						PRIN	TED;	00/07/2023
DEPARTMENT	OF HEALTH AND HUM	MAN SERVICES				FORM APPROVED		
CENTERS FOR	EENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 09	38-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED		
		155770	B. WING			05/11/2023		
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS				1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE		COMP	LETION

TWINE OF	TROVIDER OR SOLI EIER	1002 SISTER BARBARA WAY					
VILLAS	OF GUERIN WOODS	GEOR	GEORGETOWN, IN 47122				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(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			
E 0000							
Bldg							
Diag	An Emergency Preparedness Survey was	E 0000	Plan of Correction for the Villas				
	conducted by the Indiana Department of Health in	E 0000	of Guerin Woods 2023 Life				
	accordance with 42 CFR 483.73.		Safety Code with Emergency				
	decordance with 12 CTR 103.75.		Preparedness Survey.				
	Survey Dates: 05/10/23 and 05/11/2023		The creation and submission of				
	Sarvey Bates. 03/10/23 and 03/11/2023		this Plan of Correction does not				
	Facility Number: 011509		constitute an admission by this				
	Provider Number: 155770		provider of any conclusion set				
	AIM Number: 200909280		forth in the statement of				
	711117 Trainedi. 200707200		deficiencies, or of any violation				
	At this Emergency Preparedness survey, Villas of		of regulation.				
	Guerin Woods was found not in compliance with		This provider respectfully requests				
	Emergency Preparedness Requirements for		that the 2567 Plan of Correction				
	Medicare and Medicaid Participating Providers		be considered the Letter of				
	and Suppliers, 42 CFR 483.73		Credible Allegation and requests a				
			Post Certification Desk Review in				
	The facility has 68 certified beds, with a current		lieu of the Post Survey Revisit.				
	census of 66.						
	Quality Review completed on 05/17/23						
	The requirement at 42 CFR, Subpart 483.73 is NOT						
	MET as evidenced by:						
E 0004	403.748(a), 416.54(a), 418.113(a),						
SS=C	441.184(a), 482.15(a), 483.475(a), 483.73(a),						
Bldg	484.102(a), 485.625(a), 485.68(a),						
Diag	485.727(a), 485.920(a), 486.360(a),						
	491.12(a), 494.62(a)						
	Develop EP Plan, Review and Update						
	Annually						
	§403.748(a), §416.54(a), §418.113(a),						
	§441.184(a), §460.84(a), §482.15(a),						
	§483.73(a), §483.475(a), §484.102(a),						
	§485.68(a), §485.625(a), §485.727(a),						
	§485.920(a), §486.360(a), §491.12(a),						
	§494.62(a).						
	3 10 1.02(α).						

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

(X6) DATE

TITLE

Eric Will Administrator 06/01/2023

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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	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BUILDING B. WING		COM	PLETED 11/2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZII ISTER BARBARA WA GETOWN, IN 47122		
(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 C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive errogram that mees section. The emer program must include the following elem. (a) Emergency Pladevelop and main preparedness plar and updated at least must do all of the section. The emergency Planes are section, utilizing a section, utilizing a section, utilizing a section and updated at least emergency Planes ergency Planes and updated at least emergency Planes ergency Planes emergency Planes ergency Plan	uirements. The [facility] ablish and maintain a mergency preparedness as the requirements of this gency preparedness ude, but not be limited to, ents: 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 at the requirements of this an all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency at that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must tain an emergency at that must be [evaluated], and this must be [evaluated], and this must be [evaluated], and this must be [evaluated],				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIEI			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5 COMPLE	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATI	
TAG	Based on record refailed to develop ar preparedness plan to at least annually in 483.73(a). This decresidents in the facility for the past evidence that the E has been reviewed twelve months.	wiew and interview, the facility and maintain an emergency hat was reviewed and updated accordance with 42 CFR ficient practice could affect all fility. The Emergency Preparedness etween 9:30 a.m. and 10:00 a.m. are Director present, the facility regency preparedness manual, been reviewed and updated live months. The most recent rided was 09/04/19. Based on the of review, the Maintenance is only been working at the four months and has not seen mergency Preparedness plan and updated within the past eviewed with the Executive enance Director during the exit	E 00		E 004 What corrective action was taken for residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The Emerg Preparedness Plan has been reviewed and updated for 202 How will other residents have the potential to be affected by the same deficient practice identified and what corrective action will be taken? All residents have the potential be affected by the alleged deficient. The facilities Emerging Preparedness plan has been reviewed and updated for 202 What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director has been educated on the requirements for reviewing an	ave ency 23. ving be ve al to ficient ency 23. nto	
					updating the Emergency Preparedness Plan annually of needed. The Emergency Preparedness Plan will be reviewed and updated in the December QA meeting for the upcoming year. This practice be ongoing every December. How will the corrective actions.	or as e will	
					be monitored to ensure the deficient practice will not recur, i.e. what quality		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 05/11/2023			<i>T</i>	
	ROVIDER OR SUPPLIER DF GUERIN WOOD		1002	ET ADDRESS, CITY, STATE, ZIP CO 2 SISTER BARBARA WAY DRGETOWN, IN 47122	DD .	
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMP	(X5) PLETION ATE
E 0013 SS=C Bldg	403.748(b), 416.5. 441.184(b), 482.1. 484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §446. §441.184(b), §460. §483.73(b), §485. §485.920(b), §486. §494.62(b). (b) Policies and prodevelop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) communication plasection. The policibe reviewed and use and procedures. *[For LTC facilities and procedures. T	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b), cocedures. [Facilities] must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 s at §483.73(b):] Policies The LTC facility must		assurance program wi into place? The Quality Assurance will review the Emerger Preparedness plan morensure the plan has been and updated as needed annually. By what date will the schanges for each deficition completed? 6/19/2023	Committee cy ithly to en reviewed and or ystemic	
	develop and imple	-				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	l í	UILDING	NSTRUCTION	(X3) DATE COMPI 05/11	LETED
	PROVIDER OR SUPPLIEI OF GUERIN WOOL		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	on the emergency (a) of this section paragraph (a)(1) of communication pl section. The policy be reviewed and of	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.					
	procedures. The develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policiaddress manager nonmedical emerglimited to: Fire; ed failure; care-related disasters likely to safety of the parti. The policies and prepared to the safety of the particular to the policies and prepared to the process to the particular to the policies and prepared to the prepared to t	PACE organization must ement emergency icies and procedures, based of plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not juipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be lated at least every 2 years.					
	and procedures. develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) of communication pl section. The polic be reviewed and	ties at §494.62(b):] Policies The dialysis facility must ement emergency icies and procedures, based of plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE A. BUILDING B. WING	<u></u>	DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failures, care-related supply interruption likely to occur in the area. Based on record restailed to develop are preparedness policited policies and procedupdated at least and CFR 483.73(b). The all residents in the failures include: Based on review of plan on 05/11/23 be with the Maintenant documentation in the procedures, however,	the Emergency Preparedness etween 9:30 a.m. and 10:00 a.m. ce Director present, there was he plan for facility policies and er the policies and procedures wed by the facility within the month period. The most ew provided was 09/04/19. at the time of review, the tor said he has only been ity for the past four months idence that the Emergency has been reviewed and past twelve months.	E 0013	E 113 What corrective action was taken for residents found to have been affected by the deficient practice? The Emergency Preparedness Plan's policies and procedures have been reviewed and updated for 2023. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficiel practice. The Emergency Preparedness Plan's policies and procedures have been reviewed and updated for 2023. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director has been educated on the requirements for reviewing and updating the Emergency Preparedness policies and procedures annually and as needed. The policies and procedures will be reviewed and updated in the December Quality Assurance meeting for the	nt

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2023				
	ROVIDER OR SUPPLIER OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
E 0029 SS=C Bldg	403.748(c), 416.54 441.184(c), 482.15 484.102(c), 485.65 485.727(c), 485.95 491.12(c), 494.620 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.6 §485.920(c), §486 §494.62(c). (c) The [facility] man emergency preplan that complies local laws and mu	4(c), 418.113(c), 5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),	TAG	upcoming year. This practice is be ongoing every December. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Commodification will review and update the Emergency Preparedness Plate policies during the monthly Qualities during the monthly Qualities during the interview of the plan has been reviewed and updated an needed and or least annually. By what date will the systemic changes for each deficiency becompleted? 6/19/2023	will ns ut ittee in's A s s		
	-	riew and interview, the facility	E 0029	E 029	06/19/2023		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/11/2023
VILLAS (PROVIDER OR SUPPLIE		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
	failed to develop ar preparedness comm with Federal, State, and updated at leas 42 CFR 483.73(c). affect all occupants Findings include: Based on review of plan on 05/11/23 be with the Maintenan facility's emergency did include a plan t emergency prepare complies with Federal however the comm reviewed by the fact twelve month perior review provided wat the time of review at the time of reviews at the time of reviews at the Emergency reviewed and update months. This finding was recommended.	and maintain an emergency nunication plan that complies and local laws was reviewed at annually in accordance with This deficient practice could The Emergency Preparedness etween 9:30 a.m. and 10:00 a.m. are Director present, the y preparedness plan provided to develop and maintain an andness communication plan that areal, State, and local laws, unication plan has not been could be the most recent date of the as 09/04/19. Based on interview are well as the facility for the most recent date of the mos		What corrective action wataken for residents found have been affected by the deficient practice? No residents were found to been affected by this alleg deficient practice. The Empreparedness Communicated Plan has been reviewed and updated. The plan complies Federal, State, and Local I and it will be reviewed and at least every 2 years. How will other residents to the potential to be affected the same deficient practice identified and what correct action will be taken? All residents have the potential be affected by the alleged practice. The Emergency Preparedness Communicated Plan has been reviewed and updated. The plan complies Federal, State, and Local I and it will be reviewed and at least every 2 years. What measures will be puplace and what systematic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director been educated on the requirements for reviewing updating the Emergency Preparedness Communicated Plan. The Emergency Preparedness Communicated Plan will be reviewed and an incomplete Emergency Preparedness Communicated Plan will be reviewed and it will be reviewed and it is a possible to the requirements for reviewing updating the Emergency Preparedness Communicated Plan. The Emergency Preparedness Communicated Plan will be reviewed and it is a possible to the proviewed and it is a poss	as I to I have ed ergency ation as with aws updated having ed by ce be ctive ential to deficient ation ad as with aws updated having ad by ce be ctive ential to deficient ation ad as with aws updated having and ation ation ation

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ı	JILDING		COMPL	
		155770	B. Wl	ING		05/11/	/2023
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(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	TE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §483. §485.68(d), §485. §485.920(d), §486 §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84,	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)			in the December Quality Assurance meeting for the upcoming year. This practice is be ongoing every December. How will the corrective actio be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place? The Quality Assurance Comm will review the Emergency Preparedness Communication Plan monthly to ensure the pla has been reviewed and updat needed and or at least annual By what date will the system changes for each deficiency completed? 6/19/2023	ut ittee an ed as ly. ic	

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CAHs at §486.625, "Organizations" under

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING COMPLE B. WING 05/11/2					
	F PROVIDER OR SUPPLIEF			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§486.360, and RHTraining and testindevelop and main preparedness traithat is based on the in paragraph (a) consistent as ection, policies at (b) of this section, plan at paragraph training and testing reviewed and updown training and testing. The land maintain an estraining and testing the emergency plate of this section, risk (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 (a)(1) of this section. The train must be reviewed annually.	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. s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in 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 assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		155770	B. WII	NG		05/11/	/2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	at §483.470(i).			1110			Bille
	*[For ESRD Facility Training, testing, a dialysis facility mu emergency preparand patient orienta on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the communic of this section. The orientation programupdated at every 2 Based on record reversal failed to develop an preparedness training was reviewed and un accordance with 42 practice could affect Findings include: Based on review of plan on 05/11/23 be with the Maintenand documentation avairant emergency prepared program, however the program has not be within the most recent date of Based on interview Maintenance Direct working at the faciliand has not seen evitation and	the Emergency Preparedness tween 9:30 a.m. and 10:00 a.m. ce Director present, there was lable to show the facility had uredness training and testing en reviewed by the facility ent twelve month period. The review provided was 09/04/19. at the time of review, the or said he has only been ity for the past four months idence that the Emergency has been reviewed and	E 00	036	E 036 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to habeen affected by this alleged deficient practice. The facility's Emergency Preparedness trai and testing program was revie and updated. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents have the potential be affected by the alleged defi practice. The facility's Emerge Preparedness training and test program was reviewed and updated.	nve s ning ewed al in? al to icient ency	06/19/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	_	viewed with the Executive enance Director during the exit 1/23.		What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director had been educated on the requirements of the Emerger Preparedness testing and traprogram. The Emergency Preparedness training and temprogram Plan will be reviewed updated in the December Quantum Assurance meeting for the upcoming year. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Commuli review the Emergency Preparedness training and temprogram plan to ensure it has been reviewed and updated a needed and or at least annual during the December monthly meeting. By what date will the system changes for each deficiency completed? 6/19/2023	is incy ining sting d and ality s) the put mittee sting is as ally y QA inic	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485.	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2)				

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED 1B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	 JILDING	INSTRUCTION	(X3) DATE	SURVEY
	PROVIDER OR SUPPLIE		1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY BETOWN, IN 47122	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION
TAG	EP Testing Requistance \$416.54(d)(2), \$4\$460.84(d)(2), \$4\$483.475(d)(2), \$4\$485.625(d)(2), \$485.625(d)(2), \$491.12(d)(2) *[For ASCs at \$4 OPO, "Organizat CMHCs at \$485.9 \$491.12, and ES (2) Testing. The pexercises to test annually. The far following: (i) Participate in a community-based (A) When a common accessible, or functional exercise (B) If the fact natural or manmactivation of the sis exempt from electromactional exercise actual event. (ii) Conduct an accessible, or functional exercise exempt from electromactional exercise actual event. (ii) Conduct an accessible or functional exercise actual event. (ii) Conduct an accessible or functional exercise actual event. (ii) Conduct an accessible or functional exercise actual event. (ii) A second full-full-full-full-full-full-full-full	418.113(d)(2), §441.184(d)(2), 482.15(d)(2), §483.73(d)(2), 6484.102(d)(2), §485.68(d)(2), 6485.727(d)(2), §485.920(d)	TAG	DEFICIENCY		DATE

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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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING COMPLETE B. WING 05/11/20:			ETED			
		PROVIDER OR SUPPLIER DF GUERIN WOOD			1002 SI	NDDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
PRI) ID EFIX AG	(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
		set of problem star messages, or prepto challenge an er (iii) Analyze the [farmaintain document exercises, and em the [facility's] eme *[For Hospices at (2) Testing for hoothe patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a commaccessible, condubased functional emergency exempt from engascale community-facility-based functional exercise of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercises	emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and atation of all drills, tabletop pergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or experiences a natural or ency that requires activation plan, the hospital is using in its next required full pased exercise or individual ational exercise following the gency event. Individual exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise or workshop that is and includes a group					

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	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BUILDING B. WING	onstruction 	COME	PLETED 1/2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZIP C SISTER BARBARA WAY GETOWN, IN 47122		
(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 COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	set of problem star messages, or prepto challenge an ento challenge an ento care directly. The exercises to test the per year. The hose (i) Participate in a that is community-(A) When a commaccessible, condufacility-based functional emergency exempt from engatull-scale communifunctional exercise emergency event. (ii) Conduct an activat may include, I following: (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, community-based functional exercise (B) A mock disast (C) A tabletop exerci	pared questions designed hergency plan. pices that provide inpatient hospice must conduct he emergency plan twice pice must do the following: In annual full-scale exercise based; or unity-based exercise is not an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based following the onset of the ditional annual exercise out is not limited to the scale exercise that is or a facility based e; or er drill; or ercise or workshop led by a lides a group discussion clinically-relevant fro, and a set of problem ed messages, or prepared				

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DEPARTMENT		FORM APPROVED OMB NO. 0938-039					
STATEMEN	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DA'	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		1002	et address, city, state, zip c ? SISTER BARBARA WAY PRGETOWN, IN 47122			
	1					(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5) COMPLETION	
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPRO				
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based func (B) If the [PRTF, I an actual natural of that requires activ plan, the [facility] its next required fr or individual, facili following the onse (ii) Conduct a exercise or and th limited to the follo (A) A second full- community-based facility-based func (B) A mo (C) A tableto is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or pre to challenge an el	PRTF, Hospital, CAH] must a to test the emergency ar. The [PRTF, Hospital, of following: an annual full-scale exercise abased; or annual individual, actional exercise; or Hospital, CAH] experiences for man-made emergency attorn of the emergency attorn of the emergency attorn of the emergency attorn of the emergency attornal exercise at of the emergency event. In an [additional] annual att may include, but is not wing: In a scale exercise that is a or individual, a citional exercise; or the exercise or workshop that for and includes a group an anarrated, emergency scenario, and a attements, directed pared questions designed					

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needed.

and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as

*[For PACE at §460.84(d):]

