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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		JILDING	NSTRUCTION	(X3) DATE COMPL 01/21/	ETED
	ROVIDER OR SUPPLIER	JRSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
E 0000	REGULATORT OR	LISC IDENTIFY THOU INFORMATION		IAG			DATE
Bldg	conducted by the In- Health in accordanc Survey Date: 01/21		E 0	000			
	Ridge Village Nursi found not in complic Preparedness Require Medicaid Participati CFR 483.73	Preparedness survey, Northing & Rehabilitation Center was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 43.					
E 0004 SS=C Bldg	484.102(a), 485.62 485.727(a), 485.92 491.12(a), 494.62(Develop EP Plan, Annually The [facility] must Federal, State and preparedness requ must develop esta comprehensive en	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a), (a) Review and Update					

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

TITLE

(X6) DATE

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155763		UILDING	INSTRUCTION	COMPL 01/21/	ETED
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CE	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The emergency princlude, but not be elements: (a) Emergency Pladevelop and main preparedness planand updated at least and updated at l	reparedness program must a limited to, the following an. The [facility] must tain an emergency at that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or ap and maintain a mergency preparedness ts the requirements of this an all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed and innually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years. It will be reviewed the facility updated the Emergency	E 0		what corrective action(s) will b accomplished for those reside	e nts	
	accordance with 42 practice could affect	EEP) at least annually in CFR 483.73(a). This deficient t all occupants.			found to have been affected b deficient practice; No residents will be affected this alleged deficient practic	by	
	Findings include: Based on review of	the facility's Emergency EEP			how other residents having the potential to be affected by the	е	

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Event ID:

K3VX21 Facility ID: 011296

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION	(X3) DATE COMPL 01/21/	ETED
	PROVIDER OR SUPPLIER	JRSING & REHABILITATION CEN	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(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)	ATE	(X5) COMPLETION DATE
	with the Administra on 01/21/20 at 11:0 documentation coul EEP was reviewed a on an interview dur Administrator stated in the last year but of	tor and Maintenance Director 0 a.m. and at 3:00 p.m., no d be provided to show the and updated annually. Based ing records review, the d the EEP has been reviewed			same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility have the potential to affected. No residents will be affected by this alleged deficient practice. Emergen Preparedness Policy and Procedure was reviewed on 1/17/2019. Emergency Preparedness Policy and Procedure will be reviewed and up-dated if warranted. what measures will be put interplace and what systemic chawill be made to ensure that the deficient practice does not remain the made to ensure that the deficient practice does not remain the made to ensure that the deficient practice does not remain the made to ensure that the deficient practice does not remain the made to ensure that the deficient practice does not remain the made to ensure the facility's Emergency Preparedness Plan. The facility's Emergency Preparedness Plan will be reviewed and up-dated as warranted. The Emergency Preparedness Plan annual review will be added to the facilities QAPI meeting agent to occur in January of each preceding year. 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 or designee will monitor the	o nges ne cur;	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		UILDING	ONSTRUCTION	(X3) DATE COMPL 01/21	ETED
	PROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(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 DEFICIENCY)	IATE	(X5) COMPLETION DATE
					Emergency Preparedness F annually ongoing and polic and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has be achieved for three consecureviews and plan will be adjusted accordingly.	y een	
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E (b) Policies and pidevelop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The polici	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures rocedures. [Facilities] must					
	and procedures. In develop and imple preparedness police on the emergency (a) of this section, paragraph (a)(1) of communication placetion. The police be reviewed and the development of the police of the procedure of the police of the polic	s at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, based or 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. ties at §494.62(b):] Policies					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155763	B. WI	_		01/21	/2020
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
NORTH I	RIDGE VILLAGE N	URSING & REHABILITATION CE	ENTE		AIL RIDGE RD N, IN 46701		
(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 APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	1	The dialysis facility must					
		ement 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 every 2					
		rgencies include, but are					
	1 -	equipment or power					
		ted emergencies, water					
		n, and natural disasters					
		he facility's geographic					
	area.						
	Based on record rev	view and interview, the facility	E 00)13	what corrective action(s) will be	е	02/20/2020
	failed to annually re	eview and update the			accomplished for those resider	nts	
	Emergency Prepare	edness Plan (EPP) policies and			found to have been affected by	/ the	
		olicies and procedures must be			deficient practice;		
	_	ted at least annually in			No residents will be affected	-	
		CFR 483.73(a). This deficient			this alleged deficient practice).	
	practice could affect	et all occupants.					
					how other residents having the	Э	
	Findings include:				potential to be affected by the		
	Danad an over of	anion afaba facilia la EED 141			same deficient practice will be		
		eview of the facility's EEP with			identified and what corrective		
		irector and Administrator on			action(s) will be taken;		
		.m. and 3:00 p.m., no provided for review to show			All residents residing in the	20	
		and procedures were reviewed			facility have the potential to be affected. No residents will be		
		ly. Based on an interview			affected by this alleged		
		ew, the Administrator stated			deficient practice. Emergency	v	
		eviewed in the last year but			Preparedness Policy and	,	
		locumentation to show the			Procedure was reviewed on		
		procedures were reviewed			1/17/2019. Emergency		
	annually.	•			Preparedness Policy and		
					Procedure will be reviewed		
					and updated as warranted by	,	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION	(X3) DATE COMPI 01/21	LETED
	PROVIDER OR SUPPLIER	JRSING & REHABILITATION CEN	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(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) what measures will be put interplace and what systemic char will be made to ensure that the deficient practice does not recommended. Maintenance Director was re-educated regarding annumerous should be sho	o nges ne cur;	(X5) COMPLETION DATE
					review of the Emergency Preparedness Plan. The facility's Emergency Preparedness Plan will be reviewed and updated as warranted by 2/20/2020. The Emergency Preparedness P annual review will be added the facilities QAPI meeting agenda to occur in January	lan to	
					each preceding year. how the corrective action(s) be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place Maintenance Director or designee will monitor the Emergency Preparedness Pannually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has be achieved for three consecut reviews and plan will be adjusted accordingly.	will ir, ; and lan /	
E 0015 SS=C Bldg	(1), 482.15(b)(1), 4 485.625(b)(1) Subsistence Need	8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), s for Staff and Patients rocedures. [Facilities]					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		UILDING	NSTRUCTION	COM	e survey pleted 1/2020
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CE	ENTE	600 TRA	ODDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	must develop and preparedness police on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The police be reviewed and use (annually for LTC) policies and procest following: (1) The provision of staff and patients shelter in place, into the following: (i) Food, water pharmaceutical suse (ii) Alternate is maintain the follow (A) Temphealth and safety sanitary storage of (B) Emer (C) Fire of alarm systems. (D) Seward *[For Inpatient Hose Policies and procest (G) The following and procest (G) The following and procest (G) The policies address the follow (iii) The provision hospice employs they evacuate or sare not limited to the communication of the provision of the p	implement emergency dicies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this dies and procedures must updated every 2 years or At a minimum, the edures must address the of subsistence needs for whether they evacuate or include, but are not limited er, medical and upplies sources of energy to wing: detection, extinguishing, and for the safe and of provisions. regency lighting. detection, extinguishing, and detection, extinguishing, and age and waste disposal. spice at §418.113(b)(6)(iii):] edures. are additional requirements ted inpatient care facilities or and procedures must ving: sion of subsistence needs yees and patients, whether shelter in place, include, but the following: , water, medical, and					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155763	B. WI	NG		01/21/	2020
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CEN	ITE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAU	(B) Altern maintain the follow (1) T patient health and sanitary storage or (2) E (3) F and alarm systems (C) Sewa Based on record reversided to ensure Emergery include at a magnetic state of they evacuate or should be also be a provisions; (B) Emergery and for the same provisions; (B) Emergery and substitute and the same provisions include: Based on records rethe Maintenance Director of the Maintenance Director of the Maintenance of th	nate sources of energy to ving: Temperatures to protect safety and for the safe and f provisions. Emergency lighting. Fire detection, extinguishing, s. age and waste disposal. view and interview, the facility ergency Preparedness Plan ininimum, (1) The provision of or staff and residents, whether elter in place, include, but are allowing: (i) Food, water, accutical supplies. (ii) f energy to maintain - (A) object resident health and afe and sanitary storage of ergency lighting; (C) Fire thing, and alarm systems; and ste disposal in accordance (3(b)(1). This deficient practice	E 00		what corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; No residents will be affected this alleged deficient practice will 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 la affected. No residents will be affected by this alleged deficient practice. Policy and Procedure for sewage and waste disposal outage has be implemented and added to the facility's Emergency Preparedness Plan. what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recomplemented over the implementation of the Policy and Procedure for sewage and pro	nts y the by e. ne ges eur;	02/20/2020

