STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155809	A. BUILDING -- B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREY STONE HEALTH & REHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/16/22 Facility Number: 012935 Provider Number: 155809 AIM Number: 201207690 At this Emergency Preparedness survey, Grey Stone Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 100 and had a census of 88 at the time of this survey. Quality Review completed on 11/21/22	E 0000	December 11, 2022 Department of Health and Human Services Centers for Medicare & Medicaid Services To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the Recertification and Life Safety Survey. Enclosed is our Plan of Correction for all of the deficiencies we received during our Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. Thank you for your consideration in this matter. Sincerely, Eric Hunter, Administrator Grey Stone Health and Rehabilitation eric.hunter@saberhealth.com 260-494-2740	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Hunter	Administrator	12/14/2022

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

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	486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	led by a facilitator and includes a group discussion using a narrated, clinically-relevant 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 and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant 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 and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.			

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises			

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	to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the			

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	following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise			

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	is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of			

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	problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 0039	E039 Testing Requirements 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will conduct exercises to test the emergency plan twice annually.*** 2. How other residents having the potential to be affected by the	12/30/2022

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	b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 10:19 a.m., no documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill is not available was available for review. Also, documentation of an additional annual exercise of choice within the last year was not available for review. Based on interview at the time of records review, the Maintenance Director stated both required exercises have not been		same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. The exercises to test the emergency plan will correct this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The Administrator and the Maintenance Director will undergo education on semiannual Emergency Plan exercises, with at least one being a full-scale exercise that is community based, and at least one other full-scale exercise that is community based, or a mock disaster drill, or a tabletop exercise. Will also analyze the facility response, maintain and analyze the drills, tabletops, emergency events, and revise the facility emergency plan as needed. The first exercise will be completed by December 16th, 2022, and the second exercise will be completed by December 30th, 2022.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Administrator and the Maintenance Director will***	

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	conducted within the last 12 months. This finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference.		***discuss Emergency Plan exercises in each Life Safety meeting and will ensure exercises are planned no longer than 6 months apart from each other, after the first two are completed. Each discussion will be documented in the Life Safety minutes.*** 5. By what date the systemic changes for each deficiency will be completed? ***All education, exercises, and exercising planning will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/22 Facility Number: 012935 Provider Number: 155809 AIM Number: 201207690 At this Life Safety Code survey, Grey Stone Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the	K 0000	December 11, 2022 Department of Health and Human Services Centers for Medicare & Medicaid Services To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the Recertification and Life Safety Survey. Enclosed is our Plan of Correction for all of the deficiencies we received during our	

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	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility was partially protected by a Type II EES 150 kW gas generator. The facility has a capacity of 100 and had a census of 88 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/21/22		Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. Thank you for your consideration in this matter. Sincerely, Eric Hunter, Administrator Grey Stone Health and Rehabilitation eric.hunter@saberhealth.com 260-494-2740	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or	K 0345	K345 Fire Alarm System – Testing and Maintenance 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will test and***	12/30/2022

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	more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: Based on record review with the Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 10:29 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 02/08/22. Based on interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six after the annual fire alarm inspection was not conducted. This finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)		***maintain the fire alarm system twice annually. The first exercise was completed on February 8th, 2022, and the second will be completed by December 16th, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. The testing and maintenance of the fire alarm system twice annually will correct this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The Administrator and the Maintenance Director will undergo education on fire alarm systems to ensure they will tested and maintained no fewer than twice a year.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Administrator and the Maintenance Director will discuss Fire Alarm Testing and Maintenance in each Life Safety meeting and will ensure the practices are planned no longer***	

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			than 6 months apart from each other, beginning with the next planned to be completed by December 16th, 2022. Each discussion will be documented in the Life Safety minutes. 5. By what date the systemic changes for each deficiency will be completed? ***All education, maintenance, and maintenance planning will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include:	K 0346	K346 Fire Alarm System – Out of Service 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will provide the policy for action taken when the fire alarm system is down for more than 4 hours. The policy***	12/30/2022