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X		(V2) MIII TIDI E CO	NICTRICTION		VID NO. 0936-039	
			(X2) MULTIPLE CO	NSTRUCTION	ľ í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>		PLETED
		155770	B. WING		05/1	1/2023
NAME OF 1	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COL STER BARBARA WAY)	
VILLAS	OF GUERIN WOOD	OS .	GEORG	SETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ILD BE ROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	(2) Testing. The F	PACE organization must				
	conduct exercises	to test the emergency				
	plan at least annu	ally. The PACE				
	organization must	_				
	_	an annual full-scale exercise				
	that is community					
	· ·	nunity-based exercise is not				
	' '	ict an annual individual,				
		ctional exercise; or				
	1	xperiences an actual natural				
	` '	ergency that requires				
		mergency plan, the PACE				
		gaging in its next required				
		nity based or individual,				
		ctional exercise following the				
	•	_				
	onset of the emer	_				
	, ,	in additional exercise every				
		the year the full-scale or				
		e under paragraph (d)(2)(i)				
		conducted that may include,				
	but is not limited to	_				
	' '	scale exercise that is				
		or individual, a facility				
	based functional e					
	(B) A mock disas					
	. ,	ercise or workshop that is				
	1	and includes a group				
	discussion, using					
	•	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er	- · ·				
	. ,	PACE's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	the PACE's emerg	gency plan, as needed.				
	*[For LTC Facilitie	es at 8483 73/d\·1				
		ity] must conduct exercises				
		ency plan at least twice per				
	I w was the emerge	moy plan at least twice hel	I			I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		155770	B. W	ING		05/11/	/2023
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS		GEORG	GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	1 -	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t						
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
	facility-based fund	ct an annual individual,					
	I	ility] facility experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
		mpt from engaging its next					
		le community-based or					
		based functional exercise					
		et of the emergency event.					
	_	dditional annual exercise					
		but is not limited to the					
	following:						
	_	scale exercise that is					
		or an individual, facility					
	based functional e	exercise; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		LTC facility] facility's					
	l '	naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
	-	CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	ľ	UILDING	NSTRUCTION	COMP	LETED /2023
	PROVIDER OR SUPPLIE			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122	-	
(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)	ON BE PRIATE	(X5) COMPLETION DATE
	(i) Participate in a that is community (A) When a commaccessible, condufacility-based fund (B) If the ICF/IID on a tural or man-mactivation of the eis exempt from erfull-scale community-based fund onset of the emer (ii) Conduct an additive that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the IC maintain documel exercises, and en the ICF/IID's eme *[For HHAs at §48 (d)(2) Testing. The exercises to test to the least annually. The following: (i) Participate in a community-based (A) When a control of the ICF (III) is the community-based (A) When a control of the ICF (IIII) is the community-based (A) When a control of the ICF (IIIIIIII) is the community-based (A) When a control of the ICF (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	n annual full-scale exercise -based; or nunity-based exercise is not lect an annual individual, ctional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID gaging in its next required hity-based or individual, ctional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. CF/IID's response to and hation of all drills, tabletop hergency events, and revise regency plan, as needed. 34.102] the HHA must conduct the emergency plan at the HHA must do the					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	 UILDING	NSTRUCTION		SURVEY LETED /2023
	OF PROVIDER OR SUPPLIES		1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	individual, facility- every 2 years; or. (B) If the HH- natural or man-mactivation of the exempt from engatull-scale community-based functional exercise of this section is led by a facility-based function (B) A mock of (C) A tableto is led by a facility discussion, using clinically-relevant set of problem stamessages, or preto challenge an embedding and embedding the HHA's emergent the HHA's emergent the HHA's emergent to CPO sat §4 (d)(2) Testing. The exercises to test to CPO must do the (i) Conduct a papor workshop at le exercise is led by group discussion, relevant emergent	A experiences an actual ade emergency that requires are aging in its next required nity-based or individual, ational exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is a or an individual, ational exercise; or isaster drill; or preserving exercise or workshop that for and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and antation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The	IAU			DATE

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING B. WING	CONSTRUCTION	COMPLETED 05/11/2023	
	OF PROVIDER OR SUPPLIER S OF GUERIN WOOD		1002	T ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY RGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	emergency plan. actual natural or requires activation OPO is exempt for required testing exempt for required testing exercises, and enthe [RNHCl's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test to to test to t	PO's response to and notation of all tabletop hergency events, and revise OPO's] emergency plan, as a 3.748]: e RNHCI must conduct the emergency plan. The her following: er-based, tabletop exercise a led by a facilitator, using a relevant emergency et of problem statements, as, or prepared questions enge an emergency plan. NHCI's response to and notation of all tabletop hergency events, and revise regency plan, as needed. When and interview, the facility hercises to test the emergency her year, including drills using the emergency of facility must do the annual full-scale exercise that dright in the response of the manual full-scale exercise is not an annual individual,	E 0039	E 039 What corrective action(s) wibe taken for those residents found to have been affected the deficient practice? No residents were found to have been affected by this alleged deficient practice. The facility conducted an exercise that work community-based to test the emergency plan and supporting documentation is readily available.	by ave as	

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 A. BUILDING B. WING		JNSTRUCTION	COMPL 05/11/	ETED		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	S	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		gency that requires activation			The second exercise has been	n	
	of the emergency plan, the LTC facility is exempt			scheduled.			
		ext required full-scale in a					
	-	r individual, facility-based					
		exercise for 1 year following	How will you identify other				
	the onset of the actu				residents having the potentia	ai	
	1 1	itional exercise that may			to be affected by the same		
		mited to the following:			deficient practice and what corrective action will be take	m2	
a. A second full-scale exercise that is community-based or an individual, facility-based					All residents, staff, and familie		
functional exercise.					had the potential to be affecte		
b. A mock disaster drill; or					this alleged deficient practice.	-	
	c. A tabletop exercise or workshop that is led by a				facility conducted an exercise		
	facilitator that includes a group discussion, using				was community-based to test		
	a narrated, clinically-relevant emergency scenario,				emergency plan and supportir		
	-	n statements, directed			documentation is readily available	_	
	_	ed questions designed to	The second exercise has been				
	challenge an emerge	-			scheduled.		
	(iii) Analyze the LT	C facility's response to and					
	maintain documenta	ation of all drills, tabletop			What measures will be put in	ito	
	exercises, and emer	gency events, and revise the			place or what systemic		
	LTC facility's emer	gency plan, as needed in			changes will you make to		
	accordance with 42				ensure that the deficient		
	-	ice could affect all occupants			practice does not recur?		
	in the facility.		The maintenance director has				
					been educated on the		
	Findings include:				requirements of the Emergence	-	
	D 1	4 F D 1			Preparedness testing as relate	ed to	
		the Emergency Preparedness			an annual community-based	· •	
	_	tween 9:30 a.m. and 10:00 a.m. ce Director present, the facility			exercise and the requirements the second exercise. The	s ior	
		de documentation of a			administrator and maintenanc	•	
	_	xercise during the past 12			director will schedule and plan		
		rther unable to provide			each exercise to ensure the	ı	
		second exercise conducted			requirements are met.		
		ve months. The Maintenance			How the corrective action(s)		
		only been working at the			will be monitored to ensure t		
		four months and has not seen			deficient practice will not		
		xercises have been performed			recur, i.e. what quality		
		nergency Preparedness plan			assurance program will be p	ut	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E RIATE COMPLETION DATE
	_	viewed with the Executive enance Director during the exit		into place? The Quality Assurance Comwill review the Emergency Preparedness planned exert and completed exercises at monthly meeting to ensure compliance and to make fur recommendations. By what date will the syste changes for each deficient completed? 6/19/2023	cises the ther mic
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.1 (e) Emergency an The [LTC facility at implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generate generator must be the location requir Care Facilities Coul Interim Amendment 12-4, TIA 12-5, an Code (NFPA 101)	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		UILDING	NSTRUCTION	COMPL 05/11/	ETED	
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	S	 GEORG	GETOWN, IN 47122		
(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)	ΓE	(X5) COMPLETION DATE
	structure is built o structure or buildin 482.15(e)(2), §483	ng is renovated. 3.73(e)(2), §485.625(e)(2)				
	The [hospital, CAl implement the em inspection, testing requirements four	ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] Id in the Health Care FPA 110, and Life Safety				
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency perational during the sit evacuates.				
	§483.73(g), and C The standards inc this section are ap reference by the D Federal Register i 552(a) and 1 CFR the material from You may inspect a					
	Boulevard, Baltim Archives and Rec (NARA). For informathis material at NA go to: http://www.archive _of_federal_regula If any changes in	arce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are afterence, CMS will publish a				

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023				
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	document in the F	ederal Register to					
	announce the cha						
		Protection Association, 1					
	Batterymarch Par	k,					
	Quincy, MA 0216	9, www.nfpa.org,					
	1.617.770.3000.						
	` '	th Care Facilities Code,					
		ed August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued	•					
		FPA 99, issued August 9,					
	2012.	5DA 00 : 1A4 1 7					
	(IV) HA 12-4 to NI 2013.	FPA 99, issued March 7,					
		FPA 99, issued August 1,					
	2013.	FA 99, Issued August 1,					
		FPA 99, issued March 3,					
	2014.	TA 99, 1930CG Walch 9,					
		fe Safety Code, 2012					
	edition, issued Au						
		IFPA 101, issued August					
	11, 2011.						
	(ix) TIA 12-2 to NI	FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NF	PA 101, issued October					
	22, 2013.						
	` '	FPA 101, issued October					
	22, 2013.						
	, ,	Standard for Emergency and					
	•	ystems, 2010 edition,					
	2009	chapter 7, issued August 6,					
		view and interview, the facility	I E O	041	E 041		06/10/2022
		t the emergency power system	E U	U 4 I	What corrective action(s) will be	20	06/19/2023
	_	and maintenance requirements			accomplished for those reside		
		Care Facilities Code, NFPA			found to have been affected b		
		y Code in accordance with 42			deficient practice?	,	
	CFR 483.73(e)(2).	, 			No residents were found to ha	ve	
					been affected by this alleged	=	
	This applies to all V	Villas except Villa 1 which is an			deficient practice. The facilities	s five	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			/EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPLETED)
		155770	B. W	'ING		05/11/202	3
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			ISTER BARBARA WAY		
VILLAS C	OF GUERIN WOOD	s			GETOWN, IN 47122		
			-		, T	ı	(77.5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	MPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	_	la, and Villa 4 which does not			generators have the require w	-	
		generator, furthermore, Villas			inspections, monthly load toac		
		nergency generator. This			test, annual maintenance, and		
	includes five emerg	ency generators.			4-hour load test completed an	d	
		11.7			documented according to the		
		review and interview, the			NFPA emergency power and		
	-	sure a written record of weekly			standby system requirements		
	-	5 generators was maintained					
		Chapter 6-4.4.1.3 of 2012			How will you identify other		
	•	patteries for on-site generators			residents having the potentia	aı	
		in accordance with NFPA 110,			to be affected by the same		
		lard for Emergency and			deficient practice and what		
		tems. 8.3.7 requires storage			corrective action will be take		
		electrolyte levels or battery			All residents have the potentia		
	-	nnection with systems shall be			be affected by the alleged def	icient	
		nd maintained in full			practice. The facilities five		
	-	anufacturer's specifications.			generators have the require w	-	
		tive batteries shall be repaired			inspections, monthly load toac		
	_	ately upon discovery of			test, annual maintenance, and		
	_	5.4.2 of NFPA 99 requires a			4-hour load test completed an	d	
		spection, performance,			documented according to the		
		nd repairs shall be regularly			NFPA emergency power and		
		ilable for inspection by the			standby system requirements		
		risdiction. This deficient					
	-	t all residents, staff and			What measures will be put in	ito	
	visitors in each Vill	a.			place or what systemic		
	Findings 1 1 1				changes you will make to		
	Findings include:				ensure that the deficient		
	D1 ' C	Alexander in a di			practice does not recur?		
		the generator inspection			The Maintenance Director has	1	
	-	between 9:30 a.m. and 3:30			been educated on the NFPA's	•	
	•	tenance Director present, there			TLC emergency and standby		
		ion available to show the			power system requirements.	ne	
		or was inspected/tested weekly			administrator/designee will		
	-	ost recent 52 week period			complete the Performance		
		3/22). Based on interview at			Improvement Tool after review	-	
	the time of record review, the Maintenance				the weekly inspections/testing		
		es test/inspect each of the five			documentation weekly, the		
		ors weekly but does not			monthly load toad test		
	always document th	ne test/inspection results.			documentation during 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. BU	JILDING		COMPL	ETED
		155770	B. W	ING		05/11/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	2			STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	s			GETOWN, IN 47122		
	arn a c. n.v.		1		, 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	This finding was re	viewed with the Executive			scheduled monthly Quality Assurance meeting and the		
	_	enance Director during the exit			annual maintenance and 4-ho	ur	
	conference on 05/1	_			load test documentation during		
	conference on 03/1	1723.			each Decembers scheduled C	•	
	2. Based on record	review and interview, the			meeting to ensure the	u t	
		intain a complete written record			requirements are met. This		
		or load testing for 5 of 5			practice will be ongoing.		
		of the past 12 months.			Non-compliance of weekly		
		(a) of 2012 NFPA 99 requires			inspections/testing documenta	ation	
	_	he generator serving the			weekly, the monthly load toad		
	emergency electrica	al system to be in accordance			documentation will result in		
	with NFPA 110, the	e Standard for Emergency and			disciplinary action up to and		
	Standby Powers Sy	stems, Chapter 8. Chapter			including termination.		
	6.4.4.2 of NFPA 99	requires a written record of					
	inspection, perform	ance, exercising period, and			How the corrective action (s))	
	repairs for the gener	rator to be regularly			will be monitored to ensure t	he	
	maintained and ava	ilable for inspection by the			deficient practice will not		
		risdiction. Chapter 6-4.4.1.3 of			recur, i.e., what quality		
	-	ires batteries for on-site			assurance program will be p	ut	
	-	maintained in accordance with			into place?		
		dition, Standard for Emergency			The Quality Assurance Comm	ittee	
	_	Systems. 8.3.7 requires			will review the Performance		
		cluding electrolyte levels or			Improvement Tool at the		
		d in connection with systems			scheduled monthly QA meetin	g to	
	-	veekly and maintained in full			ensure the NFPA's TLC		
	*	anufacturer's specifications.			emergency and standby powe		
		tive batteries shall be repaired			system requirements are being	g	
	-	ately upon discovery of			met.		
	_	5.4.2 of NFPA 99 requires a			By what date will the system		
		spection, performance,			changes for each deficiency	be	
	• •	nd repairs shall be regularly			completed?		
		ilable for inspection by the risdiction. This deficient			6/19/2023		
		t all residents, staff and					
	visitors in each Vill						
	visitois iii cacii VIII	u.					
	Findings include:						
	Based on record rev	view on 05/10/23 between 9:30					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLE B. WING 05/11/2			LETED			
	F PROVIDER OR SUPPLIED OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	a.m. and 3:30 p.m. present, there was a documentation ava months (nothing size emergency generat time of record revice confirmed there was test documentation the five emergency. This finding was reduced by the five emergency. This finding was reduced facility failed to endicate the maintenance and the generators was main the standard for Powers Systems, at schedule for routing testing of the EPSS requires a permane inspections, tests, erepairs shall be main the following: (1) report (2) Identification and the concluding parts replifor the time as reconstructed the following including parts replifor the time as reconstructed the following including parts replifor the time as reconstructed the following including parts replifor the time as reconstructed the findings include: Based on record real a.m. and 3:30 p.m.	with the Maintenance Director no monthly generator load test illable for 6 of the past 12 nee 09/26/22) for the five ors. Based on interview at the ew, the Maintenance Director is no emergency generator load for 6 of the past 12 months for generators. Eviewed with the Executive enance Director during the exit 1/23. Treview and interview, the sure a written record of routine sting for 5 of 5 emergency ntained and available. NFPA for Emergency and Standby 18.3.3 requires a written emaintenance and operational eshall be established. 8.3.4 int record of the EPSS exercising, operation, and intained and readily available. permanent record shall include The date of the maintenance cation of the servicing ification of any unsatisfactory orrective action taken, faced (4) Testing of any repair mmended by the manufacturer. Lice could affect all residents,						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		UILDING	NSTRUCTION	(X3) DATE COMPI 05/11/	ETED	
	PROVIDER OR SUPPLIEI OF GUERIN WOOL		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	show that the five of had routine mainter months. Based on review, the Maintenar only four months are evidence/document has been performed in house or from an This finding was reduced to the properties of the testing of 5 system in accordant for Emergency and Section 8.4.9, as refacilities Code, Section 8.4.9 states Power Systems shad every three years. It is greater than 4 hours terminate the test at 6.4.1.1.6.1 states the electrical system pour at Type 10, Class X 110, Section 8.4.9. or Natural Gas) EP available EPSS load affect all residents, Findings include: Based on record regard and 3:30 p.m. present, the facility	mergency generators have nance during the past 12 interview at the time of record nance Director said he has not seen ation that routine maintenance of the on the five generators either noutside vendor. Viewed with the Executive enance Director during the exit 1/23. The review and interview, the poide complete documentation of 5 Emergency Power Standby coe with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care extino 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency ll be tested at least once within where the assigned class is so, it shall be permitted to fiter 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified at Level 1 generator sets. NFPA 5.3 states for spark-ignited (LP S's, loading shall be the d. This deficient practice could staff, and visitors.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	A. BUILDING CC) DATE SURVEY COMPLETED	
		155770	B. WIN	IG		05/11/	2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	gas fueled emergen- months for the five was confirmed by the time of record reviee This finding was re-	cy generator within the past 36 emergency generators. This he Maintenance Director at the w. viewed with the Executive enance Director during the exit		IAG	BEIGHACT		DATE
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 05/1 Facility Number: 0 Provider Number: 200 At this Life Safety 0 Woods, was found a Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (I 1002 was surveyed Health Care Occupa This one story facility on the story of	11509 155770 909280 Code survey, Villas of Guerin not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, JCC), and 410 IAC 16.2. Villa with Chapter 19, Existing	K 00	00	Plan of Correction for the Vil of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey. The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requitate the 2567 Plan of Correction be considered the Letter of Credible Allegation and request Post Certification Desk Review lieu of the Post Survey Revisit	n of not his et ion nests on sts a	
	corridors, and all re	ridors, spaces open to the sident sleeping rooms. The ty of 10 and had a census of s visit.					