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	· /	JILDING	ONSTRUCTION 	(X3) DATE S COMPLE 01/21/2	ETED
	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701	0112112	-020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY 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	REGULATORY O	R LSC IDENTIFYING INFORMATION		IAG	waste disposal outage. Police and Procedure for sewage at waste disposal outage has be implemented and added to the facility's Emergency Preparedness Plan. how the corrective action(s) who be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place. Maintenance Director or designee will monitor the Emergency Preparedness Plan.	nd ne he vill r,	DATE
					annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has be achieved for three consecutiveviews and plan will be adjusted accordingly.	een	
E 0025 SS=F Bldg	482.15(b)(7), 483 485.625(b)(7), 48 Arrangement with [(b) Policies and preparedness pole on the emergency (a) of this section paragraph (a)(1) communication placetion. The policies be reviewed and years (annually for	8.113(b)(5), 441.184(b)(7), .475(b)(7), 483.73(b)(7), 5.920(b)(6), 494.62(b)(6) Other Facilities procedures. The [facilities] I implement 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 or LTC).] At a minimum, the edures must address the					

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DEPARTMENT OF HEALTH AND HUM	MAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	COMPLETED
	155763	B. WI	NG	01/21/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF FROVIDER OR SOFFLIER			600 TRAIL RIDGE RD	
NORTH RIDGE VILLAGE NI	IRSING & REHABILITATION CEN	TE	AL BION IN 46701	

X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	following:]				
	*[For Hospices at §418.113(b), PRFTs at				
	§441.184,(b) Hospitals at §482.15(b), and				
	LTC Facilities at §483.73(b):] Policies and				
	procedures. (7) [or (5)] The development of				
	arrangements with other [facilities] [and]				
	other providers to receive patients in the event				
	of limitations or cessation of operations to				
	maintain the continuity of services to facility				
	patients.				
	*[For PACE at §460.84(b), ICF/IIDs at				
	§483.475(b), CAHs at §486.625(b), CMHCs				
	at §485.920(b) and ESRD Facilities at				
	§494.62(b):] Policies and procedures. (7) [or				
	(6), (8)] The development of arrangements				
	with other [facilities] [or] other providers to				
	receive patients in the event of limitations or				
	cessation of operations to maintain the				
	continuity of services to facility patients.				
	*[For RNHCIs at §403.748(b):] Policies and				
	procedures. (7) The development of				
	arrangements with other RNHCIs and other				
	providers to receive patients in the event of				
	limitations or cessation of operations to				
	maintain the continuity of non-medical				
	services to RNHCl patients. Based on record review and interview, the facility	E 0025	what corrective action(s) will be	02/20/2024	
	failed to Emergency Preparedness Plan (EEP)	E 0025	what corrective action(s) will be	02/20/2020	
	include the development of arrangements with		accomplished for those residents found to have been affected by the		
	other LTC facilities and other providers to receive		deficient practice;		
	residents in the event of limitations or cessation		No residents will be affected by		
	of operations to maintain the continuity of		this alleged deficient practice.		
	services to LTC residents in accordance with 42		and unoged demoining processes.		
	CFR 483.73(b)(7). This deficient practice could		how other residents having the		
	affect all occupants.		potential to be affected by the		
	^		same deficient practice will be		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155763	B. WING 01/21/2			/2020	
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CEN	TE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(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	ιΤΕ	(X5) COMPLETION
TAG	Based on records re the Maintenance Di 01/21/20 at 11:32 a of arrangements wire other providers to re of limitations or cessavailable for review Based on an interview Administrator stated places to go in the enot confirmed agree facilities. The Administrators were agreements withe previous Administrators.	eview of the facility's EEP with rector and Administrator on a.m. and 3:00 p.m., development the other LTC facilities and exceive residents in the event exaction of operations was not a during the time of survey. Ew during records review, the distribution of an evacuation but has exements with other LTC inistration also stated, there with other LTC facilities made by inistrator but did not know who is with or the location of the		TAG	action(s) will be taken; All residents residing in the facility have the potential to affected. No residents will be affected by this alleged deficient practice. North Ridge Village does have arrangements with other providers to receive resident in the event of limitations or cessations of operations. Written mutual aide agreements have been developed and are signed by North Ridge Village and receiving facility. what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recommended to the policy and procedure regarding mutual aid agreements. Written mutual aid agreements have been developed and are signed by North Ridge Village and receiving facility. how the corrective action(s) where the deficient practice will not recurred to ensure the deficient practice will not recurred. What quality assurance program will be put into place: Maintenance Director or designee will monitor the Emergency Preparedness Plannally oppoint and policy and policy.	be ge ts ooges e cur;	DATE

