tels PM program duri	ges e ur; he bipe pipe to ill be ent at I be	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 45 of 56

CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155826	r í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIER			5404 GI	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0355 SS=F	NFPA 101	oguichere			facility monthly QAPI. by what date the systemic changes for each deficiency w be completed. September 21, 2022	ill	
SS=F Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to inspect 20 extinguishers in the Standard for Portable 7.2.1.2 states fire exeither manually or be device / system at a Section 7.2.2 states electronic monitoring include a check of a (1) Location in designation (2) No obstruction to (3) Pressure gauge roperable range or potentially for the following population of the cartridge-operated expelling-type cartridge-operated expelling-type (5) Condition of the nozzle for wheeled (6) Indicator for nor using pushto-test prosection 7.2.4.1 state inspections shall keep the cartridge-operated expelling pushto-test prosections shall keep the cartridge operated the cartridge operated expelling pushto-test prosections shall keep the cartridge operated	iguishers guishers are selected, d, and maintained in IFPA 10, Standard for iguishers. 12, NFPA 10 In and interview, the facility of 21 portable fire facility each month. NFPA 10, Ite Fire Extinguishers, Section tinguishers shall be inspected by means of an electronic minimum of 30-day intervals. Ite periodic inspection or Ite go fire extinguishers shall It least the following items: It gnated place It is access or visibility Ite eading or indicator in the Ite osition Ite of the property of the property of the property of the periodic inspection Iterated place Iterated	K 0	355	what corrective action(s) will be accomplished for those resider found to have been affected by deficient practice; Facility fire extinguishers were inspected and retagged 09.02. by Safecare, how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice. what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recommended the process of the deficient practice of fire educated on importance of fire	onts y the 22 cility ed. this ges eur;	09/21/2022

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 46 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/22/2022	
PROVIDER OR SUPPLIE		5404 (CADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD NAPOLIS, IN 46254		
SUMMARY (EACH DEFICIENT REGULATORY OF require corrective at where at least monounce conducted, the date performed and the performed and the performing the inspection 7.2.4.4 require conducted, recesshall be kept on a treatinguisher, on an amaintained on file, Section 7.2.4.5 require demonstrate that at inspections have be practice could affer and visitors in the section of the s	AND THE LOFTS STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION action. Section 7.2.4.3 requires thly manual inspections are the manual inspection was initials of the person pection shall be recorded. uires where manual inspections ag or label attached to the fire inspection checklist or by an electronic method. uires records shall be kept to teast the last 12 monthly een performed. This deficient et all residents, as well as staff facility. Sons made with the tant during a tour of the 2 between 9:19 a.m. and 10:41 at 12:37 p.m. to 2:09 p.m., the a tags on the fire extinguishers the entire facility were missing aspection documented for the 2. The facility had a bus that ted had a portable fire but it was not onsite at the time the extinguisher on it to be an an interview at the time of the Assistant Maintenance man monthly inspection on each of reable fire extinguishers must ced and agreed that they were ring the exit conference with the	5404 (GEORGETOWN ROAD	thly have els vill be cient hat ill be ee will ty	
contrary to this def	dence could be provided icient finding.				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 47 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155826	B. W	ING	_	08/22	/2022
NAME OF B	DOMDED OF GUIDNI 155			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	<u>C</u>		5404 G	EORGETOWN ROAD		
EVERGR	EEN CROSSING A	AND THE LOFTS		INDIAN	IAPOLIS, IN 46254		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)						
K 0374	NFPA 101						
SS=E		lding Spaces - Smoke					
Bldg. 01	Barrie	5 - F					
		lding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
	Doors in smoke ba	arriers are 1-3/4-inch thick					
	solid bonded wood	d-core doors or of					
		esists fire for 20 minutes.					
	•	e plates of unlimited height					
	-	ors are permitted to have					
		assemblies per 8.5. Doors					
	_	automatic-closing, do not					
		nd are not required to swing					
		egress travel. Door opening					
	-	ım clear width of 32 inches					
	for swinging or ho						
	19.3.7.6, 19.3.7.8,		17.0	27.4			00/06/2022
		on and interview, the facility f 7 sets of barrier doors would	K 0	3/4	what corrective action(s) will be		09/06/2022
		ent of smoke for at least 20			accomplished for those reside found to have been affected b		
		7.8 requires doors in smoke			deficient practice;	y u i c	
		ly with LSC Section 8.5.4. LSC			Facility Maintenance correcte	2d	
		ors in smoke barrier shall close			door closure on 09.06.22	.	
	_	only the minimum clearance			233. 3.334.0 311 03.00.22		
		r operation. This deficient			how other residents having the	е	
		at as many as 18 residents, 4			potential to be affected by the		
	staff and 2 visitors.	,			same deficient practice will be	!	
					identified and what corrective		
	Findings include:				action(s) will be taken;		
					All residents residing in the fac	cility	
	Based on observation	ons made with the			have the potential to be affect	•	
	Maintenance Assist	ant during a tour of the			No residents were affected by		
	facility on 08/22/22	at 9:59 a.m., the set of smoke			alleged deficient practice.		
	barrier nearest to re-	sident room #160 did not close					
		sted on three separate			what measures will be put into)	
		s a six-inch gap between the			place and what systemic chan	iges	
	doors when closed t	to their fullest. Based on			will be made to ensure that the	_	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 48 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155826	B. WING 08/22/2022			/2022	
				CTD FFT A	ADDRESS SITE OF STATE OF		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD		
EVEDOD	EEN CROSSING A	ND THE LOETS			APOLIS, IN 46254		
EVERGR	LEEN CROSSING A	IND THE LOFTS		INDIAN	APOLIS, IN 40254		
(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
	_	e time of observations, the			deficient practice does not rec	ur;	
		ant acknowledged these			Maintenance Director educate		
		t close completely and stated			smoke barrier doors and prope	er	
		them adjusted as soon as he			closure of smoke barrier doors	S.	
		Ouring the exit conference with					
		ities Manager and the			how the corrective action(s) w	ill be	
		ant at 2:15 p.m., no additional			monitored to ensure the deficie		
		ence could be provided			practice will not recur, i.e., wha		
	contrary to this defi-	cient finding.			quality assurance program will	l be	
					put into place; and		
	3.1-19(b)				Admin designee will monitor		
					smoke doors on Tels Pm prog	ram	
					during monthly QAPI.		
					by what date the systemic		
					changes for each deficiency w	ill	
					be completed.		
					September 6, 2022		
K 0531	NFPA 101						
SS=F	Elevators						
Bldg. 01	Elevators						
Diag. 01	2012 EXISTING						
		with the provision of 9.4.					
		ected and tested as					
	· ·	A17.1, Safety Code for					
	l <u></u>	alators. Firefighter's					
		d monthly with a written					
	record.	,					
		conform to ASME/ANSI					
	_	le for Existing Elevators					
		l existing elevators, having					
		of 25 feet or more above or					
	below the level that	at best serves the needs of					
	emergency persor	nnel for firefighting					
		n with Firefighter's Service					
		ASME/ANSI A17.3.					
	-	er's service Phase I key					
		detector automatic recall,					