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 01 COMPLE B. WING 05/11/2				
	ROVIDER OR SUPPLIER OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0291 SS=F Bldg. 01	were sprinkled and services were sprinkled and services were sprinkled and services were sprinkled. All the services were sprinkled accordance Lighting the services with 7 the services of the services of the services with 7 the services of the services o	npleted on 05/17/23 ng ng ng ng ng of at least 1-1/2-hour ed automatically in 1.9. niew, observation, and ty failed to ensure there was the testing of 5 of 5 battery were tested monthly for 30 the past 12 months, and tutes during the past 12 months would provide lighting during tages. LSC 19.2.9.1 requires shall be provided in ction 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less prunctional testing shall be for a minimum of 1 1/2 hours thing system is battery ritten records of visual s shall be kept by the owner	K 0	291	K 291 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights were tested for 90 minutes and documented accordingly. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents have the potentia be affected by the alleged defipractice. All 5 of the facilities' battery backup lights were test for 90 minutes and documented accordingly.	ve that d n? I to cient	06/19/2023
	Based on record rev	riew on 05/10/23 between 9:30			What measures will be put in	to	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155770	B. W	ING		05/11/	2023
NAMEOFI	DROVIDED OD CUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	K		1002 S	ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOL	DS		GEOR	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	with the Maintenance Director			place or what systemic		
		did have a preventative			changes you will make to		
		report that battery powered			ensure that the deficient		
		vere tested monthly, however,			practice does not recur?		
		cond monthly testing			The Maintenance Director has		
		ce 09/26/22. Furthermore, there			been educated on the NFPA's	;	
		tion available to show the five			emergency battery backup		
		nergency lights were tested			lighting's testing requirements		
	-	nutes. Based on an interview at review, the Maintenance			The 5 battery backup lights wi	II be	
		PM form for the battery			tested monthly by the	o for	
	_	y lights did not include 30			maintenance director/designe 30 seconds and 90 minutes	e 101	
		sting for each battery powered			annually with completed		
		2. Furthermore, he said there			documentation. The		
	_	tion available for an annual 90			administrator/designee will		
		the past 12 month period.			complete a Performance		
		e facility with the Maintenance			Improvement Tool monthly for	r 6	
		23 between 10:00 a.m. and 12:00			months after reviewing the mo		
		as equipped with five			testing report to ensure the lig	-	
	emergency battery				will provide lighting during a p		
		F - · · · · · · · · · · · · · · · · · ·			outage. Non-compliance with	01101	
	This finding was re	eviewed with the Executive			emergency battery backup ligh	htina	
	_	enance Director during the exit			testing will result in disciplinar	-	
	conference on 05/1				action up to and including	,	
					termination.		
	3.1-19(b)						
					How the corrective action (s))	
					will be monitored to ensure t	the	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?	_	
					The Quality Assurance Comm	iittee	
					will review Performance		
					Improvement Tool related to		
					emergency battery backup		
					lighting's monthly testing for		
					compliance and further		
					recommendations during the		
					scheduled monthly meeting.		

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	· /	ILDING	ONSTRUCTION 01	(X3) DATE : COMPL 05/11 /	ETED
NAME OF I	PROVIDER OR SUPPLIEF	R	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY				
VILLAS (OF GUERIN WOOD	S			GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					By what date will the system changes for each deficiency completed? 6/19/2023		
K 0324 SS=C Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under Cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the cooking facilities through 19.3.2.5.5 Based on record refailed to ensure 1 or was inspected semi Edition, Standard for Protection of Commission 11.4 states	nt is protected in NFPA 96, Standard for oll and Fire Protection of sing Operations, unless: ng equipment (i.e., small is microwaves, hot plates, if for food warming or limited ance with 18.3.2.5.2, sopen to the corridor in ents with 30 or fewer with the conditions under 15.3, or some in smoke compartments atients 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 control of 18.3.2.5.4, 19.3.2.5.1	K 03	324	E 324 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to ha	1	06/19/2023

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trained, qualified, and certified person(s)

acceptable to the authority having jurisdiction

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If o

been affected by this alleged

deficient practice. The kitchen

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023		
NAME OF I	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	OS			ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE.	DATE
	and in accordance v	with Table 11.4. Table 11.4,			exhaust system in the identifie	ed .	
	Schedule for Inspec	ction for Grease Buildup,			Villa has been inspected and		
		rving moderate volume			cleaned.		
	cooking operations	-					
		PA 96, 11.6.1 states, upon			How will you identify other		
	_	thaust system is found to be			residents having the potential	al	
		deposits from grease laden			to be affected by the same		
	_	inated portions of the exhaust			deficient practice and what	_	
		aned by a properly trained,			corrective action will be take		
	· ·	fied person(s) acceptable to the			All residents have the potentia		
		risdiction. Hoods, grease			be affected by the alleged def		
		ns, ducts, and other			practice. The kitchen exhaust		
		be cleaned to remove being to surfaces			systems in the other 7 villas h		
		contaminated with grease or			been inspected and cleaned in		
		the exhaust system is cleaned,			indicated by the inspection.		
		d with powder or other			What measures will be put in	nto.	
		n exhaust cleaning service is			place or what systemic	ilo	
		howing the name of the			changes you will make to		
		, the name of the person			ensure that the deficient		
		k, and the date of inspection or			practice does not recur?		
		aintained on the premises.			The Maintenance Director has	S	
	1	ice could affect all residents,			been educated on the Standa	rd for	
	staff, and visitors in				Ventilation Control and Fire		
					Protection of Commercial Cod	king	
	Findings include:				Operations requirements as		
					related to required inspections	and	
		view on 05/10/23 between 9:30			cleaning of the ventilation sys	tem.	
	1	with the Maintenance Director			The inspection will be schedu	led	
	1 -	spection documentation			by the maintenance		
	_	e past twelve months for the			director/designee for monthly		
	~	system was dated 04/20/23.			annual inspections/cleaning.	The	
	_	hood exhaust system			administrator/designee will		
		vailable within six months prior			complete a Performance		
		e. Based on interview at the			Improvement Tool monthly to		
		ew, the Maintenance Director			ensure the inspections were		
		nd a range hood exhaust			completed and the findings we	ere	
	o4/20/23 date.	vithin six months prior to the			addressed as needed.	1	
	07/20/25 date.				Non-compliance with required testing inspections and cleani		
	i e				I resultd it spections and death	เเนอ	I

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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)	(X5) COMPLETION DATE		
	_	viewed with the Executive enance Director during the exit 1/23.		will result in disciplinary action to and including termination. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Comm will review the Performance Improvement Tool related to kitchen ventilation inspections compliance and to make further recommendations as needed. By what date will the system changes for each deficiency completed? 6/19/2023	he ut ittee for er		
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are respectively. 1. Based on record facility failed to ensure devices connected the performed. NFPA the 2010 Edition, at inspections, testing.	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	K 345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to ha	ı		

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regarding tests and all the applicable information

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been affected by this alleged

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		<u>01</u>	COMPLETED	
155770		B. WING			05/11/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD			
				1002 SISTER BARBARA WAY			
VILLAS OF GUERIN WOODS				GEORGETOWN, IN 47122			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG			_	TAG	DEFICIENCY)	DATE	
	requested in Figure 14.6.2.4:				deficient practice. The		
	(1) Date			components of the identified Fire			
	(2) Test frequency			Alarm System have been tested,		ed,	
	(3) Name of property				calibrated as needed, and		
	(4) Address			inspected per the NFPA 70,			
	(5) Name of person performing inspection,				National, Electric Code, and		
	maintenance, tests, or combination thereof, and				NFPA 72, National Fire Alarm		
	affiliation, business address, and telephone number			and Signaling Code.			
	(6) Name, address, and representative of				How will you identify other		
	approving agency (ies)				residents having the potential		
	(7) Designation of the detector(s) tested			to be affected by the same			
	(8) Functional test of detectors			deficient practice and what			
	(9)*Functional test of required sequence of			corrective action will be taken?		en?	
	operations				All residents, staff, and visitors		
	(10) Check of all smoke detectors				have the potential to be affected		
	(11) Loop resistance for all fixed-temperature,				by the alleged deficient practice.		
	line-type heat detectors				The facilities other Fire Alarm		
	(12) Functional test of mass notification system				Systems have been tested,		
	control units				calibrated as needed, and		
	(13) Functional test of signal transmission to mass				inspected per the NFPA 70,		
	notification systems				National, Electric Code, and		
	(14) Functional test of ability of mass notification			NFPA 72, National Fire Alarm and		and	
	system to silence fire alarm notification appliances				Signaling Code.		
	(15) Tests of intelligibility of mass notification						
	system speakers				What measures will be put into		
	(16) Other tests as required by the equipment			place or what systemic			
	manufacturer's published instructions			changes you will make to			
	(17) Other tests as required by the authority			ensure that the deficient			
	having jurisdiction			practice does not recur?			
	(18) Signatures of tester and approved authority			The Maintenance Director has			
	representative				been educated on testing and		
	(19) Disposition of problems identified during test				maintenance of a fire alarm		
	(e.g., system owner notified, problem			system accordance with the			
	corrected/successfully retested, device				requirements of NFPA 70,		
	abandoned in place)				National Electric Code, and NFPA		
	This deficient practice could affect all occupants				72, National Fire Alarm and		
	in the facility.				Signaling Code and that		
T. 1					documentation is readily available		
Findings include:					for review. The		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	 UILDING	onstruction 01	(X3) DATE COMPL 05/11 /	ETED
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	a.m. and 3:30 p.m. present, the facility semi-annual visual report dated 06/24/maintenance staff, I documentation availinspection and function connected to the first interview at the time confirmed by the M. This finding was reduced to the first interview at the time confirmed by the M. This finding was reduced to the first interview at the time confirmed by the M. This finding was reduced to a serious district of the first interview at the time confirmed by the M. This finding was reduced to a serious and Maintenance on 05/1 and 1-19(b). 2. Based on record facility failed to ensure available to show the sensitivity tested we prior. NFPA 72, N. Edition, Section 14 sensitivity shall be installation, and even After the second resensitivity tests independent of the second resensitivity tests and remained within its range, the length of shall be permitted to years. If the frequence or areas when increase over the proposed of these alarmations of the performed. In the facility of the facili	with the Maintenance Director was able to provide a fire alarm system inspection 22 performed by the facility's nowever, there was no lable for an annual visual tional test of all devices e alarm system. Based on e of record review, this was laintenance Director. viewed with the Executive enance Director during the exit 1/23. review and interview, the sure documentation was nat all smoke detectors were ithin the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of ery alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity time between calibration tests to be extended to a maximum of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of ery alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity time between calibration tests to be extended to a maximum of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector checked within 1 year of the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector the past 24 months or ational Fire Alarm Code, 2010 .4.5.3.1 states detector the past 24 months or ational Fire Alarm Code, 2		administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspection will result in disciplinary action to and including termination. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Commonwill review the Performance Improvement Tool related to Falarm Systems for compliance and for further recommendation by what date will the system changes for each deficiency completed? 6/19/2023	ction n up the ut iittee ire e ons. ic	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO JILDING	INSTRUCTION 01	(X3) DATE COMPL	
		155770	B. WI	NG		05/11/	/2023
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1) Calibrated test r						
		calibrated sensitivity test					
	instrument.	avinusant amongod for the					
		quipment arranged for the					
	purpose. (4) Smoke detector.	fire alarm control unit					
		by the detector causes a signal					
	_	where its sensitivity is outside					
	its listed sensitivity	range.					
	` '	sensitivity method acceptable					
	to the authority hav	0.0					
		have sensitivity outside the					
		ensitivity range shall be					
	cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or						
		spray device that administers					
		centration of aerosol into the					
		eient practice could affect all					
		visitors in the facility.					
	Findings include:						
	Based on record rev	view on 05/10/23 between 9:30					
	a.m. and 3:30 p.m.	with the Maintenance Director					
		was unable to produce a					
		sitivity report for all smoke					
	-	st 24 month period. Based on					
		e of record review, the					
		for confirmed there was no					
	available for the pas	sitivity testing documentation					
	avanable for the pas	st 24 months.					
	This finding was re	viewed with the Executive					
	_	enance Director during the exit					
	conference on 05/1						
	3.1-19(b)						
K 0353	NFPA 101						
SS=F	Sprinkler System	- Maintenance and Testing					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155770	B. W	NG		05/11/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				STER BARBARA WAY		
VILLAS C	F GUERIN WOOD	S			SETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
Bldg. 01	•	Maintenance and Testing					
	•	er and standpipe systems					
		ted, and maintained in					
		IFPA 25, Standard for the					
		g, and Maintaining of					
	Water-based Fire Protection Systems. Records of system design, maintenance,						
		ting are maintained in a					
	•	id readily available.					
		system last checked					
	a) Date sprinker	system last oncored					
	b) Who provided	system test					
	.,	- ,					
	c) Water system	supply source					
	Provide in REMAF	RKS information on					
	coverage for any r	non-required or partial					
	automatic sprinkle	r system.					
	9.7.5, 9.7.7, 9.7.8,						
		riew, observation, and	K 0	353	E 353		06/19/2023
		ty failed to document sprinkler			What corrective action(s) will	1	
		in accordance with NFPA 25			be accomplished for those		
		tler system during 41 of the			residents found to have beer	1	
	•	PA 25, Standard for the			affected by the deficient		
		and Maintenance of			practice?		
		rotection Systems, 2011			The identified facility's dry		
	· ·	.4.2 states gauges on dry pipe			sprinkler system gauges and		
		nall be inspected weekly to			control valve were inspected, a	and	
		nir and water pressures are			maintenance performed as		
		Section 5.1.2 states valves and			indicated. The documentation	IS	
	_	nections shall be inspected,			readily available.		
		ed in accordance with Chapter 2 states Table 13.1.1.2 shall be			How will you identify other		
		on, testing and maintenance of			residents having the potentia	al .	
		onents and trim. Section 4.3.1			to be affected by the same	11	
		be made for all inspections,			deficient practice and what	ļ	
		nce of the system and its			corrective action will be take	n?	
		all be made available to the			All residents, staff, and visitors		
		isdiction upon request. This			have the potential to be affected		
		ould affect all residents, staff,			by the alleged deficient practic		
	F	,,	1		-,g-= do		

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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 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 and visitors in the facility. An audit was completed on the remainder Villas to identify Findings include: sprinkler system gauges and control valve were not inspected a. Based on record review on 05/10/23 between and lacking maintenance as 9:30 a.m. and 3:30 p.m. with the Maintenance required. The identified areas were Director present, there was no documentation corrected. The documentation is available to show the facility's dry sprinkler readily available. system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at What measures will be put into the time of record review, the Maintenance place or what systemic Director confirmed there was no documentation changes you will make to available to show that the facility's sprinkler ensure that the deficient gauges have been inspected at least weekly practice does not recur? during 41 of the past 52 weeks. Based on The Maintenance Director has observations with the Maintenance Director been educated on the facility's dry during a tour of the facility on 05/11/23 between sprinkler system gauges, control 10:00 a.m. and 12:00 p.m. the facility had three valves, required inspections, and pressure gauges at the sprinkler riser. maintenance. The administrator/designee will b. Based on record review on 05/10/23 between complete a Performance 9:30 a.m. and 3:30 p.m. with the Maintenance Improvement Tool after reviewing Director present, there was no monthly sprinkler the monthly documentation of the system control valves inspection documentation weekly and monthly inspections for 8 of the past 12 months. Based on interview at and maintenance that is performed the time of record review, the Maintenance as required. Non-compliance of Director confirmed the lack of sprinkler system the required weekly and monthly inspections on the control valves during the past inspections and required 12 months. maintenance will result in disciplinary action up to and This finding was reviewed with the Executive including termination Director and Maintenance Director during the exit conference on 05/11/23. How the corrective action (s) will be monitored to ensure the 3.1-19(b)deficient practice will not recur, i.e., what quality assurance program will be put into place?