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and procedures will be

OLIVIERS I OI	t MEDICINE & MEDIC	I SERVICES	_			U	10.00000
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155763			JILDING		COMPLETED		
		155763	B. W	ING		01/21	/2020
	PROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
E 0029 SS=C	403.748(c), 416.5 441.184(c), 482.1				up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has be achieved for three consecuti reviews and plan will be adjusted accordingly.		
Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C (c) The [facility] m an emergency pre plan that complies local laws and mu at least every 2 ye Based on record rev failed to annually re Emergency Prepare communication plan State, and local laws	41.184(c), 482.15(c), 483.475(c), 483.73(c), 84.102(c), 485.625(c), 485.68(c), 85.727(c), 485.920(c), 486.360(c), 91.12(c), 494.62(c) Development of Communication Plan a) The [facility] must develop and maintain in emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). Based on record review and interview, the facility aniled to annually review and update the Emergency Preparedness Plan (EPP) communication plan that complies with Federal, tate, and local laws in accordance with 42 CFR 83.73(c). This deficient practice could affect all		029	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; No residents will be affected this alleged deficient practice.	ents by the	02/20/2020
	the Maintenance Di 01/21/20 at 11:30 a documentation was	view of the facility's EEP with rector and Administrator on .m. and 3:00 p.m., no provided for review to show			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 facility have the potential to	be	
	updated annually. E records review, the has been reviewed i find the documenta	cation plan was reviewed and Based on an interview during Administrator stated the EEP on the last year but could not tion to show the EPP's a was reviewed annually.			affected. No residents will be affected by this alleged deficient practice. The facilit communication plan has bee updated to include a method for sharing information and	y's en	

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Facility ID: 011296

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medical documentation for

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC	_				OM	B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION	(X3) DATE : COMPL 01/21/	ETED
	ROVIDER OR SUPPLIER	URSING & REHABILITATION CE	ENTE	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	residents to other LTC facilit	ies.	DATE
					what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recommendated over the requirements of the facility's communication plan. The facility's communication plan. The facility's communication plan has been updated to include method for sharing information and medical documentation residents to other LTC facility. The monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance Director or designee will monitor the Emergency Preparedness Plannually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPl committee until 100% has be achieved for three consecution reviews and plan will be adjusted accordingly.	ges e eur; n a ion for ies. vill and an	
E 0032 SS=C Bldg	441.184(c)(3), 482 483.73(c)(3), 484	5.54(c)(3), 418.113(c)(3), 2.15(c)(3), 483.475(c)(3), 102(c)(3), 485.625(c)(3), 727(c)(3), 485.920(c)(3),					

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486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 01/21/2020 155763 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 TRAIL RIDGE RD NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE **ALBION. IN 46701** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility E 0032 what corrective action(s) will be 02/20/2020 failed to ensure the Emergency Preparedness Plan accomplished for those residents (EPP) communication policy included (3) Primary found to have been affected by the and alternate means for communicating with the deficient practice; following: (i) LTC facility's staff (ii) Federal, State, No residents will be affected by tribal, regional, or local emergency management this alleged deficient practice. agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. how other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on records review of the facility's EEP with action(s) will be taken; the Maintenance Director and Administrator on All residents residing in the 01/21/20 at 11:30 a.m. and 3:00 p.m., the EPP facility have the potential to be

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found.

communication plan provided did not address

primary and alternate means for communication.

Based on interview at the time of record review,

means for communication policy could not be

the Administrator stated the primary and alternate

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affected. No residents will be

deficient practice. The facility's

communication plan has been

updated to address primary

affected by this alleged

and alternate means for

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO FUILDING VING	ONSTRUCTION	COME	E SURVEY PLETED 1/2020
	PROVIDER OR SUPPLIER RIDGE VILLAGE N	URSING & REHABILITATION CE	ENTE	STREET A 600 TR ALBION	D		
(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 CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
					what measures will be place and what systemic will be made to ensure the deficient practice does in Maintenance Director re-educated over the requirements of the factommunication plan. The facility's communication has been updated to adprimary and alternate in for communication. how the corrective action be monitored to ensure the deficient practice will not i.e., what quality assurant program will be put into plantenance Director of designee will monitor the Emergency Prepared in annually ongoing and plantenance of progress will be updated as warranted. The report of progress will be updated to the QAPI committee until 100% in achieved for three constreviews and plan will be adjusted accordingly.	c changes nat the ot recur; illity's he in plan Idress neans n(s) will the c recur, nce place; and ir he ess Plan policy A be has been secutive	
E 0033 SS=C Bldg	(4)-(6), 441.184(c 483.475(c)(4)-(6), (4)-(5), 485.625(c	416.54(c)(4)-(6), 418.113(c) 0(4)-(6), 482.15(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c) 0(4)-(6), 485.68(c)(4), 5.920(c)(4)-(6), 491.12(c)(4),					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155763	B. Wl	ING		01/21/	/2020
	PROVIDER OR SUPPLIER	RENABILITATION CEI	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	BROWDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Methods for Shari	ing Information					
	-	nust develop and maintain					
		eparedness communication					
	1 '	s with Federal, State and					
		ist be reviewed and updated					
	1	ears (annually for LTC).]					
		on plan must include all of					
	the following:						
	(4) A method for s	sharing information and					
	1	tation for patients under the					
		necessary, with other					
		o maintain the continuity of					
	care.						
	release patient inf under 45 CFR 16- provision is not re §484.102(c), COF (6) [(4) or (5)]A m	ne event of an evacuation, to formation as permitted 4.510(b)(1)(ii). [This quired for HHAs under RFs under §485.68(c)] eans of providing information condition and location of					
	_	e [facility's] care as					
	_ ·	5 CFR 164.510(b)(4).					
	*[For RNHCIs at § for sharing inform documentation for care, as necessar maintain the continuitten election st	§403.748(c):] (4) A method					
	means of providin general condition under the facility's CFR 164.510(b)(4	Os at §491.12(c):] (4) A ag information about the and location of patients acare as permitted under 45 and interview, the facility	E 00	033	what corrective action(s) will b	e	02/20/2020