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 49 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	-	
EVERGR	REEN CROSSING A	AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX ΓAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		e Phase II emergency in-car		IAG	DEI IOLENO I		DATE
	_	chine room smoke					
		vator lobby smoke					
	detectors.)						
	19.5.3, 9.4.2, 9.4.3						
	Based on record rev		K 053	1	what corrective action(s) will be		09/06/2022
	· ·	ility failed to maintain testing			accomplished for those residents		
		refighter recall in accordance Testing. LSC 9.4.6.2 states that			found to have been affected b	y the	
		re fighters' emergency			deficient practice; Maintenance Director tested firefighter recall on elevator on		
		dance with 9.4.3 shall be					
	-	y operation with a written			09.06.22	•	
		gs made and kept on the					
		d by ASME A17.1/CSA B44,			how other residents having th	е	
	Safety Code for Ele	vators and Escalators. This			potential to be affected by the		
		ould all residents, staff, and			same deficient practice will be	;	
		eess to the second floor of the			identified and what corrective		
	facility.				action(s) will be taken;		
	TO 11 1 1 1				All residents residing in the fa	-	
	Findings include:				have the potential to be affect		
	Rosed on record rev	view with the Maintenance			No residents were affected by	tnis	
	Assistant on 08/22/2				alleged deficient practice.		
		nonthly generator testing for			what measures will be put into)	
		onth period was not available			place and what systemic char		
		last documented date of			will be made to ensure that th	-	
	testing being 08/31/	2021. Based on interview at			deficient practice does not red		
		eview, the Maintenance			Maintenance Director or design	nee	
		t he was unaware of the need			will maintain weekly testing of	:	
		on the facility elevators			elevator firefighter recall.		
	_	nction and stated that he would				:::: L	
		e Maintenance Director the			how the corrective action(s) w		
		m. During the exit conference Facilities Manager and the			monitored to ensure the defici practice will not recur, i.e., wh		
		ant at 2:15 p.m., no additional			quality assurance program wi		
		ence could be provided			put into place; and	50	
	contrary to this defi	-			Elevator firefighter recall PM h	nas	
	-	-			been added to Tels. Results of		
	3.1-19(b)				audit to bring to monthly QAP	l for	
					six months or until compliance		