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The Quality Assurance Committee will review the Performance

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	er iic
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	ay be used instead of			
	1. Based on record facility failed to prodocumentation for a quarters. This defic residents, as well as facility.	review and interview, the vide quarterly fire drill 3 of 3 shifts during 2 of 4 ient practice could affect all staff and visitors in the	K 0712	K 712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have	n
	on 05/10/23 betwee the Maintenance Di lacked fire drill doc	the facility's fire drill reports n 9:30 a.m. and 3:30 p.m. with rector present, the facility umentation for the following luring the past 12 month		been affected by this alleged deficient practice. Fire drills he been conducted on both shifts (Days, Nights) in all 8 villas. Documentation is readily available. How will you identify other	5

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155770	B. W	ING		05/11/2	2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			STER BARBARA WAY		
VILLAS	OF GUERIN WOOD	ıs.			GETOWN, IN 47122		
	. COLIMIA AAOOD			SEOING			
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	period:				residents having the potentia	al	
		of the first quarter (January,			to be affected by the same		
	February, and March) of 2023				deficient practice and what		
	b. Second shift (evening) of the second quarter				corrective action will be take		
		ne) of 2022 and so far in 2023			All residents, staff and visitors		
	c. Third shift (night) of the first quarter (January,				have the potential to be affect		
	February, and March) of 2023				by the alleged deficient practic		
	Based on interview at the time of record review,				Fire drills have been conducte	ed on	
the Maintenance Director confirmed the lack of				both shifts (Days, Nights) at			
fire drill reports during the previously mentioned				expected and unexpected time			
	shifts and quarters.				under various conditions in all	-	
	TTT : 0" 1"	e de tatal es es			villas. Documentation includes	8	
	This finding was reviewed with the Executive Director and Maintenance Director during the exit				employee signatures that		
					participated in each drill and		
	conference on 05/1	1/23.			transmission of the alarm that		
	2.1.10(1)				received by monitoring compa	iny.	
	3.1-19(b)						
	2 D11				What measures will be put in	ito	
		review and interview, the			place or what systemic		
		ovide complete fire drill I of 9 fire drills performed			changes you will make to		
		nonth period. This deficient			ensure that the deficient		
		et all residents in the facility.			practice does not recur?		
	practice could affect	t an residents in the facility.			The Maintenance Director has been educated on the	·	
	Findings include:				requirements of conducting		
	i manigo metade.				monthly fire drills in all 8 Villas	. n	
	Based on review of	the facility's fire drill reports			both day shift and night shift a		
		n 9:30 a.m. and 3:30 p.m. with			expected and unexpected time		
	the Maintenance Di				under various conditions and		
		Il report performed on 03/28/23			required documentation of tho		
		first quarter) did not include			that participated in the drills ar		
	•	atures of staff that participated			transmission of the alarm that		
	_	sed on interview at the time of			received by the monitoring	.,===	
		Maintenance Director			company. The		
		of staff signatures on the fire			administrator/designee will		
	drill report dated 03				complete a Performance		
	· •				Improvement Tool to ensure the	he I	
	This finding was re	viewed with the Executive			monthly fire drills were conduc		
		enance Director during the exit			at expected and unexpected t		
	conference on 05/1	_	1		under various conditions mont		

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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 01 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 on both shifts and validate proper 3.1-19(b)documentation is completed. Non-compliance with required fire 2. Based on record review and interview, the drills and documentation will result facility failed to ensure 3 of 9 fire drill reports in disciplinary action up to and included complete documentation of the including termination transmission of a fire alarm signal to the monitoring company/fire department during the How the corrective action (s) past twelve months. LSC 19.7.1.4 requires fire will be monitored to ensure the drills in health care occupancies shall include the deficient practice will not transmission of the fire alarm signal and recur, i.e., what quality simulation of emergency conditions. This assurance program will be put deficient practice could affect all residents. into place? The Quality Assurance Committee Findings include: will review the Performance Improvement Tool related to the Based on review of the facility's fire drill reports competition and proper on 05/10/23 between 9:30 a.m. and 3:30 p.m. with documentation of the required fire the Maintenance Director present, fire drill reports drills for compliance and to make dated 08/27/22, 10/27/22 and 03/28/23 were not further recommendations. provided with documentation for the transmission By what date will the systemic of the alarm to the monitoring company. Based on changes for each deficiency be interview at the time of record review, the completed? Maintenance Director acknowledged there was no 6/19/2023 information on the previously mentioned fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3-1.19(b) K 0914 **NFPA 101** SS=F Electrical Systems - Maintenance and Bldg. 01 **Testing** Electrical Systems - Maintenance and

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Testing

Hospital-grade receptacles at patient bed

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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 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 VILLAS OF GUERIN WOODS (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 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and K 0914 K 914 06/19/2023 interview; the facility failed to ensure complete What corrective action(s) will documentation was available for all be accomplished for those nonhospital-grade electrical receptacles in all residents found to have been resident room locations tested at least annually. affected by the deficient NFPA 99, Health Care Facilities Code 2012 Edition, practice? Section 6.3.4.1.3 states receptacles not listed as No residents were found to have hospital-grade, at patient bed locations and in been affected by this alleged locations where deep sedation or general deficient practice. Non-hospital anesthesia is administered, shall be tested at grade receptacles in resident intervals not exceeding 12 months. Additionally, rooms have been tested for Section 6.3.3.2, Receptacle Testing in Patient Care polarity, continuity of ground Rooms requires the physical integrity of each circuit, and retention force of receptacle shall be confirmed by visual inspection. grounding blade. Receptacles The continuity of the grounding circuit in each were replaced as indicated by the electrical receptacle shall be verified. Correct tests. polarity of the hot and neutral connections in How will you identify other each electrical receptacle shall be confirmed; and

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f '		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155770	B. WI	NG		05/11/	2023
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122	•	
			Т				(37.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		e grounding blade of each			residents having the potentia	al	Bill
		e (except locking-type			to be affected by the same		
	_	e not less than 115 grams (4			deficient practice and what		
	ounces). This defici	ent practice could affect all			corrective action will be take	n?	
	residents.				All residents, staff and visitors		
					have the potential to be affect	ed	
	Findings include:				by the alleged deficient praction		
					Non-hospital grade receptacle	s in	
		view on 05/10/23 between 9:30			resident rooms have been tes		
a.m. and 3:30 p.m. with the Maintenance Director				for polarity, continuity of groun	nd		
	present, there was no documentation available of				circuit, and retention force of		
	an annual resident room receptacle test for non				grounding blade. Receptacles		
hospital-grade receptacles. Based on interview at the time of record review, the Maintenance				were replaced as indicated by	the		
					tests.		
	resident rooms were	the electrical receptacles in			M/hat magazinas will be mut in		
		s he knew. He further said he			What measures will be put in	ito	
	_	enance Director at the facility			place or what systemic changes you will make to		
		s and could not find			ensure that the deficient		
	· ·	now that annual testing per			practice does not recur?		
		ele Testing requirements was			The Maintenance Director was	8	
	_	nt information within the past			educated on documenting the		
	_	prior. Based on observations			annual testing of non-hospital		
	-	n 10:00 a.m. and 12:00 p.m.			grade receptacles in resident		
		facility with the Maintenance			rooms, to include testing for		
	Director, there were	at least four electrical			polarity, continuity of ground		
	receptacles in each	resident room.			circuit, and retention force of t	he	
					grounding blade. Receptacles	3	
	_	viewed with the Executive			were replaced as indicated by	the	
		enance Director during the exit			tests. The administrator/desig	nee	
	conference on 05/1	1/23.			will complete a Performance		
	2.1.10(1)				Improvement Tool to ensure		
	3.1-19(b)				non-hospital grade receptacle		
					tested annually, replace when		
					indicated by testing, and requi		
					documentation. Non-complian		
					with required annual test will r		
					in disciplinary action up to and including termination	1	
					molaumy termination		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/11/2023
	ROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP CO SISTER BARBARA WAY GETOWN, IN 47122	DD .
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pre annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. der load conditions include		How the corrective act will be monitored to en deficient practice will recur, i.e., what quality assurance program wi into place? The Quality Assurance will review the Performal Improvement Tool relate testing non-hospital grareceptacles annually for compliance and to make recommendations. By what date will the schanges for each deficience of the completed? 6/19/2023	Issure the not Il be put Committee ance ed to de e further ystemic

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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 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 VILLAS OF GUERIN WOODS (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 loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4. 6.5.4. 6.6.4 (NFPA 99), NFPA 110. NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the K 0918 K 918 06/19/2023 facility failed to ensure a written record of weekly What corrective action(s) will inspections for 1 of 1 generator was maintained be accomplished for those for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 residents found to have been NFPA 99 requires batteries for on-site generators affected by the deficient shall be maintained in accordance with NFPA 110, practice? 2010 Edition, Standard for Emergency and No residents were found to have Standby Power Systems. 8.3.7 requires storage been affected by this alleged batteries, including electrolyte levels or battery deficient practice. The facilities five voltage, used in connection with systems shall be generators have the require weekly inspected weekly and maintained in full inspections/tested, monthly load compliance with manufacturer's specifications. toad test, annual maintenance. 8.3.7.2 states defective batteries shall be repaired and 4-hour load test completed or replaced immediately upon discovery of and documented according to defects. Chapter 6.5.4.2 of NFPA 99 requires a meet NFPA emergency power and written record of inspection, performance, standby system requirements. exercising period, and repairs shall be regularly maintained and available for inspection by the How will you identify other authority having jurisdiction. This deficient residents having the potential practice could affect all residents, staff and to be affected by the same

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visitors.

Findings include:

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deficient practice and what corrective action will be taken?

All residents, staff, and visitors

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u> COMP		ETED
		155770	B. W	ING		05/11/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
\/// 1 4 0 6		0			ISTER BARBARA WAY		
VILLAS	OF GUERIN WOOD	5		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					have the potential to be affected	ed	
	Based on review of	the generator inspection			by the alleged deficient practic		
		between 9:30 a.m. and 3:30			The facilities five generators h		
	_	enance Director present, there			the require weekly		
	_	ion available to show the			inspections/tested, monthly loa	ad	
		or was inspected/tested weekly			toad test, annual maintenance		
		est recent 52 week period			and 4-hour load test complete		
	-	3/22). Based on interview at			and documented according to		
		eview, the Maintenance			meet NFPA emergency power		
		es test/inspect of the			standby system requirements.		
		or weekly but does not always			Standby System requirements.	•	
	document the test/ir	•			What measures will be put in	nto	
	document the test in	ispection results.			place or what systemic		
	This finding was re	viewed with the Executive			changes you will make to		
	_	enance Director during the exit			ensure that the deficient		
	conference on 05/1	_			practice does not recur?		
	conference on 05/1	1723.			The Maintenance Director has		
	3.1-19(b)				been educated on the NFPA's		
	3.1-17(0)				LTC emergency and standby	•	
	2 Based on record	review and interview, the			power system requirements. T	ho	
		intain a complete written record			administrator/designee will	IIC	
	-	or load testing for 1 of 1			complete the Performance		
		of the past 12 months. Chapter			Improvement Tool for 6 month	10	
		12 NFPA 99 requires monthly			after reviewing the weekly	15	
	` ′	ator serving the emergency			inspections/testing documenta	tion	
		be in accordance with NFPA					
	-	or Emergency and Standby			weekly, the monthly load toad	lesi	
		hapter 8. Chapter 6.4.4.2 of			documentation during the scheduled monthly Quality		
		written record of inspection,			_		
	-	ising period, and repairs for the			Assurance meeting and the annual maintenance and 4-ho		
	_	ilarly maintained and available					
	-	-			load test documentation during	~	
	for inspection by th				each Decembers scheduled C	ĮΑ	
	-	er 6-4.4.1.3 of 2012 NFPA 99			meeting to ensure the		
	_	or on-site generators shall be			requirements are met. This		
		dance with NFPA 110, 2010			practice will be ongoing.		
		or Emergency and Standby			Non-compliance of weekly		
	-	3.7 requires storage batteries,			inspections/testing documenta		
		e levels or battery voltage,			weekly, the monthly load toad	test	
		with systems shall be			documentation will result in		
	inspected weekly ar	nd maintained in full	1		disciplinary action up to and		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002 \$	CADDRESS, CITY, STATE, ZIP COD BISTER BARBARA WAY RGETOWN, IN 47122	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	compliance with ma 8.3.7.2 states defect or replaced immedi defects. Chapter 6. written record of in exercising period, a maintained and ava authority having jurpractice could affect visitors. Findings include: Based on record revalum, and 3:30 p.m. present, there was a documentation avairements (nothing siremergency generate time of record revice confirmed there was test documentation the emergency generate time of record revice confirmed there was test documentation the emergency generate time of record revice confirmed there was test documentation the emergency generated there was test documentation the emergency generated the emergency generated there was test documentation available.	anufacturer's specifications. ive batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly itable for inspection by the risdiction. This deficient it all residents, staff and are with the Maintenance Director to monthly generator load test lable for 6 of the past 12 are 09/26/22) for the or. Based on interview at the rew, the Maintenance Director is no emergency generator load for 6 of the past 12 months for erator. Viewed with the Executive enance Director during the exit	IAU	including termination. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Commill review the Performance Improvement Tool related emergency and standby pow system requirements for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	the out nittee er ner