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155763		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/21/2020		
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	E RIATE	(X5) COMPLETION DATE	
TAG	failed to ensure the (EPP) communication method for sharing documentation for a facility's care, as ne providers to mainta means, in the event resident information 164.510(b)(1)(ii); (i information about the location of resident permitted under 45 accordance with 42 deficient practice of the Maintenance Di 01/21/20 at 11:30 a communication plans sharing information for residents under necessary, with other maintain the continuinterview at the tim Administrator states information and metaling information and information a	Emergency Preparedness Plan on policy included (4) A information and medical residents under the LTC cessary, with other health care in the continuity of care; (5) A of an evacuation, to release a spermitted under 45 CFR (5) A means of providing the general condition and sunder the facility's care as CFR 164.510(b)(4) in CFR 483.73(c)(4). This build affect all occupants. The eview of the facility's EEP with rector and Administrator on a.m. and 3:00 p.m., the EPP and did not include a method for and medical documentation the LTC facility's care, as the er health care providers to uity of care. Based on the of record review, the did the method for sharing dical documentation for TC facilities policy could not		TAG	accomplished for those reside found to have been affected deficient practice; No residents will be affected this alleged deficient practice will 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 affected. No residents will affected by this alleged deficient practice. The facilic communication plan has be updated to include a method for sharing information and medical documentation for residents to other LTC facility be made to ensure that the deficient practice does not remain the facility's communication plan. The facility's communication plan. The facility's communication plan. The facility's communication plan. The facility's communication plan and medical documentation residents to other LTC facility communication plan. The facility's communication plan information method for sharing information	by the d by ice. he e e be be ity's een od i lities. hto anges he ecur; 's an le a ation n for lities. will	DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION	COMI	E SURVEY PLETED 1/2020
	PROVIDER OR SUPPLIER RIDGE VILLAGE NI	URSING & REHABILITATION C	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP O AIL RIDGE RD N, IN 46701	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 0034 SS=C Bldg	403.748(c)(7), 416 441.184(c)(7), 484 483.73(c)(7), 484. 485.68(c)(5), 494. Information on Oc [(c) The [facility] m an emergency pre plan that complies local laws and mu at least every 2 ye The communication the following: (7) [(5) or (6)] A m information about needs, and its abi to the authority ha Incident Comman *[For ASCs at 416 providing informat	6.54(c)(7), 418.113(c)(7), 2.15(c)(7), 483.475(c)(7), 102(c)(6), 485.625(c)(7), 727(c)(5), 485.920(c)(7), 62(c)(7) cupancy/Needs nust develop and maintain eparedness communication with Federal, State and st be reviewed and updated ears (annually for LTC).] on plan must include all of			program will be put int Maintenance Director designee will monitor Emergency Prepared annually ongoing and and procedures will to up-dated as warrante report of progress wi forwarded to the QAF committee until 100% achieved for three co reviews and plan will adjusted accordingly	r or r the lness Plan d policy be ed. A ill be Pl 6 has been onsecutive be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155763	B. W	ING		01/21/2020	
	PROVIDER OR SUPPLIER	JRSING & REHABILITATION CEN	ITE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
	*[For Inpatient Homeans of providing hospice's inpatient its ability to provid	spice at §418.113(c):] (7) A g information about the t occupancy, needs, and e assistance, to the					
	Command Center Based on record rev failed to ensure the (EPP) communicati providing informati occupancy, needs, a assistance, to the au the Incident Comma accordance with 42 deficient practice co Findings include: Based on records re the Maintenance Di 01/21/20 at 11:30 a. EPP communication of providing inform occupancy, needs, a assistance to the aut the Incident Comma on interview at the of during exit conferer through the EPP and addressed a means of	wiew and interview, the facility Emergency Preparedness Plan on policy included a means of on about the LTC facility's and its ability to provide thority having jurisdiction or and Center, or designee in CFR 483.73(c)(7). This build affect all occupants. View of the facility's EEP with rector and Administrator on m. and 3:00 p.m., the provided a plan did not address a means ation about the LTC facility's and its ability to provide chority having jurisdiction or and Center, or designee. Based time of records review and ance, the Administrator looked did could not find a plan that of providing information about ecupancy, needs, and its ability	E 0	034	what corrective action(s) will be accomplished for those reside found to have been affected by deficient practice; No residents will be affected this 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 facility have the potential to affected. No residents will be affected by this alleged deficient practice. The facility communication plan has been updated to include a means providing information about the facility's occupancy, need and its ability to provide assistance. what measures will be put interplace and what systemic chant will be made to ensure that the deficient practice does not recommunicated over the requirements of the facility's	ents by the liby e. e be e y's en for eds,	02/20/2020

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	OF CORRECTION	IDENTIFICATION NUMBER 155763		UILDING	INSTRUCTION	COMPL 01/21/	ETED
	ORTH RIDGE VILLAGE NURSING & REHABILITATION CE 4) ID SUMMARY STATEMENT OF DEFICIENCIE		NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(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
					communication plan. The facility's communication plan has been updated to include means for providing information about the facility occupancy, needs, and its ability to provide assistance how the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place; and Maintenance Director or designee will monitor the Emergency Preparedness Plannually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has be achieved for three consecution reviews and plan will be adjusted accordingly.	a y's ill be ent at Il be	
E 0036 SS=F Bldg	484.102(d), 485.62 485.727(d), 485.92 491.12(d), 494.62(EP Training and T *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs at §486.360, RHC/FH	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting 403.748, ASCs at §416.54, 13, PRTFs at §441.184, Hospitals at §482.15, , CORFs at §485.68, i, "Organizations" under at §485.920, OPOs at					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	r í	UILDING	NSTRUCTION	COMI	E SURVEY PLETED 1/2020
	PROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	preparedness train that is based on the in paragraph (a) of assessment at passection, policies and (b) of this section, plan at paragraph training and testing reviewed and updd *[For LTC at §483 testing. The LTC maintain an emergency plan is this section, risk and (a)(1) of this section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plan is this section, risk and testing program emergency plan is the section, risk and testing program emergency plan is this section, risk and (a)(1) of this section is section. The train must be reviewed an emergency plan is this section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section. The train must be reviewed an emergency plan is the section in the section	ragraph (a)(1) of this nd procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. 73(d):] (d) Training and facility 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 483.475(d):] Training and 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 et forth in paragraph (c) 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					

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	XI) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155763			MULTIPLE CO BUILDING VING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/21/2020	
	PROVIDER OR SUPPLIER	URSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(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)	ATE	(X5) COMPLETION DATE
	dialysis facility mule emergency preparand patient orienta on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the community of this section. The orientation programupdated at every 2 Based on record revisited to develop an Preparedness Plan (program that is base accordance with 42 practice could affect Findings include: Based on records rethe Maintenance Di 01/21/20 at 11:30 and not include a training on interview at the stagain at the exit constated the facility has	view and interview, the facility d maintain an Emergency EPP) training and testing ed on the emergency plan CFR 483.73(d). This deficient	EO	0036	what corrective action(s) will accomplished for those reside found to have been affected the deficient practice; No residents will be affected this alleged deficient practice will 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 affected. No residents will be affected by this alleged deficient practice. The facilit training and testing program has been added to the Emergency Preparedness P what measures will be put in place and what systemic chain will be made to ensure that the deficient practice does not recompared the facility's training and testing program. The	ents by the d by ce. he e ty's n lan. nto nges he cur;	02/20/2020