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL		
155826 B. v			B. WING 08/22/2022					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(X4) ID	SUMMARY 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	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					achieved. by what date the systemic changes for each deficiency who be completed. September 6, 2022	vill		
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Assistant on 08/22/22 at 11:41 p.m., no documentation could be provided regarding a fire drill for the fourth quarter (October, November, or December) of 2020 on the first, second, or third		K 0	712	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The facility will conduct fire dri One per shift, per month, per quarter. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice.	nts y the Ils. cility ed.	09/21/2022	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 51 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2022				
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	survey. During the of Divisional Facilities Maintenance Assist information or evide contrary to this defit 3.1-19(b)	ant at 2:15 p.m., no additional ence could be provided			what measures will be put into place and what systemic char will be made to ensure that the deficient practice does not red Maintenance was educated or drills. how the corrective action(s) we	nges e eur; n fire			
	3.1-51(c)				monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place; and Executive Director or designer monitor fire drills monthly for smonths. Fire drills have been added to Tels PM program. Results will be brought to mor QAPI	at I be e will six			
					by what date the systemic changes for each deficiency w be completed. September 21, 2022	vill			
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the bracess shall be provided to nis capability for the life branches. Maintenance generator and transfer ormed in accordance with							

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 52 of 56

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 01 B. WING			COMPLETED 08/22/2022	
155826		B. WING	<u> </u>		08/22/	2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
	exercised under lot year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Noircuit breakers ar program for period components is est manufacturer requisite of maintenance are and readily availal and circuits are mand separate from Minimizing the posterior emergency power consideration for refeated to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior for the ground facility failed to ensing the posterior facility failed to ensing the posterior failed	and 30 minutes 12 times a intervals, and exercised on this for 4 continuous hours. It derivated cold start and usal transfer of all EES inducted by competent on the analysis of stored of the cold start and usal transfer of all EES inducted by competent of the cold start and usal transfer of all EES inducted by competent of the cold start and usal transfer of all EES inducted by competent of the cold start and usal transfer of all EES inducted by competent of the cold start and testing of stored or the cold start and testing are in the cold start and a discally exercising the cold testing are maintained of the cold testing are maintained of the cold start and the cold st	K 091		what corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; Maintenance will conduct wee exercise, monthly load test, per Tels PM program. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the fact have the potential to be affected by alleged deficient practice.	nts y the kly er e cility ed.	09/21/2022

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 53 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022	
	NAME OF PROVIDER OR SUPPLIER EVERGREEN CROSSING AND THE LOFTS			5404 GI	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD APOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: Based on record review with the Maintenance Assistant on 08/22/22 at 9:59 a.m., documentation for weekly generator testing for 52 of the last 52-week period was not available for review. Based on interview at the time of record review, the Maintenance Assistant stated that he was only the Assistant and that he could not reach the Maintenance Director by text message or phone to locate the necessary current documentation. During the exit conference with the Divisional Facilities Manager and the Maintenance			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not rec Maintenance Director was educated on Generator testing Tels PM. Maintenance will pro testing documentation to QAP monthly review. how the corrective action(s) wi monitored to ensure the deficie	ges e ur; g per vide I for ill be ent	(X5) COMPLETION DATE
	evidence could be predeficient finding. 3.1-19(b) 2) Based on record facility failed to man of monthly generated 12 months. Chapter requires monthly te the emergency elect accordance with NI Emergency and States. NFPA 110 8.4.2 service to be exercing minimum of 30 min 99 requires a writte performance, exercing generator to be regular for inspection by the jurisdiction. This described in the performance of t	eficient practice could affect all			practice will not recur, i.e., what quality assurance program will put into place; and Executive Director or designed monitor generator testing monthly. Then monthly for continuous compliance. by what date the systemic changes for each deficiency who be completed. September 21, 2022	be will	

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet Page 54 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		A. BUILDING B. WING	01	COMPI	COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIER		5404	ET ADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD		
EVERG	REEN CROSSING A	AND THE LOFTS	INDI	ANAPOLIS, IN 46254		
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	Assistant on 08/22/for monthly general 12-month period will be assed on interview the Maintenance Assistant at Maintenance Direct to locate the necess During the exit confacilities Manager Assistant at 2:15 periodence could be provided to deficient finding. 3.1-19(b) 3) Based on record facility failed to enswas performed for generator. NFPA 92012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect Findings include: Based on record reverse Assistant on 08/22/of an annual fuel quenerator was avail interview at the time.	22 at 9:59 a.m., documentation tor testing for 12 of the last as not available for review. at the time of record review, ssistant stated that he was and that he could not reach the tor by text message or phone ary current documentation. ference with the Divisional and the Maintenance m., no additional information or provided contrary to this review and interview, the sure an annual fuel quality test the facility's diesel-powered P., Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient				

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

Event ID:

J5YA21

Facility ID: 013280

If continuation sheet

Page 55 of 56

PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155826		` ′	ILDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/22/2022		
NAME OF PROVIDER OR SUPPLIER EVERGREEN CROSSING AND THE LOFTS			STREET ADDRESS, CITY, STATE, ZIP COD 5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF		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
	unaware of the need	for an annual fuel quality test					
	on the diesel genera	tor and stated that if the					
	documentation was	not in the logbook provided,					
	he had no idea wher	e it would be located. During					
	the exit conference	with the Divisional Facilities					
	Manager and the Manager	aintenance Assistant at 2:15					
	p.m., no additional i	information or evidence could					
	be provided contrar	y to this deficient finding.					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J5YA21 Facility ID: 013280 If continuation sheet Page 56 of 56