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	 UILDING	nstruction 01	(X3) DATE COMPL 05/11/	ETED
	OF PROVIDER OR SUPPLIE S OF GUERIN WOOL		1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX	(EACH DEFICIEN	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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION
TAG	repairs shall be ma 8.3.4.1 requires the the following: (1) report (2) Identific personnel (3) Not condition and the c including parts rep- for the time as recor This deficient pract staff and visitors. Findings include: Based on record re a.m. and 3:30 p.m. present, there was a show that the emer routine maintenance Based on interview the Maintenance D Maintenance Direct months and has not evidence/document has been performed house or from an o This finding was re Director and Maint conference on 05/1 3.1-19(b) 4. Based on record facility failed to pre for the testing of 5 System in accordar for Emergency and Section 8.4.9, as re Facilities Code, Se	atation that routine maintenance If on the generator either in utside vendor. Eviewed with the Executive enance Director during the exit	TAG			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		l í	JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIE		<u> </u>	1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Power Systems shat every three years. greater than 4 hour terminate the test at 6.4.1.1.6.1 states the electrical system pat Type 10, Class 2, 110, Section 8.4.9 or Natural Gas) EP available EPSS loa affect all residents, Findings include: Based on record rea.m. and 3:30 p.m. present, the facility documentation of a gas fueled emerger months for the five was confirmed by time of record revi	all be tested at least once within Where the assigned class is s, it shall be permitted to fter 4 hours. NFPA 99 Section nat Type 1 and Type 2 essential ower sources shall be classified K, Level 1 generator sets. NFPA .5.3 states for spark-ignited (LP 'S's, loading shall be the d. This deficient practice could staff, and visitors. view on 05/10/23 between 9:30 with the Maintenance Director of could not provide a four hour load test of the LP ney generator within the past 36 emergency generators. This the Maintenance Director at the ew.					
K 0000							
Bldg. 03	Licensure Survey v Department of Hea 483.90(a).	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR 10/23 and 05/11/23	K 0	000	Plan of Correction for the Vi of Guerin Woods 2023 Life Safety Code with Emergenc Preparedness Survey. The creation and submissio this Plan of Correction does constitute an admission by provider of any conclusion	y n of not this	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		DISTRUCTION 03	(X3) DATE SURVEY COMPLETED 05/11/2023
	1002 SI	ISTER BARBARA WAY	
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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Villa 1004 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.		forth in the statement of deficiencies, or of any violati of regulation. This provider respectfully request that the 2567 Plan of Correction be considered the Letter of Credible Allegation and request Post Certification Desk Review lieu of the Post Survey Revisit.	ests on sts a v in
NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30	K 0291	K 291 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	
	DENOTIDER OR SUPPLIER DF GUERIN WOODS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Villa 1004 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/17/23 NFPA 101 Emergency Lighting	DENTIFICATION NUMBER 155770 A. BUILDING B. WING PROVIDER OR SUPPLIER DF GUERIN WOODS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Villa 1004 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/17/23 NFPA 101 Emergency Lighting Emerge	DEFOUNDER OF CORRECTION IDENTIFICATION NUMBER 155770 STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas of Guerin Woods, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety Code (LSC), and 410 LAC 16.2. Villa 1004 was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 10 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 05/17/23 NFPA 101 Emergency Lighting Emergency Lighting Emergency Lighting Emergency Lighting Emergency with 7.9 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30 seconds during 6 of the past 12 months, and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155770	B. W	NG		05/11/	2023
				CTD FET	ADDRESS STEW STATE ZID SOD		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\/!!! \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		00			STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	05		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	to ensure the light v	vould provide lighting during			No residents were found to ha	ve	
	periods of power ou	itages. LSC 19.2.9.1 requires			been affected by this alleged		
	emergency lighting shall be provided in				deficient practice. All 5 of the		
		ction 7.9. Section 7.9.3.1.1 (1)			facilities battery backup lights	that	
		testing shall be conducted			were tested for 90 minutes and		
	_	nimum of 3 weeks and a			documented accordingly.	-	
	-	ks between tests, for not less			accumented accordingly:		
) Functional testing shall be			How will you identify other		
		for a minimum of 1 1/2 hours			residents having the potentia	nI .	
		ghting system is battery			to be affected by the same		
		ritten records of visual			deficient practice and what		
	•	s shall be kept by the owner			corrective action will be take	n?	
	for inspection by th				All residents have the potentia		
		eficient practice could affect all			be affected by the alleged defi		
	_	s staff and visitors in the			practice. All 5 of the facilities'	Ololit	
	facility.	s starr and visitors in the			battery backup lights were test	hat	
	lacinty.				for 90 minutes and documente		
	Findings include:				accordingly.	·u	
	i manigs merade.				accordingly.		
	Based on record rev	view on 05/10/23 between 9:30			What measures will be put in	to	
		with the Maintenance Director			place or what systemic	.0	
	_	did have a preventative			changes you will make to		
		report that battery powered			ensure that the deficient		
	` ′	ere tested monthly, however,			practice does not recur?		
		and monthly testing			The Maintenance Director has		
		e 09/26/22. Furthermore, there			been educated on the NFPA's		
		ion available to show the five			emergency battery backup		
		nergency lights were tested			lighting's testing requirements.		
		nutes. Based on an interview at			The 5 battery backup lights wil		
		eview, the Maintenance			tested monthly by the	i bc	
		PM form for the battery			maintenance director/designed	for	
		y lights did not include 30			30 seconds and 90 minutes	, 101	
		ting for each battery powered			annually with completed		
	_	2. Furthermore, he said there			documentation. The		
	_				administrator/designee will		
	was no documentation available for an annual 90				_		
	minute test during the past 12 month period.				complete a Performance	6	
	During a tour of the facility with the Maintenance		Improvement Tool monthly for 6				
	Director on 05/11/23 between 10:00 a.m. and 12:00 p.m., the facility was equipped with five				months after reviewing the mo	-	
					testing report to ensure the light		
	emergency battery p	powered lights.			will provide lighting during a po	ower	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 03	(X3) DATE SURV COMPLETED 05/11/202)			
	PROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(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 SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE CO.	(X5) MPLETION DATE		
	Director and Mainte conference on 05/11	viewed with the Executive enance Director during the exit 1/23.		outage. Non-compliance emergency battery back testing will result in disci action up to and includin termination.	up lighting plinary			
	3.1-19(b)			How the corrective activial be monitored to endeficient practice will no recur, i.e., what quality assurance program will into place? The Quality Assurance will review Performance Improvement Tool related emergency battery back lighting's monthly testing compliance and further recommendations during scheduled monthly meet. By what date will the sychanges for each deficience completed? 6/19/2023	sure the ot I be put Committee d to up I for I the ing.			
K 0321 SS=F Bldg. 03	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPL	ETED
		155770	B. W	NG		05/11/	/2023
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹		l	ISTER BARBARA WAY		
\/II I A S (OF GUERIN WOOD	ns		1	GETOWN, IN 47122		
VILLAG	JI GOLININ WOOL			GLOING	3L10WN, IN 47 122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	nonrated or field-a	applied protective plates that					
	do not exceed 48	inches from the bottom of					
	the door. Describe the floor and zone locations of						
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation						
		-Fired Heater Rooms					
	, -	er than 100 square feet)					
		nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)						
	e. Trash Collectio						
	(exceeding 64 gal	•					
		orage Rooms/Spaces					
	(over 50 square fe	•					
	Hazard - see K32	classified as Severe					
		on and interview, the facility	K_0	221	K 321		06/19/2023
		f 1 egress corridor in 1 of 2	K U	321	What corrective action(s) wil		00/19/2023
		its was not used to store			be accomplished for those	•	
	_	al. This deficient practice			residents found to have beer	1	
		dents, staff, and visitors.			affected by the deficient	-	
		, , ,			practice?		
	Findings include:				No residents were found to ha	ve	
					been affected by this alleged		
	Based on observation	ons on 05/11/23 between 10:00			deficient practice. The		
	a.m. and 12:00 p.m	. during a tour of the facility			combustible materials that we	re in	
	_	ice Director, the Beauty Shop			beauty shop were removed.		
		ll was being used to store]		
		ver type totes full of items,			How will you identify other		
	cardboard boxes, o	ld furniture, and mattresses,			residents having the potentia	al	
	and a variety of oth	er storage items. This area			to be affected by the same		
	was open to the egr	ress corridor. Based on			deficient practice and what		
	interview at the tim	e of observation, the			corrective action will be take	n?	
	Maintenance Direc	tor said this area has been this			All residents have the potentia	ıl to	
	way ever since he's	been at the facility.			be affected by the alleged defi	cient	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155770	B. Wl	ING		05/11/	/2023
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			STER BARBARA WAY		
VILLAS	OF GUERIN WOOD	os			GETOWN, IN 47122		
			1				Г
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	TE1 : C 1:				practice. The facility conducte	d an	
	-	viewed with the Executive			audit to ensure combustible		
	Director and Maintenance Director during the exit conference on 05/11/23.				materials are not stored in egr		
					corridors in smoke compartme		
	2110(1)				Identified items were removed	l.	
	3.1-19(b)				What magazires will be said in	140	
					What measures will be put in	ιιO	
					place or what systemic		
					changes you will make to ensure that the deficient		
					practice does not recur? The Maintenance Director has		
					been educated on proper stora		
					of combustible materials and t	-	
					combustible materials must be		
					moved if they are identified as		
					being stored appropriately. Th		
					maintenance director/designed		
					complete daily rounds to ident		
					non-compliance with storing	y	
					combustible materials and cor	rect	
					immediately. The administrato		
					complete a weekly Performan		
					Improvement tool to identify		
					continued non-compliance.		
					Non-compliance with daily		
					environmental rounds and		
					combustible material storage v	will	
					result in disciplinary action up		
					and including termination.		
					How the corrective action (s))	
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					The Quality Assurance Comm	ittee	
					will review the Performance		
					Improvement Tool and make		
			1		further recommendations or		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION (X3) DAT		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL		
		155770	B. W.	ING		05/11/	/2023	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
VILLAS (OF GUERIN WOOD	os		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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	λΤΕ	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)		DATE		
					changes as needed during the	•		
					scheduled monthly meeting.			
					By what date will the system			
					changes for each deficiency completed?	be		
					6/19/2023			
					0/10/2020			
K 0324	NFPA 101							
SS=C	Cooking Facilities							
Bldg. 03	Cooking Facilities							
	Cooking equipme	•						
		NFPA 96, Standard for						
		l and Fire Protection of						
		ing Operations, unless:						
		ng equipment (i.e., small						
		is microwaves, hot plates,						
		I for food warming or limited						
	19.3.2.5.2	ance with 18.3.2.5.2,						
		open to the corridor in						
	•	ents with 30 or fewer						
	<u> </u>	rith the conditions under						
	18.3.2.5.3, 19.3.2							
	* cooking facilities	in smoke compartments						
	with 30 or fewer p	atients comply with						
	conditions under	18.3.2.5.4, 19.3.2.5.4.						
	•	protected according to						
		3 are not required to be						
		rdous areas, but shall not						
	be open to the co							
	_	1 18.3.2.5.4, 19.3.2.5.1						
	through 19.3.2.5.5	view and interview, the facility	IZ A	224	E 324		06/10/2022	
		f 1 kitchen exhaust systems	K 0	324	What corrective action(s) wil	11	06/19/2023	
		annually. NFPA 96, 2011			be accomplished for those	•		
	•	or Ventilation Control and Fire			residents found to have been	n		
	· ·	nercial Cooking Operations,			affected by the deficient	-		
		the entire exhaust system shall			practice?			
		ease buildup by a properly			No residents were found to ha	ave		
		nd certified person(s)			been affected by this alleged			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED
	NT OF DEFICIENCIES	ī	(V2) N	HH TIDLE C	ONSTRUCTION	(X3) DATE	B NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	UILDING	03	COMPL	
AND FLAN	OF CORRECTION	155770	B. W		03	05/11/	
		133770	В. "			03/11/	2020
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
VILLAS	OF GUERIN WOOD	OS			SISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	acceptable to the au	thority having jurisdiction			deficient practice. The kitchen	1	
	and in accordance	with Table 11.4. Table 11.4,			exhaust system in the identifie		
	Schedule for Inspec	ction for Grease Buildup,			Villa has been inspected and		
	requires systems se	rving moderate volume			cleaned.		
	cooking operations	shall be inspected					
	semiannually. NFI	PA 96, 11.6.1 states, upon			How will you identify other		
	inspection, if the ex	chaust system is found to be			residents having the potenti	al	
	contaminated with	deposits from grease laden			to be affected by the same		
	vapors, the contami	inated portions of the exhaust			deficient practice and what		
	system shall be clea	aned by a properly trained,			corrective action will be take	n?	
	qualified, and certif	fied person(s) acceptable to the			All residents have the potentia	al to	
	authority having ju	risdiction. Hoods, grease			be affected by the alleged def	icient	
	removal devices, fa	ins, ducts, and other			practice. The kitchen exhaust		
		be cleaned to remove			systems in the other 7 villas h	ave	
		ninants prior to surfaces			been inspected and cleaned in	f	
		contaminated with grease or			indicated by the inspection.		
		the exhaust system is cleaned,					
		ed with powder or other			What measures will be put in	nto	
		n exhaust cleaning service is			place or what systemic		
		howing the name of the			changes you will make to		
		, the name of the person			ensure that the deficient		
		k, and the date of inspection or			practice does not recur?		
	_	aintained on the premises.			The Maintenance Director has		
	_	ice could affect all residents,			been educated on the Standa	rd for	
	staff, and visitors in	the facility.			Ventilation Control and Fire		
	E' 1' ' 1 1				Protection of Commercial Cod	oking	
	Findings include:				Operations requirements as		
	D 1 .	05/10/221			related to required inspections		
		view on 05/10/23 between 9:30			cleaning of the ventilation sys		
	-	with the Maintenance Director			The inspection will be schedu	ied	
	1 *	spection documentation			by the maintenance		
	_	e past twelve months for the			director/designee for monthly		
	1 ~	system was dated 04/20/23.			annual inspections/cleaning.	Ine	
	There was no range	e hood exhaust system			administrator/designee will		

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04/20/23 date.

inspection report available within six months prior

to the 04/20/23 date. Based on interview at the

time of record review, the Maintenance Director

system inspection within six months prior to the

said he could not find a range hood exhaust

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complete a Performance

addressed as needed.

Improvement Tool monthly to

ensure the inspections were

completed and the findings were

Non-compliance with required

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X)	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b)			testing inspections and cleaning will result in disciplinary action upon to and including termination. 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? The Quality Assurance Committ will review the Performance Improvement Tool related to kitchen ventilation inspections for compliance and to make further recommendations as needed. By what date will the systemic changes for each deficiency be completed? 6/19/2023	e dee dee
K 0345 SS=F Bldg. 03	in accordance with complying with the National Electric C National Fire Alart Records of system and testing are respected. 3, 9.6.1.5, N 1. Based on record facility failed to ensure devices connected the performed. NFPA the 2010 Edition, at	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	K 345 What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice? No residents were found to have	the

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provided that includes the following information

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been affected by this alleged

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CENTERS FOR MEDICARE & MEDICAID SERVICES

T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		UILDING	nstruction <u>03</u>	(X3) DATE COMPL 05/11 /	ETED
ROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
SUMMARY (EACH DEFICIEN REGULATORY OF regarding tests and requested in Figure (1) Date (2) Test frequency (3) Name of proper (4) Address (5) Name of person maintenance, tests, affiliation, business number (6) Name, address, approving agency ((7) Designation of t (8) Functional test operations (10) Check of all set (11) Loop resistanc line-type heat detec (12) Functional test control units (13) Functional test notification systems (14) Functional test system to silence fir (15) Tests of intellig system speakers (16) Other tests as r manufacturer's publ (17) Other tests as r having jurisdiction (18) Signatures of t representative (19) Disposition of (e.g., system owner corrected/successful	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION all the applicable information 14.6.2.4: Ty performing inspection, or combination thereof, and address, and telephone and representative of ties) the detectors of required sequence of the detectors of mass notification system of signal transmission to mass of ability of mass notification the alarm notification appliances gibility of mass notification		1002 SI	STER BARBARA WAY SETOWN, IN 47122 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) deficient practice. The components of the identified F Alarm System have been tests calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. How will you identify other residents having the potential be affected by the same defici practice and what corrective a will be taken? All residents, staff, and visitors have the potential to be affect by the alleged deficient practic The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm Signaling Code. What measures will be put into place or what systemic chang you will make to ensure that the deficient practice does not recome the control of the maintenance Director has been educated on testing and maintenance of a fire alarm system accordance with the requirements of NFPA 70, National Electric Code, and N 72, National Fire Alarm and	to ient action seed ce.	(X5) COMPLETION DATE
abandoned in place This deficient pract in the facility.	ice could affect all occupants			Signaling Code and that documentation is readily avail for review. The administrator/designee will	able	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIEF DF GUERIN WOOD			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	TE	DATE
	Findings include:				complete a Performance Improvement Tool monthly to		
	Based on record review on 05/10/23 between 9:30				ensure the testing, recalibration	n as	
		with the Maintenance Director			needed, and inspections are		
	1 -	was able to provide a			completed per regulations.		
		fire alarm system inspection 22 performed by the facility's			Non-compliance with required		
		however, there was no			testing, calibration, and inspec will result in disciplinary action		
		ilable for an annual visual			to and including termination.	ир	
		tional test of all devices			How the corrective action (s) v	vill	
	_	e alarm system. Based on			be monitored to ensure the		
	interview at the tim	e of record review, this was			deficient practice will not recur	-,	
	confirmed by the Maintenance Director.				i.e., what quality assurance		
					program will be put into place?		
	_	viewed with the Executive			The Quality Assurance Comm	ittee	
		enance Director during the exit			will review the Performance		
	conference on 05/1	1/23.			Improvement Tool related to F		
	3.1-19(b)				Alarm Systems for compliance and for further recommendation		
	3.1-17(0)				By what date will the systemic		
	Based on record	review and interview, the			changes for each deficiency b		
		sure documentation was			completed?	_	
	available to show th	nat all smoke detectors were			6/19/2023		
		ithin the past 24 months or					
	1 ~	ational Fire Alarm Code, 2010					
		.4.5.3.1 states detector					
	· ·	checked within 1 year of					
		ery alternate year thereafter.					
		quired calibration test, if icate that the detector has					
	I	listed and marked sensitivity					
		time between calibration tests					
		o be extended to a maximum of					
	_	uency is extended, records of					
	detector caused nui	sance alarms and subsequent					
		ms shall be maintained. In					
		re nuisance alarms show an					
	_	revious year, calibration tests					
		To ensure that each smoke					
	detector is within it	s listed and marked sensitivity					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	(1) Calibrated test r (2) Manufacturer's instrument. (3) Listed control e purpose. (4) Smoke detector arrangement where at the control unit v its listed sensitivity (5) Other calibrated to the authority hav Detectors found to listed and marked s cleaned and recalib The detector sensiti measured using any an unmeasured con detector. This defic residents, staff, and Findings include: Based on record reva.m. and 3:30 p.m. present, the facility smoke detector sen detectors for the painterview at the tim Maintenance Direct smoke detector sen available for the pa	quipment arranged for the /fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be rated, or replaced. vity cannot be tested or repray device that administers centration of aerosol into the cient practice could affect all visitors in the facility. //iew on 05/10/23 between 9:30 with the Maintenance Director was unable to produce a sitivity report for all smoke st 24 month period. Based on e of record review, the for confirmed there was no sitivity testing documentation st 24 months. viewed with the Executive enance Director during the exit						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155770		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIEF DF GUERIN WOOD		STREET 1002 S GEOR		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 03	Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location arra) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record revinterview; the facili system inspections for 1 of 1 dry sprinkle system inspections for 1 of 1 dry sprinkle system inspection. Testing, Water-Based Fire PEdition, Section 5.2 sprinkler systems shensure that normal abeing maintained. Sire department contested, and maintain 13. Section 13.1.1. utilized for inspectivalves, valve compostates records shall tests, and maintenant and maintenant states.	supply source RKS information on non-required or partial er system.	K 0353	E 353 What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice? The identified facility's dry sprinkler system gauges and control valve were inspected, maintenance performed as indicated. The documentation readily available. How will you identify other residents having the potenti to be affected by the same deficient practice and what corrective action will be take All residents, staff, and visitor	and is al

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155770	B. W	ING		05/11/	2023
				CENTER	ADDRESS STEV STATE STR SOD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
	0. 0. IEDIN I W0.00				ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	os —		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	authority having jur	risdiction upon request. This			have the potential to be affected	ed	
		ould affect all residents, staff,			by the alleged deficient practic		
	and visitors in the facility.				An audit was completed on the		
	, in the second				remainder Villas to identify		
	Findings include:				sprinkler system gauges and		
					control valve were not inspect	ed	
	a. Based on record	review on 05/10/23 between			and lacking maintenance as		
		p.m. with the Maintenance			required. The identified areas	were	
		ere was no documentation			corrected. The documentation		
	_	ne facility's dry sprinkler			readily available.		
		e inspected weekly during 41]		
		period. Based on interview at			What measures will be put in	ito	
	^	eview, the Maintenance			place or what systemic		
		there was no documentation			changes you will make to		
		nat the facility's sprinkler			ensure that the deficient		
		represented at least weekly			practice does not recur?		
		st 52 weeks. Based on			The Maintenance Director has	;	
	-	ne Maintenance Director			been educated on the facility's		
		facility on 05/11/23 between			sprinkler system gauges, cont	-	
	-	00 p.m. the facility had three			valves, required inspections, a		
	pressure gauges at t				maintenance. The		
		•			administrator/designee will		
	b. Based on record	review on 05/10/23 between			complete a Performance		
	9:30 a.m. and 3:30	p.m. with the Maintenance			Improvement Tool after review	/ina	
		ere was no monthly sprinkler			the monthly documentation of	-	
	•	res inspection documentation			weekly and monthly inspection		
	for 8 of the past 12	months. Based on interview at			and maintenance that is perfo		
	•	eview, the Maintenance			as required. Non-compliance		
	Director confirmed	the lack of sprinkler system			the required weekly and month		
		control valves during the past			inspections and required	,	
	12 months.				maintenance will result in		
					disciplinary action up to and		
	This finding was re	viewed with the Executive			including termination		
	_	enance Director during the exit					
	conference on 05/1	9			How the corrective action (s))	
					will be monitored to ensure t		
	3.1-19(b)				deficient practice will not	-	
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			A. BUILDING B. WING	03	COMPLETED 05/11/2023		
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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)	DATE		
14.0740				The Quality Assurance Comm will review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	er i c		
K 0712 SS=F Bldg. 03	alarm signal and s conditions. Fire dri and unexpected tir conditions, at least The staff is familiar aware that drills ar routine. Where dri 9:00 PM and 6:00 announcement material audible alarms. 19.7.1.4 through 1 1. Based on record facility failed to producumentation for 3 quarters. This defic residents, as well as facility. Findings include: Based on review of on 05/10/23 between	t quarterly on each shift. If with procedures and is the part of established tills are conducted between AM, a coded ty be used instead of 19.7.1.7 Thereview and interview, the twide quarterly fire drill tof 3 shifts during 2 of 4 tient practice could affect all staff and visitors in the 19.30 a.m. and 3:30 p.m. with	K 0712	K 712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to habeen affected by this alleged deficient practice. Fire drills habeen conducted on both shifts (Days, Nights) in all 8 villas.	ve ve		
		n 9:30 a.m. and 3:30 p.m. with rector present, the facility		(Days, Nights) in all 8 villas. Documentation is readily avail	able.		