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	NSTRUCTION	(X3) DATE COMPI 01/21	
	ROVIDER OR SUPPLIER RIDGE VILLAGE NI	JRSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701	•	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
					facility's training and testi program has been added to Emergency Preparedness	to the	
					how the corrective action(s) be monitored to ensure the deficient practice will not re i.e., what quality assurance program will be put into plan Maintenance Director or designee will monitor the Emergency Preparedness annually ongoing and policand procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has achieved for three consecutives and plan will be adjusted accordingly.	cur, ce; and Plan cy been	
E 0037 SS=F Bldg	441.184(d)(1), 482. 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 496 EP Training Progr *[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) T [facility] must do a	am 403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, t, "Organizations" under at §486.360, RHC/FQHCs raining program. The					

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	NT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		UILDING	NSTRUCTION	(X3) DATE COMPL 01/21	ETED
	PROVIDER OR SUPPLIEF	R URSING & REHABILITATION CE	ENTE	600 TRA	DDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	(ii) Provide er training at least ex (iii) Maintain of emergency prepa (iv) Demonstre emergency procedupdated, the [facilion the updated proparedness polinew and existing individuals preparedness procedures in training at least existing provide extraining at least existing provides (including provides) (iv) Periodical emergency prepared emergency p	mergency preparedness very 2 years. documentation of all redness training. rate staff knowledge of dures. ergency preparedness edures are significantly lity] must conduct training policies and procedures. §418.113(d):] (1) Training. It do all of the following: ing in emergency icies and procedures to all hospice employees, and roviding services under resistent with their expected ate staff knowledge of dures. emergency preparedness every 2 years. Illy review and rehearse its redness plan with hospice ding nonemployee staff), hasis placed on carrying out excessary to protect patients documentation of all		TAG	DEFICIENCY)		DATE
		edures are significantly					
		pice must conduct training					
	on the updated p	policies and procedures.					
	program. The PR following:	141.184(d):] (1) Training TF must do all of the ing in emergency					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155763	B. WING		01/21/2020
NAME OF P	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	
NODTU		LIDOING & DELIADU ITATION OF		AIL RIDGE RD	
NOKIHI	NIDGE VILLAGE N	URSING & REHABILITATION CEN	ALBION	N, IN 46701	
(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)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	1 ' '	icies and procedures to all			
	_	staff, individuals providing er arrangement, and			
		stent with their expected			
	roles.	sterit with their expected			
		I training, provide			
	1 ' '	redness training every 2			
	years.	3 ,			
	(iii) Demonstr	rate staff knowledge of			
	emergency proce	dures.			
	(iv) Maintain	documentation of all			
	emergency prepa	redness training.			
	1 ' '	rgency preparedness			
	1 '	edures are significantly			
	I	F must conduct training on			
	the updated p	policies and procedures.			
	*[For LTC Facilitie	es at §483.73(d):] (1)			
	_	. The LTC facility must do all			
	of the following:				
	(i) Initial traini	ing in emergency			
		icies and procedures to all			
	_	staff, individuals providing			
		er arrangement, and			
		stent with their expected			
	role.				
	, ,	mergency preparedness			
	training at least ar	documentation of all			
	emergency prepa				
	1	rate staff knowledge of			
	emergency proce	_			
	*[For CORFs at §-	485.68(d):](1) Training. The			
	CORF must do all	of the following:			
	` '	tial training in emergency			
	1	icies and procedures to all			
	new and existing				
	I providing ser	vices under arrangement	1	1	

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and volunteers, consistent with their

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155763	A. BU B. W	JILDING ING		COMPL 01/21/	
		155763	B. W.	ing	_	01/21/	2020
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
NODTIL					AIL RIDGE RD		
NORTH	RIDGE VILLAGE N	URSING & REHABILITATION CEN	NIE	ALBION	I, IN 46701		
(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
	expected roles.						
		mergency preparedness					
	training at least ev	documentation of the					
	training.	documentation of the					
		rate staff knowledge of					
		dures. All new personnel					
		and assigned specific					
		es regarding the CORF's					
		vithin 2 weeks of their first					
	workday. The train	ning program must include					
	instruction in the le	ocation and use of alarm					
	systems and signa	als and firefighting					
	equipment.						
		ergency preparedness					
		edures are significantly					
	-	RF must conduct training on					
	the updated p	policies and procedures.					
	 *[For CAHs at §48	35.625(d):] (1) Training					
	-	H must do all of the					
	following:						
	(i) Initial traini	ing in emergency					
	preparedness poli	icies and procedures,					
		eporting and extinguishing					
	· •	on, and where necessary,					
		ents, personnel, and					
		ntion, and cooperation with					
		nd disaster authorities, to all					
	_	staff, individuals providing					
	services under an	•					
	roles.	onsistent with their expected					
		mergency preparedness					
	training at least ev						
		documentation of the					
	training.						
	_	rate staff knowledge of					
	emergency proced	•					
		ergency preparedness					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPI	LETED
		155763	B. W	NG		01/21	/2020
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			AIL RIDGE RD		
NORTH	RIDGE VII I AGE N	URSING & REHABILITATION CEN	ITF	1	N, IN 46701		
NOITH		OKSING & KEHABIEHATION CEL	· · · ·	ALDIOI	· · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	policies and proce	edures are significantly					
	updated, the CAH	I must conduct training on					
	the updated	policies and procedures.					
	*[For CMHCs at §	3485.920(d):] (1) Training.					
	The CMHC must	provide initial training in					
	emergency prepa	redness policies and					
	procedures to all	new and existing staff,					
	individuals provid	ing services under					
	arrangement, and	l volunteers, consistent with					
	their expected rol	es, and maintain					
	documentation of	the training. The CMHC					
	must demonstrate	e staff knowledge of					
	emergency proce	dures. Thereafter, the					
	CMHC must prov	ide emergency					
		ining at least every 2 years.					
		view and interview, the facility	E 00)37	what corrective action(s) will	be	02/20/2020
		nnual training for the			accomplished for those reside	nts	
		edness Program (EPP). The LTC			found to have been affected b	y the	
	-	of the following: (i) Initial			deficient practice;		
		ncy preparedness policies and			No residents will be affected	by	
	-	ew and existing staff,			this alleged deficient practic	e.	
		ng services under arrangement,					
	-	nsistent with their expected			how other residents having th		
		emergency preparedness			potential to be affected by the		
		nually; (iii) Maintain			same deficient practice will be)	1
		ill emergency preparedness			identified and what corrective		
		onstrate staff knowledge of			action(s) will be taken;		
		ures in accordance with 42 CFR			All residents residing in the		
		deficient practice could affect			facility have the potential to		
	all residents in the	facility.			affected. No residents will be	}	1
					affected by this alleged		
	Findings include:				deficient practice. The facilit	-	
					training and testing program	1	
		eview of the facility's EEP with			has been added to the		
		irector and Administrator on			Emergency Preparedness Pl	an.	
		n.m. and 3:00 p.m., no					
		innual EEP training, and no			what measures will be put into		
		how staff could demonstrate			place and what systemic char	-	
	knowledge of the E	EPP was available for review.			will be made to ensure that the	е	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/21/2020
	PROVIDER OR SUPPLIER	JRSING & REHABILITATION CEN	600 TF	ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD N, IN 46701	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	review, the Adminis	ew at the time of records strator stated documentation of ining could be found		deficient practice does not re Maintenance Director educa regarding the facility's train and testing program. The facility's training and testing program has been added to Emergency Preparedness P how the corrective action(s) be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place Maintenance Director or designee will monitor the Emergency Preparedness P annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has b achieved for three consecut reviews and plan will be adjusted accordingly.	eted ing g the Plan. will ur, e; and Plan y
K 0000					
Bldg. 01	Licensure Survey w	11296 155763	K 0000		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763		JILDING	nstruction 01	(X3) DATE COMPL 01/21 /	ETED
	ROVIDER OR SUPPLIER	URSING & REHABILITATION CEN	ITE	600 TRA	DDRESS, CITY, STATE, ZIP COD AIL RIDGE RD I, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Village Nursing & I found not in compli Participation in Med Subpart 483.70(a), I 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type V (111) constructions and detectors in the resist separated from an a Residential Care Fa 2-hour fire resistance capacity of 77 beds of this survey.						
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used						