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	Based on records review with the Maintenance Director and the Administrator in Training (AIT) on 11/16/22 at 10:35 a.m., the "Fire Alarm out of Service" policy stated to contact the "Department of Health" but the plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the "Department of Health" but not via the IDOH Gateway link or at the e-mail address listed above. The finding was reviewed with the AIT and Maintenance Director during the exit conference. 3.1-19(b)		***states that the Administrator or designee will contact The Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov. If the gateway portal is nonoperational then the incident reporting form will be completed by the Administrator or designee and the form will be emailed to incidents@isdh.in.gov. This process will began immediately after the 4th hour of the fire alarm system being down. The policy will be provided by December 16th, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. The policy, once provided, will correct this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The policy on steps taken in the even the fire system is down for more than four hours will be copied and added to the life safety manual, as well as at each nurses station.*** 4. How the corrective action	

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			will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Maintenance Director will ensure the policies remain in the designated locations and will audit each area weekly for a duration of six months. All audit will be logged. Any occurrence where the policy is not in place, it will be immediately replaced.*** 5. By what date the systemic changes for each deficiency will be completed? ***All policies and audits will be completely in place by December 16th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure10 of 10 sprinkler heads in the kitchen were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 11/16/22 at 1:00 p.m., all the sprinkler heads in the kitchen were loaded with dirt and grease. Based on interview at the time of observation, the Maintenance Director confirmed the sprinkler heads in the kitchen were loaded with dirt and grease. The finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	K353 Sprinkler System – Testing and Maintenance 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will test and maintain the automatic sprinkler systems will be done in accordance with NFPA 25, and will be completed by December 11th, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. The testing and maintenance of the automatic sprinkler systems will be done in accordance with NFPA 25 will correct this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The Maintenance Director will perform the inspection and cleaning on all sprinkler heads and will perform cleaning as necessary. A record will also be kept stated the date the sprinkler system was last***	12/30/2022

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			checked, who provided the test, and the water system supply source. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***Maintenance Director/designee will Testing and Maintenance the Sprinkler System weekly. Cleaning and/or additional maintenance will be performed as necessary. All records of testing and maintenance will be logged, and will begin no later than December 11th, 2022.*** 5. By what date the systemic changes for each deficiency will be completed? ***All maintenance and reporting will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities			

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	having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and the Administrator in Training (AIT) on 11/16/22 at 10:35 a.m., the "Sprinkler System out of Service" policy stated to contact the "Department of Health" but the plan failed to include contacting the Indiana Department of	K 0354	K354 Sprinkler System – Out of Service 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will provide the policy for action taken when Sprinkler System is down for more than 4 hours. The policy states that the Administrator or designee will contact The Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov. If the gateway portal is nonoperational then the incident reporting form will be completed by the Administrator or designee and the form will be emailed to incidents@isdh.in.gov. This process will began immediately after the 4th hour of the Sprinkler system being down. The policy will be provided by December 16th, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	12/30/2022

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	Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the "Department of Health" but not via the IDOH Gateway link or at the e-mail address listed above. The finding was reviewed with the AIT and Maintenance Director during the exit conference. 3.1-19(b)		action will be taken? ***All residents have the potential to be affected. The policy, once provided, will correct this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The policy on steps taken in the even the Sprinkler system is down for more than four hours will be copied and added to the life safety manual, as well as at each nurses station.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Maintenance Director will ensure the policies remain in the designated locations and will audit each area weekly for a duration of six months. All audit will be logged. Any occurrence where the policy is not in place, it will be immediately replaced.*** 5. By what date the systemic changes for each deficiency will be completed? ***All policies and audits will be completely in place by December 16th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	

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K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 2 of 6 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 40 residents in the 200-hall and 400-hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/16/22 at 1:11 p.m. and at 1:30 p.m., there were two soiled linen/trash barrels side by side in front of the soiled utility room totaling more than 32 gallons on the 200-hall. Also, there was a 40-gallon barrel of trash in front of the soiled utility on the 400-hall. Based on interview at the time of observation, the Maintenance Director stated there were barrels of soiled linen/trash totaling	K 0754	K754 Soiled Linen and Trash Containers 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will ensure soiled linen or trash receptacles shall not exceed 32 gallons in capacity.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. Once the facility has***	12/30/2022

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	more than 32 gallons in a 64 square foot area on the 200-hall and the 400-hall. The finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)		***only 32 gallon or less sized containers, the deficient practice will be corrected.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Central Supply/designee has placed an order for 4 trash collection receptacles which do not exceed 32 gallons. Receptacles will arrive no later than December 16th, 2022. Once the receptacles arrive, all other receptacles will be disposed of. All staff will be educated on the receptacle usage and the storage of the receptacles.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Maintenance Director/designee will monitor receptacles on five (5) separate occasions each week to ensure proper receptacles are being used and are not being packed beyond capacity. Any occurrence of noncompliance will be immediately addressed. This audit will begin no later than December 16th and will continue weekly for six (6) months.*** 5. By what date the systemic	