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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 03 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 lacked fire drill documentation for the following shifts and quarters during the past 12 month How will you identify other residents having the potential a. First shift (day) of the first quarter (January, to be affected by the same February, and March) of 2023 deficient practice and what b. Second shift (evening) of the second quarter corrective action will be taken? (April, May, and June) of 2022 and so far in 2023 All residents, staff and visitors c. Third shift (night) of the first quarter (January, have the potential to be affected February, and March) of 2023 by the alleged deficient practice. Based on interview at the time of record review, Fire drills have been conducted on the Maintenance Director confirmed the lack of both shifts (Days, Nights) at fire drill reports during the previously mentioned expected and unexpected times shifts and quarters. under various conditions in all 8 villas. Documentation includes This finding was reviewed with the Executive employee signatures that Director and Maintenance Director during the exit participated in each drill and conference on 05/11/23. transmission of the alarm that was received by monitoring company. 3.1-19(b) What measures will be put into 2. Based on record review and interview, the place or what systemic facility failed to provide complete fire drill changes you will make to documentation for 1 of 9 fire drills performed ensure that the deficient during the past 12 month period. This deficient practice does not recur? practice could affect all residents in the facility. The Maintenance Director has been educated on the requirements of conducting Findings include: monthly fire drills in all 8 Villas on Based on review of the facility's fire drill reports both day shift and night shift at on 05/10/23 between 9:30 a.m. and 3:30 p.m. with expected and unexpected times the Maintenance Director present, the under various conditions and the documented fire drill report performed on 03/28/23 required documentation of those (second shift of the first quarter) did not include that participated in the drills and the names and signatures of staff that participated transmission of the alarm that was in the fire drill. Based on interview at the time of received by the monitoring record review, the Maintenance Director company. The confirmed the lack of staff signatures on the fire administrator/designee will drill report dated 03/28/23. complete a Performance Improvement Tool to ensure the

This finding was reviewed with the Executive

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monthly fire drills were conducted

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 05/11/2023	
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION	
TAG	Director and Mainte conference on 05/1 3.1-19(b) 2. Based on record facility failed to ensincluded complete of transmission of a firmonitoring company past twelve months drills in health care transmission of the simulation of emerg deficient practice of the Maintenance Didated 08/27/22, 10/provided with docu of the alarm to the interview at the tim Maintenance Direct information on the reports to verify the was received by the This finding was re Director and Mainteconference on 05/1 3-1.19(b)	review and interview, the sure 3 of 9 fire drill reports documentation of the re alarm signal to the py/fire department during the . LSC 19.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This build affect all residents. The facility's fire drill reports an 9:30 a.m. and 3:30 p.m. with firector present, fire drill reports 27/22 and 03/28/23 were not mentation for the transmission monitoring company. Based on the of record review, the tor acknowledged there was no previously mentioned fire drill at transmission of the alarm the monitoring company. Viewed with the Executive the enance Director during the exit	TAG	at expected and unexpected under various conditions me on both shifts and validate documentation is completed. Non-compliance with requision drills and documentation with disciplinary action up to including termination. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Convill review the Performance Improvement Tool related to competition and proper documentation of the requision of the systematics. By what date will the systematics of the systematics of the systematics of the systematics. By what date will the systematics of the systematics of the systematics of the systematics of the systematics. By what date will the systematics of the systematics of the systematics of the systematics of the systematics. By what date will the systematics of th	ed times nonthly proper ed. ired fire fill result and (s) ire the mmittee e to the ired fire o make	
K 0914 SS=F Bldg. 03	Testing	s - Maintenance and s - Maintenance and				

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938						B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS		l '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03			(X3) DATE SURVEY COMPLETED	
		155770	B. WING			05/11/2023	
		•	STREET A 1002 S GEORG				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	less than or equal the LIM test switch activates both vis LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repair	are tested at intervals of I to 1 month by actuating th per 6.3.2.6.3.6, which ual and audible alarm. For automated self-testing, this rformed at intervals less 2 months. LIM circuits are 3.2 after any repair or electric distribution system. Intained of required tests and s or modifications, oom or area tested, and					
	Based on observati interview; the facil documentation was nonhospital-grade resident room local NFPA 99, Health C Section 6.3.4.1.3 st hospital-grade, at p locations where de anesthesia is admir intervals not excee Section 6.3.3.2, Re Rooms requires the receptacle shall be	on, record review and ity failed to ensure complete a available for all electrical receptacles in all tions tested at least annually. Care Facilities Code 2012 Edition, tates receptacles not listed as patient bed locations and in ep sedation or general histered, shall be tested at ding 12 months. Additionally, ceptacle Testing in Patient Care exphysical integrity of each confirmed by visual inspection.	K 0	914	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by	n ave al	06/19/2023

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electrical receptacle shall be verified. Correct

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tests.

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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 03 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 VILLAS OF GUERIN WOODS (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 polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and How will you identify other retention force of the grounding blade of each residents having the potential electrical receptacle (except locking-type to be affected by the same receptacles) shall be not less than 115 grams (4 deficient practice and what ounces). This deficient practice could affect all corrective action will be taken? residents. All residents, staff and visitors have the potential to be affected Findings include: by the alleged deficient practice. Non-hospital grade receptacles in Based on record review on 05/10/23 between 9:30 resident rooms have been tested a.m. and 3:30 p.m. with the Maintenance Director for polarity, continuity of ground present, there was no documentation available of circuit, and retention force of an annual resident room receptacle test for non grounding blade. Receptacles hospital-grade receptacles. Based on interview at were replaced as indicated by the the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade What measures will be put into receptacles as far as he knew. He further said he place or what systemic has been the Maintenance Director at the facility changes you will make to for only four months and could not find ensure that the deficient documentation to show that annual testing per practice does not recur? NFPA 99, Receptacle Testing requirements was The Maintenance Director was met with all pertinent information within the past educated on documenting the 12 month period or prior. Based on observations annual testing of non-hospital on 05/11/23 between 10:00 a.m. and 12:00 p.m. grade receptacles in resident during a tour of the facility with the Maintenance rooms, to include testing for Director, there were at least four electrical polarity, continuity of ground receptacles in each resident room. circuit, and retention force of the grounding blade. Receptacles This finding was reviewed with the Executive were replaced as indicated by the Director and Maintenance Director during the exit tests. The administrator/designee conference on 05/11/23. will complete a Performance Improvement Tool to ensure 3.1-19(b)non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result

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in disciplinary action up to and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			CONSTRUCTION 03	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/11/2023		
		1002	SISTER BARBARA WAY			
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		
REGULATORT OR ESC IDENTIFITING INTORMATION			including termination How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Commowill review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	he ut ittee		
Licensure Survey w Department of Head 483.90(a). Survey Dates: 05/1 Facility Number: 0 Provider Number: AIM Number: 200 At this Life Safety	vas conducted by the Indiana Ith in accordance with 42 CFR 0/23 and 05/11/23 11509 155770 909280 Code survey, Villas of Guerin	K 0000	Plan of Correction for the Vil of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey. The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion so forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully required.	n of not his et on		
	A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Dates: 05/1 Facility Number: 0 Provider Number: AIM Number: 200 At this Life Safety of	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	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 Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 200909280 At this Life Safety Code survey, Villas of Guerin	TO FORFICIENCES OF CORRECTION ITS PROVIDER SUPPLIER PROVIDER OR SUPPLIER OF GUERIN WOODS ROVIDER OR SUPPLIER OF GUERIN WOODS SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION A BUILDING DENTIFECTORY SINGUIDE SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION A BUILDING DENTIFECTORY INCLUDING DESIRED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION INCLUDING IDENTIFYING INFORMATION How the corrective action (s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place? The Quality Assurance Comm will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. By what date will the system changes for each deficiency completed? 6/19/2023 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). Facility Number: 011509 Provider Number: 155770 Alm Number: 200909280 At this Life Safety Code survey, Villas of Guerin This provider respectfully required.		

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Requirements for Participation in

Medicare/Medicaid, 42 CFR Subpart 483.90(a),

Life Safety from Fire and the 2012 edition of the

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be considered the Letter of

Credible Allegation and requests a

Post Certification Desk Review in

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 04	(X3) DATE SURVEY COMPLETED 05/11/2023	
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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	
	Life Safety Code (L 1003 was surveyed Health Care Occupa This one story facility Type V (111) constituted The facility has a findetection in the corrections, and all refacility has a capacitate the time of this via	ty was determined to be of ruction and fully sprinkled. The alarm system with smoke ridors, spaces open to the sident sleeping rooms. The try of 10 and had a census of 9 sit. I dents have customary access all areas providing facility cled.		lieu of the Post Survey Revis	it.	
K 0291 SS=F Bldg. 04	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on record revinterview; the facili documentation for the backup lights that we seconds during 6 of annually for 90 min to ensure the light we periods of power out emergency lighting accordance with Secrequires functional monthly, with a min maximum of 5 week	g of at least 1-1/2-hour ad automatically in .9. iew, observation, and ty failed to ensure there was the testing of 5 of 5 battery were tested monthly for 30 the past 12 months, and utes during the past 12 months would provide lighting during tages. LSC 19.2.9.1 requires	K 0291	K 291 What corrective action(s) wis be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights were tested for 90 minutes and documented accordingly. How will you identify other	ave s that	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	UPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
		, , , , , , , , , , , , , , , , , , ,	r í			COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER					
		155770	B. W	B. WING		05/11	12023
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD)S		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		for a minimum of 1 1/2 hours			residents having the potenti	al	
		ghting system is battery			to be affected by the same		
		ritten records of visual			deficient practice and what		
	-	ts shall be kept by the owner			corrective action will be take	en?	
	for inspection by th				All residents have the potentia	al to	
		leficient practice could affect all			be affected by the alleged def	icient	
	· ·	s staff and visitors in the			practice. All 5 of the facilities'		
	facility.				battery backup lights were tes		
					for 90 minutes and document	ed	
	Findings include:				accordingly.		
	Based on record review on 05/10/23 between 9:30				What measures will be put in	nto	
	a.m. and 3:30 p.m. with the Maintenance Director			place or what systemic			
	present, the facility did have a preventative			changes you will make to			
	maintenance (PM) report that battery powered			ensure that the deficient			
	emergency lights were tested monthly, however,				practice does not recur?		
		cond monthly testing			The Maintenance Director has	S	
		te 09/26/22. Furthermore, there			been educated on the NFPA's	3	
	was no documentation available to show the five				emergency battery backup		
	battery powered em	nergency lights were tested			lighting's testing requirements	S.	
		nutes. Based on an interview at			The 5 battery backup lights w		
	the time of record review, the Maintenance				tested monthly by the		
	Director agreed the PM form for the battery			maintenance director/designee for			
	-	y lights did not include 30			30 seconds and 90 minutes		
	second monthly testing for each battery powered			annually with completed			
	light since 09/26/22	2. Furthermore, he said there			documentation. The		
	was no documentat	ion available for an annual 90			administrator/designee will		
	minute test during t	the past 12 month period.			complete a Performance		
	During a tour of the	e facility with the Maintenance			Improvement Tool monthly for	r 6	
	Director on 05/11/2	23 between 10:00 a.m. and 12:00			months after reviewing the mo		
	p.m., the facility wa	as equipped with five			testing report to ensure the lig	jht	
	emergency battery	powered lights.			will provide lighting during a p	ower	
					outage. Non-compliance with		
	This finding was reviewed with the Executive Director and Maintenance Director during the exit				emergency battery backup lig	ery backup lighting	
					testing will result in disciplinar		
	conference on 05/1	1/23.			action up to and including		
					termination.		
	3.1-19(b)						
					How the corrective action (s)	
					will be monitored to ensure	-	

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

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING <u>04</u> CO		(X3) DATE SURVEY COMPLETED 05/11/2023	
	ROVIDER OR SUPPLIER DF GUERIN WOOD		1002 \$	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 04	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on record facility failed to ensidevices connected the performed. NFPA the 2010 Edition, at inspections, testing, provided that include the complete the system of the system.	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 review and interview, the ure the annual testing of all o 1 of 1 fire alarm system was 72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be les the following information all the applicable information	K 0345	deficient practice will not recur, i.e., what quality assurance program will be p into place? The Quality Assurance Commwill review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. By what date will the system changes for each deficiency completed? 6/19/2023 K 345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The	ic be 06/19/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. W	NG		05/11/	2023
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY		
\/II I AC /	OF GUERIN WOOD	ne .					
VILLAS	OF GUERIN WOOL)S		GEURG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	(1) Date				components of the identified F	ire	
	(2) Test frequency				Alarm System have been test	ed,	
	(3) Name of proper	ty			calibrated as needed, and		
	(4) Address				inspected per the NFPA 70,		
		performing inspection,			National, Electric Code, and		
	maintenance, tests,	or combination thereof, and			NFPA 72, National Fire Alarm		
	affiliation, business	s address, and telephone			and Signaling Code.		
	number						
	(6) Name, address,	and representative of			How will you identify other		
	approving agency (ies)			residents having the potential	al	
	(7) Designation of	the detector(s) tested			to be affected by the same		
	(8) Functional test	of detectors			deficient practice and what		
	(9)*Functional test	of required sequence of			corrective action will be take	n?	
	operations				All residents, staff, and visitors	s	
	(10) Check of all si	noke detectors			have the potential to be affect	ed	
	(11) Loop resistance	e for all fixed-temperature,			by the alleged deficient practic	ce.	
	line-type heat detec	etors			The facilities other Fire Alarm		
	(12) Functional test	t of mass notification system			Systems have been tested,		
	control units				calibrated as needed, and		
	(13) Functional test	t of signal transmission to mass			inspected per the NFPA 70,		
	notification system	s			National, Electric Code, and		
	(14) Functional test	t of ability of mass notification			NFPA 72, National Fire Alarm	and	
	system to silence fi	re alarm notification appliances			Signaling Code.		
	(15) Tests of intelli	gibility of mass notification					
	system speakers				What measures will be put ir	nto	
	` ′	required by the equipment			place or what systemic		
	manufacturer's pub				changes you will make to		
	1 1	required by the authority			ensure that the deficient		
	having jurisdiction				practice does not recur?		
		tester and approved authority			The Maintenance Director has	3	
	representative				been educated on testing and		
		problems identified during test			maintenance of a fire alarm		
	(e.g., system owner	-			system accordance with the		
		ılly retested, device			requirements of NFPA 70,		
	abandoned in place				National Electric Code, and N	FPA	
	-	tice could affect all occupants			72, National Fire Alarm and		
	in the facility.				Signaling Code and that		
					documentation is readily avail	able	
	Findings include:				for review. The		
					administrator/designee will		