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STATEM	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155763	B. WI	NG		01/21/	/2020
	F PROVIDER OR SUPPLIEF	L R URSING & REHABILITATION CEN	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701	<u> </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	· ·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	
TAG	* cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2 cooking facilities with 30 or fewer productions under a cooking facilities with 30 or fewer productions under a cooking facilities NFPA 96 per 9.2.3 cooking facil	R LSC IDENTIFYING INFORMATION sopen to the corridor in ents with 30 or fewer with the conditions under 1.5.3, or so in smoke compartments wateries comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not redous areas, but shall not redous areas, and interview, the facility of were instructed in the use of externion 1 of 1 Kitchen. NFPA structions for manually extinguishing system shall be ally in the kitchen and shall be loyees by management. This bould affect staff in the kitchen	K 0:	TAG	CROSS-REFERENCED TO THE APPROPRIA	be ents by the liby e. e be e	02/20/2020

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION 01	(X3) DATE COMPI 01/21	LETED
	ROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
	3.1-19(b)				the need to ensure kitchen are periodically re-educate over the use of the UL 300 system. All new hires for the kitchen will be educated during orientation regarding the UL 300 hood system ongoing. Dietary Manager/Designee to educated all kitchen staff regarding the UL 300 hood system quarted on-going. Maintenance Director/Designee to educated all staff annually regarding UL 300 hood system ongoing. Maintenance Director/Designee to educated all staff annually regarding UL 300 hood system ongoing. We will not receive, what quality assurance program will be put into place Maintenance Director to monitor UL 300 hood system ongoing unarterly for 4 quarters, then annually thereafter. Any negative findings will be corrected immediately and forwarded the Administrator. A report progress will be forwarded the QAPI Committee month on-going in which plan will adjusted accordingly.	d hood le g g ate he erly tte the ng. will ur, e: m	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm Systen Maintenance Fire Alarm Systen Maintenance A fire alarm systen	-					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	IULTIPLE CO UILDING 'ING	ONSTRUCTION 01	COMP	ESURVEY LETED 1/2020
	PROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	ENTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	complying with the National Electric Continual Elec	FPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ections shall be performed in e schedules in Table 14.3.1, or eed by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors (e.g. duct detectors, manual eat detectors, smoke detectors,	K	0345	what corrective action(s) will accomplished for those reside found to have been affected deficient practice; No residents will be affected this alleged deficient practice will 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 affected. No residents will affected by this alleged deficient practice. what measures will be put implace and what systemic characteristic does not remain the modern of the fire alarm system. A log titled "Semi-Annual Visual Fire Alarm Inspection" has bee initiated. how the corrective action(s) be monitored to ensure the	dents by the ed by ice. the ne	02/20/2020

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	l í	UILDING	onstruction (X3) DATE (COMPL 01/21/	ETED
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD RAIL RIDGE RD		
NORTH	RIDGE VILLAGE N	URSING & REHABILITATION CI	ENTE	ALBIO	N, IN 46701		
(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 APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
	3.1-19(b)				deficient practice will not recur, i.e., what quality assurance program will be put into place; a Maintenance Director/Designe will visually inspect required areas of the fire alarm system semi-annually. Documentation will occur on the "Semi-Annual Visual Fire Alarm Log" at the time the inspection is completed. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI Committee monthly on-going in which plan will be adjusted accordingly.	and ee n al	
K 0346 SS=C Bldg. 01	services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to \$9.6.1.6 Based on record retailed to provide a confort the protection of the pr	f Service re alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall e building shall be approved fire watch shall be rties left unprotected by the e fire alarm system has	K()346	what corrective action(s) will be accomplished for those residen found to have been affected by deficient practice:	its	02/20/2020

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alarm system has to be placed out of service for

accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.

four hours or more in a twenty four hour period in

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No residents will be affected by

this alleged deficient practice.

how other residents having the potential to be affected by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/21/2020 155763 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 TRAIL RIDGE RD NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE **ALBION. IN 46701** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: same deficient practice will be identified and what corrective Based on records review with the Maintenance action(s) will be taken; Director and Administrator on 01/21/20 at 11:10 All residents residing in the a.m. and 3:00 p.m., the fire watch plan for impaired facility have the potential to be fire alarm systems failed to include contacting the affected. No residents will be monitoring company and the Indiana State affected by this alleged Department of Health (ISDH) via the ISDH deficient practice. Fire watch Gateway link at https://gateway.isdh.in.gov as the plan has been updated to primary method or by the secondary method when include notification of the the ISDH Gateway is nonoperational by monitoring company and ISDH completing the Incident Reporting form and gateway. e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the what measures will be put into Maintenance Director acknowledged the fire place and what systemic changes watch documentation provided did not state will be made to ensure that the contacting the monitoring company and ISDH via deficient practice does not recur; the Gateway link or at the e-mail address listed **Maintenance Director educated** above in the event the fire alarm system has to be over requirements of the placed out of service for four or more hours. facility's fire watch plan. Fire watch plan has been updated 3.1-19(b) to include notification of the monitoring company and ISDH gateway. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Maintenance Director or designee will monitor the Fire Watch Plan annually ongoing and policy and procedures will be up-dated as warranted. A report of progress will be forwarded to the QAPI committee until 100% has been