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			changes for each deficiency will be completed? ***All orders, educations, and audits will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failed to develop a portable space heater police to ensure the heating element does not exceed 212 degrees for 1 of 1 portable space heaters use in staff areas. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the front admin area. Findings include: Based on observation with the Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 11:39 a.m., a portable space heater was in use in the Administrator office. There was no affixed label on the portable space heater ensuring the heating element does not exceed 212 degrees. Based on records review at 11:40 a.m., no documentation was provided to show the max temperature of the space heater. Also, there was not a space heater policy available for review.	K 0781	K781 Portable Space Heaters 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will ensure portable Space Heaters are only used by non-sleeping staff and employee areas where heating elements do not exceed 212 degrees Fahrenheit.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. All noncompliant Space Heaters have been***	12/30/2022

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	Based on interview at the time of observation, the Maintenance Director stated the max temperature of the portable the space heater was unknown and the space heater policy could not be found. This finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)		***removed as of December 9th, 2022, and the deficient practice has been corrected.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Portable Space Heaters will be prohibited from usage altogether. All staff will be educated on the prohibition of portable space heaters.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Administrator will monitor each area for Space Heater and deficient practices will be corrected immediately.*** 5. By what date the systemic changes for each deficiency will be completed? ***All educations, and removal of all space heaters will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage			

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	155809	A. BUILDING 01 B. WING	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility	K 0923	K923 Gas Equipment – Cylinder	12/30/2022

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	failed to ensure 12 of 12 oxygen cylinders were separated and marked to avoid confusion regarding full and empty cylinders. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. Also, the facility failed to ensure 1 of 12 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: #1) Based on observations with Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 12:19 a.m., the oxygen storage room contained 12 full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director stated there are signs in the oxygen storeroom stating spots for full and empty cylinders but staff are not following the signs. #2) Based on observations with Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 12:19 a.m., one 'E' type oxygen cylinder		and Container Storage 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will ensure Oxygen Cylinders will be properly stored by chains or a cart, and will be segregated where full and empty Cylinders are clearly distinguished. This practice was completed on December 9th, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. With the Oxygen Cylinders properly stored and designated, the deficient practice has been corrected.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Instructions will be placed at the storage area on proper Cylinder storage and labels designating full and empty Cylinders will be put in place. Education will be had with nursing staff of instructions and labeling. Central Supply/designee will monitor the Cylinder daily to ensure Cylinder and Container storage***	

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	was standing upright on the floor of the oxygen storage/trans-filling room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged one 'E' type oxygen cylinder in the oxygen storage/trans-filling room was not properly chained or supported in a proper cylinder stand or cart. The findings were reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)		***remain in compliance.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***Central Supply/designee will monitor Cylinder storage on five (5) separate occasions each week to ensure proper Cylinder storage and labels designating full and empty Cylinders remain in place. Any occurrence of noncompliance will be immediately addressed. This audit will begin no later than December 16th and will continue weekly for six (6) months.*** 5. By what date the systemic changes for each deficiency will be completed? ***All orders, educations, and audits will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is			

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	prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observations with Administrator in Training (AIT) and the Maintenance Director on 11/16/22 at 12:19 a.m., the oxygen storage/transfer room contained large liquid oxygen tanks. There was a vent to the outside with a mechanically ventilated exhaust fan, but there was no pull of air from the vent. Based on interview at the time of observation, the Maintenance Director looked at the fan motor and stated the belt is broke and will be replaced. The finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference. 3.1-19(b)	K 0927	K927 Gas Equipment – Transferring Cylinders 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The facility will repair the air vent in the Cylinder storage room. This practice will completed on December 23rd, 2022.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. Once the Air Vent is repaired, the deficient practice has been corrected.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Once the air vent is repaired, Maintenance Director/designee will perform Preventative Maintenance to ensure its continued working condition.***	12/30/2022

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			4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***Maintenance Director /designee will monitor air vent operation on five (5) separate occasions each week to ensure its continued working condition. Any occurrence of noncompliance will be immediately addressed. This audit will begin no later than December 30th and will continue weekly for six (6) months.*** 5. By what date the systemic changes for each deficiency will be completed? ***All orders, educations, and audits will be completely in place by December 30th, 2022.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	