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

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>04</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER DF GUERIN WOOD		100	EET ADDRESS, CITY, STATE, ZIP COD 2 SISTER BARBARA WAY ORGETOWN, IN 47122	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TION (X5) LD BE COMPLETION ROPRIATE DATE
PREFIX	REGULATORY OR Based on record revalue. And 3:30 p.m. of present, the facility semi-annual visual report dated 06/24/2 maintenance staff, It documentation availinspection and function connected to the firm interview at the time confirmed by the Market of the firm of the	cy MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION view on 05/10/23 between 9:30 with the Maintenance Director was able to provide a fire alarm system inspection 22 performed by the facility's nowever, there was no lable for an annual visual tional test of all devices e alarm system. Based on e of record review, this was faintenance Director. viewed with the Executive enance Director during the exit 1/23. review and interview, the sure documentation was nat all smoke detectors were thin the past 24 months or ational Fire Alarm Code, 2010 4.5.3.1 states detector checked within 1 year of ery alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity time between calibration tests to be extended to a maximum of lency is extended, records of sance alarms and subsequent ms shall be maintained. In the nuisance alarms show an	PREFIX	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	In the part of the
	shall be performed. detector is within its	evious year, calibration tests To ensure that each smoke s listed and marked sensitivity sted using any of the methods: nethod.			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BU B. W.	JILDING ING	04	COMPL 05/11	
		1.00770	D. 11			33,11,	2020
NAME OF F	PROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	os			GETOWN, IN 47122		
(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
	instrument.	calibrated sensitivity test					
		quipment arranged for the					
	purpose.	quipment arranged for the					
		fire alarm control unit					
		by the detector causes a signal					
	at the control unit where its sensitivity is outside						
	its listed sensitivity range.						
	1 ' '	I sensitivity method acceptable					
	to the authority hav						
		have sensitivity outside the					
	cleaned and recalib	ensitivity range shall be					
		vity cannot be tested or					
		spray device that administers					
		centration of aerosol into the					
		cient practice could affect all					
		visitors in the facility.					
	Findings include:						
		view on 05/10/23 between 9:30					
		with the Maintenance Director					
		was unable to produce a					
		sitivity report for all smoke					
	_	st 24 month period. Based on e of record review, the					
		tor confirmed there was no					
		sitivity testing documentation					
	available for the pa						
	This finding was re	viewed with the Executive					
	Director and Maint	enance Director during the exit					
	conference on 05/1	1/23.					
	3.1-19(b)						
K 0353	NFPA 101						
SS=F Bldg. 04	· ·	- Maintenance and Testing - Maintenance and Testing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		RVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 04 COMPLETED			ED
		155770	B. W	ING		05/11/2023	
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
VILLAS (OF GUERIN WOOD	S		GEOR	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		er and standpipe systems					
		ted, and maintained in					
		NFPA 25, Standard for the g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	I	sting are maintained in a					
		nd readily available.					
		system last checked					
	b) Who provided	system test					
	c) Water system supply source						
	Provide in REMARKS information on						
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8,	, and NFPA 25					
	Based on record rev	view, observation, and	K 0	353	E 353	(06/19/2023
		ty failed to document sprinkler			What corrective action(s) wi	II	
		in accordance with NFPA 25			be accomplished for those		
		der system during 41 of the			residents found to have bee	n	
	1 ^	PA 25, Standard for the			affected by the deficient		
		, and Maintenance of			practice?		
		rotection Systems, 2011			The identified facility's dry		
	· ·	2.4.2 states gauges on dry pipe			sprinkler system gauges and	.	
	1 -	nall be inspected weekly to			control valve were inspected,	and	
		air and water pressures are Section 5.1.2 states valves and			maintenance performed as	.	
	_	nections shall be inspected,			indicated. The documentation	15	
		ned in accordance with Chapter			readily available.		
		2 states Table 13.1.1.2 shall be			How will you identify other		
		on, testing and maintenance of			residents having the potenti	_{al}	
	_	onents and trim. Section 4.3.1			to be affected by the same		
		be made for all inspections,			deficient practice and what		
		nce of the system and its			corrective action will be take	n?	
		all be made available to the			All residents, staff, and visitor		
	1 -	risdiction upon request. This			have the potential to be affect		
	deficient practice co	ould affect all residents, staff,			by the alleged deficient praction		
	and visitors in the fa	acility.			An audit was completed on th		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE A. BUILDING B. WING	OCONSTRUCTION 04	(X3) DATE SURVEY COMPLETED 05/11/2023		
	ROVIDER OR SUPPLIE		1002	ET ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY RGETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE	
	Findings include:	05/10/22 L		remainder Villas to identify sprinkler system gauges ar control valve were not insp	ected	
		p.m. with the Maintenance		and lacking maintenance a required. The identified are		
		ere was no documentation		corrected. The documentat		
	_	he facility's dry sprinkler		readily available.		
		e inspected weekly during 41		roddily dvallable.		
		period. Based on interview at		What measures will be pu	t into	
	the time of record r	review, the Maintenance		place or what systemic		
	Director confirmed	there was no documentation		changes you will make to		
available to show that the facility's sprinkler				ensure that the deficient		
gauges have been inspected at least weekly				practice does not recur?		
during 41 of the past 52 weeks. Based on				The Maintenance Director		
		he Maintenance Director		been educated on the facili	· ·	
	-	facility on 05/11/23 between		sprinkler system gauges, c		
		00 p.m. the facility had three		valves, required inspection	s, and	
	pressure gauges at	the sprinkler riser.		maintenance. The		
	h D1	1 05/10/22 1		administrator/designee will		
		p.m. with the Maintenance		complete a Performance	davda a	
		p.m. with the Maintenance here was no monthly sprinkler		Improvement Tool after rev	_	
	_	ves inspection documentation		the monthly documentation		
		months. Based on interview at		weekly and monthly inspections and maintenance that is performed		
	_	review, the Maintenance		as required. Non-complian		
		the lack of sprinkler system		the required weekly and mo		
		control valves during the past		inspections and required		
	12 months.			maintenance will result in		
				disciplinary action up to an	d	
	This finding was re	eviewed with the Executive		including termination		
	Director and Maint	enance Director during the exit				
	conference on 05/1	1/23.		How the corrective action	(s)	
				will be monitored to ensu	re the	
	3.1-19(b)			deficient practice will not		
				recur, i.e., what quality		
				assurance program will be	e put	
				into place?		
				The Quality Assurance Cor		
				will review the Performance		
				Improvement Tool related t	0	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f /		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	04	COMPL	
		155770	B. WI	NG		05/11/	2023
	ROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make further ecommendations. By what date will the system changes for each deficiency completed? 6/19/2023	ic	
K 0712	NFPA 101						1
SS=F	Fire Drills						1
Bldg. 04	Bldg. 04 Fire Drills						1
	Fire drills include to alarm signal and so conditions. Fire drand unexpected the conditions, at leas The staff is familia aware that drills are routine. Where drand 9:00 PM and 6:00 announcement manudible alarms.	t quarterly on each shift. r with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of					
	facility failed to pro documentation for 3 quarters. This defice	review and interview, the vide quarterly fire drill of 3 shifts during 2 of 4 ient practice could affect all staff and visitors in the	K 0	712	K 712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		06/19/2023
	Findings include:				No residents were found to hat been affected by this alleged deficient practice. Fire drills ha		ſ
		the facility's fire drill reports			been conducted on both shifts	;	1
		n 9:30 a.m. and 3:30 p.m. with			(Days, Nights) in all 8 villas.		1
		rector present, the facility umentation for the following			Documentation is readily avail	lable.	1
		luring the past 12 month			How will you identify other		1
	period:	ming the past 12 month			residents having the potentia	al	ı

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Event ID:

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Facility ID: 011509

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	04	COMPLE	ETED
		155770	B. W	ING		05/11/2	2023
NAME OF I	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD	-	
					ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS .		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION		TAG			DATE
	· ·	ening) of the first quarter			to be affected by the same		
		and March) of 2023, and			deficient practice and what		
	second quarter (April, May, and June) of 2022 and				corrective action will be take		
	so far in 2023				All residents, staff and visitors	1	
	b. Third shift (night) of the first quarter (January,				have the potential to be affect		
	February, and March) of 2023				by the alleged deficient praction	1	
		at the time of record review,			Fire drills have been conducte	ed on	
		irector confirmed the lack of			both shifts (Days, Nights) at		
		ring the previously mentioned			expected and unexpected time		
	shifts and quarters.				under various conditions in all	-	
					villas. Documentation includes	3	
		viewed with the Executive			employee signatures that		
Director and Maintenance Director during the exit				participated in each drill and			
	conference on 05/1	1/23.			transmission of the alarm that		
	2.1.10(1-)				received by monitoring compa	iny.	
	3.1-19(b)				NA/In at we are a sure a suit! In a worst in		
	2 Paged on record	review and interview, the			What measures will be put in	ito	
		ovide complete fire drill			place or what systemic		
		1 of 9 fire drills performed			changes you will make to ensure that the deficient		
		nonth period. This deficient			practice does not recur?		
		et all residents in the facility.			The Maintenance Director has		
	practice could affect	an residents in the facility.			been educated on the	·	
	Findings include:				requirements of conducting		
	- mamas morado.				monthly fire drills in all 8 Villas	s on	
	Based on review of	the facility's fire drill reports			both day shift and night shift a		
		en 9:30 a.m. and 3:30 p.m. with			expected and unexpected time	I	
	the Maintenance Di	-			under various conditions and	1	
		ill report performed on 03/28/23			required documentation of tho	I	
		st quarter) did not include the			that participated in the drills ar		
	· ·	es of staff that participated in			transmission of the alarm that	I	
	the fire drill. Based	on interview at the time of			received by the monitoring		
	record review, the I	Maintenance Director			company. The		
	confirmed the lack	of staff signatures on the fire			administrator/designee will		
	drill report dated 03	3/28/23.			complete a Performance		
					Improvement Tool to ensure the	he	
	This finding was re	viewed with the Executive			monthly fire drills were conduc		
	Director and Maint	enance Director during the exit			at expected and unexpected t	I	
	conference on 05/1	1/23.			under various conditions mont		
					on both shifts and validate pro	-	

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING 04 B. WING		COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	3.1-19(b) 2. Based on record facility failed to ensincluded complete of transmission of a firmonitoring company past twelve months. drills in health care transmission of the simulation of emerg deficient practice considerable. Based on review of on 05/10/23 betwee the Maintenance Didated 08/27/22, 10/2 provided with docum of the alarm to the rinterview at the time Maintenance Direct information on the preports to verify that was received by the	review and interview, the ure 3 of 9 fire drill reports documentation of the re alarm signal to the sy/fire department during the LSC 19.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This hould affect all residents. the facility's fire drill reports in 9:30 a.m. and 3:30 p.m. with rector present, fire drill reports 27/22 and 03/28/23 were not mentation for the transmission monitoring company. Based on the of record review, the or acknowledged there was no previously mentioned fire drill to transmission of the alarm monitoring company. Wiewed with the Executive enance Director during the exit		documentation is complete Non-compliance with requalities and documentation in disciplinary action up to including termination. How the corrective action will be monitored to ensideficient practice will not recur, i.e., what quality assurance program will into place? The Quality Assurance Compliance and interprovement Tool related competition and proper documentation of the requalities for compliance and further recommendations. By what date will the system completed? 6/19/2023	uired fire will result o and on (s) ure the ot be put ce I to the uired fire to make stemic	
K 0914 SS=F Bldg. 04	Testing Electrical Systems Testing Hospital-grade rec	s - Maintenance and s - Maintenance and ceptacles at patient bed				

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CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO	ONSTRUCTION 04	(X3) DATE SURVEY COMPLETED 05/11/2023	
THIS TETH	or column in	155770	B. W				
	PROVIDER OR SUPPLIE		•	1002 S	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
VILLAS	OF GUERIN WOOL	OS		GEOR	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ninistered, are tested after					
		replacement or servicing.					
	_	is performed at intervals					
	-	nented performance data.					
	•	isted as hospital-grade at re tested at intervals not					
		nths. Line isolation monitors					
	_	are tested at intervals of					
		I to 1 month by actuating					
	•	th per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
		automated self-testing, this					
		rformed at intervals less					
	•	2 months. LIM circuits are					
	•	3.2 after any repair or					
	•	electric distribution system.					
		ntained of required tests and					
		s or modifications,					
	-	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
	Based on observati	on, record review and	K 0	914	K 914		06/19/2023
	interview; the facil	ity failed to ensure complete			What corrective action(s) wil	ıl	
	documentation was	s available for all			be accomplished for those		
	nonhospital-grade	electrical receptacles in all			residents found to have been	n	
		tions tested at least annually.			affected by the deficient		
		Care Facilities Code 2012 Edition,			practice?		
		tates receptacles not listed as			No residents were found to ha	ıve	
		patient bed locations and in			been affected by this alleged		
		ep sedation or general			deficient practice. Non-hospita	al	
		nistered, shall be tested at			grade receptacles in resident		
		ding 12 months. Additionally,			rooms have been tested for		
		ceptacle Testing in Patient Care			polarity, continuity of ground		
	•	e physical integrity of each			circuit, and retention force of		
	_	confirmed by visual inspection.			grounding blade. Receptacles		
		he grounding circuit in each			were replaced as indicated by	tne	
	 electrical recentact 	e suan ne verimea. Correct			1 10010		

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polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and

retention force of the grounding blade of each

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If continuation sheet

How will you identify other

residents having the potential

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 04 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 electrical receptacle (except locking-type to be affected by the same receptacles) shall be not less than 115 grams (4 deficient practice and what ounces). This deficient practice could affect all corrective action will be taken? residents. All residents, staff and visitors have the potential to be affected Findings include: by the alleged deficient practice. Non-hospital grade receptacles in Based on record review on 05/10/23 between 9:30 resident rooms have been tested a.m. and 3:30 p.m. with the Maintenance Director for polarity, continuity of ground present, there was no documentation available of circuit, and retention force of an annual resident room receptacle test for non grounding blade. Receptacles hospital-grade receptacles. Based on interview at were replaced as indicated by the the time of record review, the Maintenance tests. Director said all of the electrical receptacles in resident rooms were not hospital-grade What measures will be put into receptacles as far as he knew. He further said he place or what systemic has been the Maintenance Director at the facility changes you will make to for only four months and could not find ensure that the deficient documentation to show that annual testing per practice does not recur? NFPA 99, Receptacle Testing requirements was The Maintenance Director was met with all pertinent information within the past educated on documenting the 12 month period or prior. Based on observations annual testing of non-hospital on 05/11/23 between 10:00 a.m. and 12:00 p.m. grade receptacles in resident during a tour of the facility with the Maintenance rooms, to include testing for Director, there were at least four electrical polarity, continuity of ground receptacles in each resident room. circuit, and retention force of the grounding blade. Receptacles This finding was reviewed with the Executive were replaced as indicated by the Director and Maintenance Director during the exit tests. The administrator/designee conference on 05/11/23. will complete a Performance Improvement Tool to ensure 3.1-19(b) non-hospital grade receptacles are tested annually, replace when indicated by testing, and required documentation. Non-compliance with required annual test will result in disciplinary action up to and including termination

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If continuation sheet

How the corrective action (s)

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

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 04	(X3) DATE SURVEY COMPLETED 05/11/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
VILLAS (OF GUERIN WOOD	S		RGETOWN, IN 47122	
(X4) ID PREFIX		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 APPROPRI	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0918 SS=F Bldg. 04	System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a programmally confirm the safety and critical and testing of the switches are performed NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test under complete simula automatic or manual control of the simula automatic or manual second control of the supplementary and second control of the suppl	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer branches in accordance with in inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. indeed to a second		will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Commill review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	out nittee ner nic

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If continuation sheet

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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 04 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700,10 (NFPA 70) 1. Based on record review and interview, the K 0918 K 918 06/19/2023 facility failed to ensure a written record of weekly What corrective action(s) will inspections for 1 of 1 generator was maintained be accomplished for those for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 residents found to have been NFPA 99 requires batteries for on-site generators affected by the deficient shall be maintained in accordance with NFPA 110. practice? 2010 Edition, Standard for Emergency and No residents were found to have Standby Power Systems. 8.3.7 requires storage been affected by this alleged batteries, including electrolyte levels or battery deficient practice. The facilities five voltage, used in connection with systems shall be generators have the require weekly inspected weekly and maintained in full inspections/tested, monthly load compliance with manufacturer's specifications. toad test, annual maintenance, 8.3.7.2 states defective batteries shall be repaired and 4-hour load test completed or replaced immediately upon discovery of and documented according to defects. Chapter 6.5.4.2 of NFPA 99 requires a meet NFPA emergency power and written record of inspection, performance, standby system requirements. exercising period, and repairs shall be regularly maintained and available for inspection by the How will you identify other authority having jurisdiction. This deficient residents having the potential practice could affect all residents, staff and to be affected by the same visitors. deficient practice and what corrective action will be taken?