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achieved for three consecutive reviews and plan will be

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DEPARTMENT OF HEALTH AND HUN	MAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	uilding <u>01</u>	COMPLETED
	155763	B. WI	NG	01/21/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF FROVIDER OR SUFFEIER	S		600 TRAIL RIDGE RD	
NORTH RIDGE VILLAGE NU	JRSING & REHABILITATION CEN	TE	ALBION, IN 46701	
			•	

NORTH RIDGE VI	LLAGE NORSING & REHABILITATION CEN	TE ALBION	N, IIN 40701	
,	SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
TAG REGU	LATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			adjusted accordingly.	
Bldg. 01 Sprinkle Automat are insp accorda Inspectic Water-b Records inspectic secure le a) Date b) Who c) Water Provide coverag automat 9.7.5, 9. Based or failed to accordan 14.2.1 st 14.2.1.4 condition opening main and of one br for the pr material. occupant	r System - Maintenance and Testing r System - Maintenance and Testing ic sprinkler and standpipe systems ected, tested, and maintained in nee with NFPA 25, Standard for the on, Testing, and Maintaining of ased Fire Protection Systems. of system design, maintenance, on and testing are maintained in a ocation and readily available. esprinkler system last checked provided system test er system supply source in REMARKS information on the for any non-required or partial ic sprinkler system. 7.7, 9.7.8, and NFPA 25 arecord review and interview, the facility maintain 1 of 1 sprinkler system in the with 19.3.5.3. NFPA 25, 2011 Edition, and the secret as discussed in 14.2.1.1 and the an inspection of piping and branch line as shall be conducted every 5 years by a flushing connection at the end of one a by removing a sprinkler toward the end anch line for the purpose of inspecting resence of foreign organic and inorganic This deficient practice could affect all s.	K 0353	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents will be affected by this 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 facility have the potential to be affected. No residents will be affected by this alleged	02/20/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155763		A. B	A. BUILDING 01 COM B. WING 01/2			ATE SURVEY MPLETED /21/2020	
	ROVIDER OR SUPPLIER	JRSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COD AIL RIDGE RD N, IN 46701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	TION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
IAU	a.m., no documenta of the sprinkler pipi Based on interview the Maintenance Di documentation for a	tion for an internal inspection ng was available for review. at the time of record review, rector stated the an internal pipe inspection and was unsure when the last		IAU	internal pipe inspection was completed on 7/29/2015. Documentation of inspection has been obtained and place in fire alarm system logbook. what measures will be put in place and what systemic chawill be made to ensure that the deficient practice does not remain the management of the Maintenance Director re-educated regarding fire alarm inspection requirement A 5-year internal pipe inspection was completed of 7/29/2015. Documentation of inspection has been obtained and placed in fire alarm system logbook. how the corrective action(s) be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into placed Maintenance Director or Designee will monitor fire alarm inspection logs quart ongoing. Any negative finding will be corrected immediate and forwarded to the Administrator. A report of progress will be forwarded the QAPI Committee month on-going in which plan will adjusted accordingly.	n ed k. to nges ne cur; nts. on of ed tem will ur, e; and erly ngs ly	DATE
K 0354 SS=C	NFPA 101 Sprinkler System -						
Bldg. 01	Sprinkler System -	- Out of Service					I

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K3VX21

Facility ID: 011296

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
155763		B. W	NG		01/21/	/2020		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIEF	8			AIL RIDGE RD			
NORTH	RIDGE VILLAGE N	URSING & REHABILITATION CEI	NTE		N, IN 46701			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	<u> </u>	er system is impaired, the						
		on of the impairment has						
		areas or buildings involved						
		l risks are determined,						
	recommendations							
	_	esignated representative,						
	· ·	tment and other authorities						
	· ·	have been notified. Where						
		em is out of service for more						
		24-hour period, the						
		of the building affected are						
		approved fire watch is						
	1 3	sprinkler system has been						
	returned to service							
		, 9.7.5, 15.5.2 (NFPA 25)	17.0	254	bat compative action(a) will b	_	02/20/2020	
		view and interview, the facility of 1 correct written policies in	K 0354		what corrective action(s) will be accomplished for those residents		02/20/2020	
	-	natic sprinkler system has to be						
		ce for 10 hours or more in a			found thave been affected by	ne		
		ccordance with LSC, Section			deficient practice; No residents will be affected by this alleged deficient practice.			
	_	quires sprinkler impairment						
		with NFPA 25, 2011 Edition,						
		e Inspection, Testing and			how other residents having th	6		
		ater-Based Fire Protection			potential to be affected by the			
		5, 15.5.2 requires nine			same deficient practice will be			
		impairment coordinator shall			identified and what corrective			
	*	(b) states a fire watch should			action(s) will be taken;			
		ersonnel who continuously			All residents residing in the			
	^	area. Ready access to fire			facility have the potential to	be		
	_	ne ability to promptly notify			affected. No residents will be			
	_	are important items to			affected by this alleged			
	_	e patrol of the area, the person			deficient practice. Fire watch	l		
	_	looking for fire, but making			plan has been updated to			
	1	ire protection features of the			include notification of the			
	building such as eg	ress routes and alarm systems			monitoring company,			
	are available and fu	inctioning properly. This			insurance carrier, and ISDH			
	deficient practice co	ould affect all occupants in the			gateway.			
	facility							
					what measures will be put into)		
	Findings include:				place and what systemic chan	ges		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	A. B	MULTIPLE CO BUILDING VING	onstruction 01	COMP	E SURVEY PLETED 1/2020
	PROVIDER OR SUPPLIEF	URSING & REHABILITATION CE	NTE	600 TR	ADDRESS, CITY, STATE, ZIP COI AIL RIDGE RD N, IN 46701)	
(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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE	(X5) COMPLETION DATE
	the Maintenance Di 01/21/20 at 11:10 a plan for impaired spinclude contacting to monitoring compan Department of Heal Gateway link at http primary method or the ISDH Gateway completing the Incie-mailing it to incidinterview during the Maintenance Direct watch documentation contacting the insur company, and ISDF e-mail address lister	or acknowledged the fire on provided did not state ance carrier, monitoring If via the Gateway link or at the d above in the event the s to be placed out of service			will be made to ensure the deficient practice does in Maintenance Director e over requirements of the facility's fire watch plan watch plan has been up to include notification of monitoring company, insurance carrier, and I gateway. how the corrective action be monitored to ensure the deficient practice will not i.e., what quality assurant program will be put into put	ot recur; ducated e i. Fire odated of the SDH In(s) will he recur, ice oblace; r he Fire igoing ires will ed. A be as been iecutive	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro annually confirm t safety and critical	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the n is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			ETED	
155763		B. WING 01/21/2020					
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			AIL RIDGE RD		
NODTH I	NORTH RIDGE VILLAGE NURSING & REHABILITATION CEN				N, IN 46701		
			1 =	ALBION	N, IN 40701		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (FACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets are	e inspected weekly,					
		oad 30 minutes 12 times a					
	1 -	intervals, and exercised					
	1	nths for 4 continuous hours.					
		der load conditions include					
	a complete simula						
		ual transfer of all EES					
		nducted by competent					
	l •	nance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a					
	1 ' -	dically exercising the					
		tablished according to					
		uirements. Written records					
		nd testing are maintained					
	1 -	ble. EES electrical panels					
		arked, readily identifiable,					
	1	n normal power circuits.					
	1	ssibility of damage of the					
		source is a design					
	consideration for r	new installations. (NFPA 99), NFPA 110,					
	NFPA 111, 700.10	review and interview, the	V 0019		what corrective action(s) will be	he	02/20/2020
		intain 1 of 1 Emergency Power	K 0918		accomplished for those reside		02/20/2020
	1	accordance with NFPA 110,			found to have been affected b		
	1	ency and Standby Power			deficient practice;	y u ie	
		4.9, as required by NFPA 99			No residents will be affected	hv	
	1	es Code, Section 6.4.1.1.6.1.			this alleged deficient practic	-	
		8.4.9 states that all Level 1			anogoa aonoioni praetie	٠.	
		Systems shall be tested at least			how other residents having t	the	
		hree years. Where the			potential to be affected by the		
	1	eater than 4 hours, it shall be			same deficient practice will be		
		ate the test after 4 hours.			identified and what corrective		
	1 ^	.4.1.1.6.1 states that Type 1 and			action(s) will be taken;		
		ectrical system power sources			All residents residing in the		
		t Type 10, Class X, Level 1			facility have the potential to	be	
	l	· =	1		i '		Ī

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPLETED		
155763		B. WI	ING		01/21/	2020	
NAME OF D	BUAIDEB OD GUDDI IED		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF P	ROVIDER OR SUPPLIEF			600 TR/	AIL RIDGE RD		
NORTH F	NORTH RIDGE VILLAGE NURSING & REHABILITATION CEN			ALBION	I, IN 46701		
(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
	_	s deficient practice could			affected. No residents will be)	
	affect all building o	occupants.			affected by this alleged		
					deficient practice.		
	Findings include:						
	D 1 '	the state of the state of			what measures will be put into		
		view with the Maintenance			place and what systemic chan	-	
		nistrator on 01/21/20 at 11:32			will be made to ensure that the		
		n of a four hour run test			deficient practice does not rec	ur;	
		ne last 36 months was not			A 4-hour run test was	la a	
	•	7. Based on interview at the			conducted on 1/28/2020 for t		
	time of records review, the Maintenance Director stated a four hour continuous run was not				facility's diesel generator. The		
	conducted in the pa				facility did have an annual fu		
	conducted in the pa	ist 50 monuis.			quality test performed for the diesel generator on 10/14/20		
	2 Based on record	review and interview, the			Results of fuel quality test ha		
		sure an annual fuel quality test			been obtained and have been		
	-	1 of 1 facility's diesel powered			added to the generator	11	
	_	9, Health Care Facilities Code,			logbook. Maintenance Direct	or	
	_	on 6.5.4.1.1.2 states Type 2 EES			has been re-educated		
		1 System) generator sets shall			regarding generator inspecti	on	
	,	sted in accordance with			requirements.		
	-	Section 6.4.4.1.1.3 states			- 4		
		be performed in accordance			how the corrective action(s)	will	
		andard for Emergency and			be monitored to ensure the		
		tems, 2010 Edition, Chapter 8.			deficient practice will not recur	-,	
	NFPA 110, Section	8.3.8 states a fuel quality test			i.e., what quality assurance		
	shall be performed	at least annually using tests			program will be put into place;	and	
		I standards. This deficient			Maintenance Director or		
	practice could affect	et all residents.			Designee will monitor		
					generator inspection logs		
	Findings include:				weekly on-going. Any negati	ve	
					findings will be corrected		
		view with the Maintenance			immediately and forwarded t		
		nistrator on 01/21/20 at 11:33			the Administrator. A report o		
		tion of an annual fuel quality			progress will be forwarded to		
		enerator was available for			the QAPI Committee monthly		
		nterview at the time of records			on-going in which plan will b	е	
	· ·	nance Director stated the			adjusted accordingly.		
	facility does have a	diesel generator. The	1				

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Administrator stated the generator contractor did

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155763		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/21/2020		
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHABILITATION CENT (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 600 TRAIL RIDGE RD ALBION, IN 46701				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	take a fuel sample but could not find the report that showed the result of the fuel test.					
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 3 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym.	K 0920	what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; No residents will be affected.	ents y the		
	Findings include:		this alleged deficient practice	e. 		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155763	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION O O O O O O O O O O O O	(X3) DATE (COMPL 01/21/	ETED
	PROVIDER OR SUPPLIE	R URSING & REHABILITATION C	600	ET ADDRESS, CITY, STATE, ZIP COD TRAIL RIDGE RD ION, IN 46701	,	
(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 SHOU CROSS-REFERENCED TO THE APPIDEFICIENCY)	CTION VLD BE ROPRIATE	(X5) COMPLETION DATE
	with the Maintenar 12:03 p.m., there we the therapy gym who provided. One power stream 60601-1. Based on observation, the Ma	ons during a tour of the facility ace Director on 01/21/20 at overe three power strips in use in there resident care was over strip met 1363A, but the rips did not meet 1363A or interview at the time of aintenance Director agreed two on use in a resident care area 363A or 60601-1.		how other residents havi potential to be affected by same deficient practice widentified and what correct action(s) will be taken; All residents residing in facility have the potential affected. No residents waffected by this alleged deficient practice. what measures will be puplace and what systemic will be made to ensure the deficient practice does not power strips have been removed from the therapy Staff re-educated on power cord and extension cord on February 10, 2020 at meeting. how the corrective action be monitored to ensure the deficient practice will not i.e., what quality assurant program will be put into	y the vill be ctive the al to be vill be ut into changes nat the ot recur; py gym. wer d usage all staff n(s) will he recur, nce blace; and r II areas power times 3 imes 3 imes 3	

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CENTERSTON	OND NO. 0750-057								
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED		
		155763	B. WI	B. WING			/2020		
NAME OF PROVIDER OR SUPPLIER NORTH RIDGE VILLAGE NURSING & REHABILITATION CEN				STREET ADDRESS, CITY, STATE, ZIP COD 600 TRAIL RIDGE RD ALBION, IN 46701					
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECT			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE		
					adjusted accordingly.				

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