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Findings include:

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If continuation sheet

All residents, staff, and visitors have the potential to be affected

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. W	ING		05/11/	2023
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE 7ID COD	I	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY		
\/		.e					
VILLAS (OF GUERIN WOOD			GEURG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on review of	the generator inspection			by the alleged deficient praction	ce.	
	reports on 05/10/23	between 9:30 a.m. and 3:30			The facilities five generators h	ave	
	p.m. with the Maint	enance Director present, there			the require weekly		
	was no documentat	ion available to show the			inspections/tested, monthly lo	ad	
	emergency generate	or was inspected/tested weekly			toad test, annual maintenance) ,	
	during 31 of the mo	st recent 52 week period			and 4-hour load test complete	d	
	(nothing since 10/0	3/22). Based on interview at			and documented according to		
	the time of record re	eview, the Maintenance			meet NFPA emergency power		
	Director said he do	es test/inspect of the			standby system requirements.		
	emergency generate	or weekly but does not always					
	document the test/ii	respection results.			What measures will be put ir	nto	
					place or what systemic		
	This finding was reviewed with the Executive				changes you will make to		
	Director and Mainto	enance Director during the exit			ensure that the deficient		
	conference on 05/1	1/23.			practice does not recur?		
					The Maintenance Director has	6	
	3.1-19(b)				been educated on the NFPA's	3	
					LTC emergency and standby		
	2. Based on record	review and interview, the			power system requirements. T	Γhe	
	facility failed to ma	intain a complete written record			administrator/designee will		
	of monthly generate	or load testing for 1 of 1			complete the Performance		
	generator during 6	of the past 12 months. Chapter			Improvement Tool for 6 month	ıs	
	6.4.4.1.1.4(a) of 20	12 NFPA 99 requires monthly			after reviewing the weekly		
	testing of the genera	ator serving the emergency			inspections/testing documenta	ation	
	electrical system to	be in accordance with NFPA			weekly, the monthly load toad		
	110, the Standard fo	or Emergency and Standby			documentation during the		
	Powers Systems, Cl	hapter 8. Chapter 6.4.4.2 of			scheduled monthly Quality		
	NFPA 99 requires a	written record of inspection,			Assurance meeting and the		
	performance, exerc	ising period, and repairs for the			annual maintenance and 4-ho	ur	
	generator to be regu	ılarly maintained and available			load test documentation during	g	
	for inspection by th	e authority having			each Decembers scheduled C	•	
	jurisdiction. Chapte	er 6-4.4.1.3 of 2012 NFPA 99			meeting to ensure the		
		or on-site generators shall be			requirements are met. This		
	maintained in accor	dance with NFPA 110, 2010			practice will be ongoing.		
	Edition, Standard for	or Emergency and Standby			Non-compliance of weekly		
	Power Systems. 8.3	3.7 requires storage batteries,			inspections/testing documenta	ation	
	1	e levels or battery voltage,			weekly, the monthly load toad		
		with systems shall be			documentation will result in		
		nd maintained in full			disciplinary action up to and		
		anufacturer's specifications.			including termination.		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPL	ETED
		155770	B. W	NG		05/11/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			STER BARBARA WAY		
VILLAS	OF GUERIN WOOD	ns			GETOWN, IN 47122		
VILLAGO				OLOIK			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tive batteries shall be repaired			How the corrective action (s)		
	_	ately upon discovery of			will be monitored to ensure t	:he	
		5.4.2 of NFPA 99 requires a			deficient practice will not		
		spection, performance,			recur, i.e., what quality		
		and repairs shall be regularly			assurance program will be p	ut	
		ilable for inspection by the			into place?		
		risdiction. This deficient			The Quality Assurance Comm	ittee	
	_	et all residents, staff and			will review the Performance		
	visitors.				Improvement Tool related		
	F' 1' ' 1 1				emergency and standby powe	:r	
	Findings include:				system requirements for		
	D11	.:			compliance and to make furth	er	
	Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director				recommendations.		
	-	no monthly generator load test			By what date will the system		
	_	ilable for 6 of the past 12			changes for each deficiency	De	
		nce 09/26/22) for the			completed? 6/19/2023		
		or. Based on interview at the			0/19/2023		
		ew, the Maintenance Director					
		s no emergency generator load					
		for 6 of the past 12 months for					
	the emergency gene						
	l are emergency gene						
	This finding was re	viewed with the Executive					
	_	enance Director during the exit					
	conference on 05/1	9					
	3.1-19(b)						
	3. Based on record	review and interview, the					
	facility failed to ens	sure a written record of routine					
	maintenance and te	sting for 1 of 1 emergency				ļ	
	generator was main	tained and available. NFPA					
	110, the Standard for	or Emergency and Standby					
	Powers Systems, at	8.3.3 requires a written					
		e maintenance and operational				ļ	
	testing of the EPSS	shall be established. 8.3.4					
	requires a permaner	nt record of the EPSS					
	inspections, tests, e	xercising, operation, and					
	repairs shall be mai	ntained and readily available.					

	NT OF DEFICIENCIES			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD		04	COMPL		
		155770	B. WING			05/11/	2023	
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1	002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	BROWING BY AN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)	VIE	DATE	
	_	permanent record shall include						
		The date of the maintenance						
		eation of the servicing						
		fication of any unsatisfactory orrective action taken,						
		aced (4) Testing of any repair						
		mmended by the manufacturer.						
		ice could affect all residents,						
	staff and visitors.	,						
	Findings include:							
	Based on record review on 05/10/23 between 9:30							
	a.m. and 3:30 p.m.	with the Maintenance Director						
		no documentation available to						
		gency generator has had						
		e during the past 12 months.						
		at the time of record review,						
		irector said he has been the						
	months and has not	tor at the facility for only four						
		ation that routine maintenance						
		on the generator either in						
	house or from an ou	_						
	This find:	vianad vith the Eti						
	_	viewed with the Executive enance Director during the exit						
	conference on 05/1							
	3.1-19(b)							
	4. Based on record	review and interview, the						
		ovide complete documentation						
	1	of 5 Emergency Power Standby						
	•	ice with NFPA 110, Standard						
		Standby Power Systems,						
		quired by NFPA 99 Health Care						
		etion 6.4.1.1.6.1. NFPA 110						
		that all Level 1 Emergency ll be tested at least once within						

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

PRINTED: 06/07/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		 UILDING	04	COM	PLETED 1/2023	
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1002 SI	DDRESS, CITY, STATE, ZIP C STER BARBARA WAY SETOWN, IN 47122	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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	greater than 4 hours terminate the test af 6.4.1.1.6.1 states the electrical system po at Type 10, Class X 110, Section 8.4.9.: or Natural Gas) EPS available EPSS load affect all residents, Findings include: Based on record reva.m. and 3:30 p.m. spresent, the facility documentation of a gas fueled emergenemonths for the five was confirmed by the time of record review. This finding was reduced by the conference on 05/11 3.1-19(b)	riew on 05/10/23 between 9:30 with the Maintenance Director could not provide four hour load test of the LP by generator within the past 36 emergency generators. This he Maintenance Director at the w.				
K 0923 SS=F Bldg. 04	Storag Gas Equipment - 0 Storage Greater than or ecceptors Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPI	LETED
		155770	B. W	ING		05/11	/2023
							
NAME OF	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
	05 011501111005				ISTER BARBARA WAY		
VILLAS	OF GUERIN WOOD	os —		GEORG	GETOWN, IN 47122		
(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 APPROPRI	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL	DATE
	space of non- or l	imited- combustible					
	construction, with	door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		s by 20 feet (5 feet if					
		closed in a cabinet of					
		onstruction having a					
		ire protection rating.					
		ll to 300 cubic feet					
	· ·	compartment, individual					
		e for immediate use in					
		with an aggregate volume					
	1 ·	ual to 300 cubic feet are not					
		red in an enclosure.					
	-	handled with precautions					
	as specified in 11						
		ign readable from 5 feet is					
		ate of a cylinder storage					
	_	sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
		. When facility employs					
		gral pressure gauge, a					
		e considered empty is					
		ty cylinders are marked to					
	·	Cylinders stored in the open					
	are protected fron	· ·					
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)	,,					
		on and interview, the facility	K 0	923	K 923		06/19/2023
		inders of nonflammable gases	K U	143	What corrective action(s) w	ill	00/17/2023
	1	re properly secured from falling			be accomplished for those		
		npartments. NFPA 99, Health			residents found to have bee	'n	
		e, 2012 Edition, Section 11.3.3			affected by the deficient	,11	
		onflammable gases with a total			practice?		
	Janes Storage 101 III	minamination gases with a total	1		practice:		I

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volume equal to or less than greater than 8.5 cubic

meters (300 cubic feet) shall comply with 11.3.3.1

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If continuation sheet

No residents were found to have

been affected by this alleged

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	04	COMPLE	TED
		155770	B. Wl	NG		05/11/2	023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOL	os			GETOWN, IN 47122		
(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 APPROPRI	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		A 99, Section 11.3.3.2 states			deficient practice. Oxygen		
	_	dling cylinders specified in			cylinders have been placed in		
		accordance with 11.6.2. Section			proper carts and secured with	h the	
		freestanding cylinders shall be			thumb screw.		
	properly chained or supported in a proper cylinder						
		deficient practice could affect			How will you identify other		
	all residents, staff,	and visitors.			residents having the potent	ial	
					to be affected by the same		
	Findings include:				deficient practice and what		
					corrective action will be tak	_	
		ons on 05/11/23 between 10:00			All residents, staff and visitor		
	_	a. during a tour of the facility			have the potential to be affect		
		nce Director, there was one			by the alleged deficient pract		
		gen cylinder freestanding on the			An audit was conducted to id	-	
		om 5. The oxygen cylinder was			oxygen cylinders that were no		
		proper cylinder stand or			properly secured. The identifi		
		from falling. Based on			unsecured cylinders were see	cured	
		ne of the observation, the			immediately.		
		tor acknowledged the oxygen			l		
	1 -	ng on the floor in resident room			What measures will be put i	nto	
		d in a cylinder stand or			place or what systemic		
	otherwise secured	from failing.			changes you will make to		
	This finding was no	avious of with the Evenutive			ensure that the deficient		
	_	eviewed with the Executive tenance Director during the exit			practice does not recur? The Maintenance Director ha		
	conference on 05/1					is	
	Conneceded on 03/1	1/23.			been educated on securing oxygen cylinders in the prope	\r	
	3.1-19(b)				cylinder stand and will compl		
	3.1 17(0)				environmental rounds in all 8	l l	
					5 days a week for 4 weeks a		
					then weekly x 5 months to en		
					oxygen cylinders are being s		
					secured. The administrator w	-	
					complete a Performance		
					Improvement Tool after revie	wina	
					the environmental round she	-	
					weekly for 6 months to ensur		
					compliance. Non-compliance		
					daily environmental rounds w		
					, ,		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX		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	ATE	(X5) COMPLETION
K 0000 Bldg. 05	A Life Safety Code Licensure Survey w Department of Hea 483.90(a). Survey Dates: 05/1 Facility Number: 0 Provider Number: 200 At this Life Safety Woods, was found Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I	11509 155770 909280 Code survey, Villas of Guerin not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), and 410 IAC 16.2. Villa with Chapter 19, Existing	K 00	000	and including termination. How the corrective action (swill be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Commwill review the Performance improvement Tool for complia and to make further recommendations. By what date will the systemic changes for each deficiency be completed? 6/19/2023 Plan of Correction for the Vil of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey. The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion so forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully required that the 2567 Plan of Correction be considered the Letter of Credible Allegation and reques Post Certification Desk Review lieu of the Post Survey Revisition in the Post Survey Revisit	the out nittee ance coe e	DATE

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2023				
	PROVIDER OR SUPPLIER OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
K 0291 SS=F Bldg. 05	Type V (111) const. The facility has a findetection in the corrections, and all refacility has a capacitate at the time of this visual at the time of this visual at the time of this visual areas where resist were sprinkled and services Lighting Emergency Lighting Emergency Lighting accordance with 718.2.9.1, 19.2.9.1 Based on record revinterview; the facility documentation for the backup lights that we seconds during 6 of annually for 90 min to ensure the light we periods of power out emergency lighting accordance with Servequires functional amonthly, with a min maximum of 5 weel than 30 seconds, (3) conducted annually if the emergency lighting accordance with 2 weeks and 20 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds, (3) conducted annually if the emergency lighting accordance with 30 seconds wit	dents have customary access all areas providing facility cled. Inpleted on 05/17/23 Inguing g of at least 1-1/2-hour ed automatically in	K 0291	K 291 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights were tested for 90 minutes and documented accordingly. How will you identify other residents having the potentiat to be affected by the same deficient practice and what	n ave that d			

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inspections and tests shall be kept by the owner

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corrective action will be taken?

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NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	ì í	UILDING	nstruction 05	(X3) DATE : COMPL 05/11 /	ETED
PROVIDER OR SUPPLIEF			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
SUMMARY (EACH DEFICIEN REGULATORY OF for inspection by th jurisdiction. This d residents, as well as facility. Findings include: Based on record rev a.m. and 3:30 p.m. present, the facility maintenance (PM) of emergency lights w there was no 30 sec documentation sinc was no documentat battery powered em annually for 90 min the time of record r Director agreed the powered emergency second monthly tes light since 09/26/22 was no documentat minute test during t	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The authority having The autho				I to cient ted ed to	(X5) COMPLETION DATE
Director on 05/11/2 p.m., the facility wa emergency battery this finding was re	viewed with the Executive enance Director during the exit			Improvement Tool monthly for months after reviewing the motesting report to ensure the lig will provide lighting during a proutage. Non-compliance with emergency battery backup light testing will result in disciplinary action up to and including termination. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?	nthly ht ower hting /	

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	T OF HEALTH AND HU					RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	JILDING	ONSTRUCTION 05	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIEI		 STREET A 1002 SI GEORG	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CO		
				The Quality Assurance Comr will review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. By what date will the system changes for each deficiency completed? 6/19/2023	nic	
K 0324 SS=C Bldg. 05	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used					

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19.3.2.5.2

18.3.2.5.3, 19.3.2.5.3, or

be open to the corridor.

* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under

* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not

18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

Based on record review and interview, the facility

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CENTERS FOR MEDICARE & MEDICAID 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 05 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 failed to ensure 1 of 1 kitchen exhaust systems What corrective action(s) will was inspected semiannually. NFPA 96, 2011 be accomplished for those Edition, Standard for Ventilation Control and Fire residents found to have been Protection of Commercial Cooking Operations, affected by the deficient Section 11.4 states the entire exhaust system shall practice? be inspected for grease buildup by a properly No residents were found to have trained, qualified, and certified person(s) been affected by this alleged acceptable to the authority having jurisdiction deficient practice. The kitchen and in accordance with Table 11.4. Table 11.4, exhaust system in the identified Schedule for Inspection for Grease Buildup, Villa has been inspected and requires systems serving moderate volume cleaned. cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon How will you identify other inspection, if the exhaust system is found to be residents having the potential contaminated with deposits from grease laden to be affected by the same vapors, the contaminated portions of the exhaust deficient practice and what system shall be cleaned by a properly trained, corrective action will be taken? qualified, and certified person(s) acceptable to the All residents have the potential to authority having jurisdiction. Hoods, grease be affected by the alleged deficient removal devices, fans, ducts, and other practice. The kitchen exhaust appurtenances shall be cleaned to remove systems in the other 7 villas have combustible contaminants prior to surfaces been inspected and cleaned if becoming heavily contaminated with grease or indicated by the inspection. oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other What measures will be put into substance. When an exhaust cleaning service is place or what systemic used, a certificate showing the name of the changes you will make to servicing company, the name of the person ensure that the deficient performing the work, and the date of inspection or practice does not recur? The Maintenance Director has cleaning shall be maintained on the premises. This deficient practice could affect all residents, been educated on the Standard for staff, and visitors in the facility. Ventilation Control and Fire Protection of Commercial Cooking Findings include: Operations requirements as related to required inspections and Based on record review on 05/10/23 between 9:30 cleaning of the ventilation system. a.m. and 3:30 p.m. with the Maintenance Director The inspection will be scheduled present, the only inspection documentation by the maintenance

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available during the past twelve months for the

range hood exhaust system was dated 04/20/23.

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director/designee for monthly and

annual inspections/cleaning. The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE (A. BUILDING B. WING	construction 05	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		1002	r address, city, state, zip cod SISTER BARBARA WAY RGETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	inspection report av to the 04/20/23 date time of record revie said he could not fin system inspection w 04/20/23 date.	hood exhaust system ailable within six months prior . Based on interview at the w, the Maintenance Director and a range hood exhaust within six months prior to the viewed with the Executive enance Director during the exit 1/23.		administrator/designee will complete a Performance Improvement Tool monthly to ensure the inspections were completed and the findings w addressed as needed. Non-compliance with require testing inspections and cleani will result in disciplinary action to and including termination. How the corrective action (s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Comm will review the Performance Improvement Tool related to kitchen ventilation inspections compliance and to make furth recommendations as needed By what date will the system changes for each deficiency completed? 6/19/2023	ere d ngs n up) the out nittee s for ier
K 0345 SS=F Bldg. 05	in accordance with complying with the National Electric C National Fire Alarr	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, code, and NFPA 72, m and Signaling Code.			
	Records of system and testing are rea 9.6.1.3, 9.6.1.5, N	_			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		•	1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	1. Based on record facility failed to ensidevices connected the performed. NFPA the 2010 Edition, at inspections, testing, provided that including regarding tests and requested in Figure (1) Date (2) Test frequency (3) Name of proper (4) Address (5) Name of person maintenance, tests, affiliation, business number (6) Name, address, approving agency (7) Designation of the (8) Functional test operations (10) Check of all sm (11) Loop resistance line-type heat detect (12) Functional test control units (13) Functional test control units (14) Functional test system to silence find (15) Tests of intelliging system speakers (16) Other tests as a manufacturer's publication gurisdiction in the story of the s	review and interview, the sure the annual testing of all to 1 of 1 fire alarm system was 72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be less the following information all the applicable information 14.6.2.4: Ty performing inspection, or combination thereof, and address, and telephone and representative of test) the detectors of required sequence of the formula fixed-temperature, tors of mass notification system of signal transmission to mass of ability of mass notification re alarm notification appliances gibility of mass notification equired by the equipment	K 0	TAG	K 345 What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The components of the identified I Alarm System have been test calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. How will you identify other residents having the potentit to be affected by the same deficient practice and what corrective action will be take All residents, staff, and visitor have the potential to be affected by the alleged deficient practit The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm Signaling Code. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director has been educated on testing and	on on one of the control of the cont

	NEDICAKE & MEDIC	-	(TA)) (T = = = = = = = = = = = = = = = = = =	NOTELICATION	OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>05</u>	COMPLETED
		155770	B. WING		05/11/2023
NAME OF	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·		ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY	
VILLAS (OF GUERIN WOOD	os .		GETOWN, IN 47122	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	(19) Disposition of	problems identified during test		maintenance of a fire alarm	
	(e.g., system owner	notified, problem		system accordance with the	
	corrected/successfu	lly retested, device		requirements of NFPA 70,	
	abandoned in place)		National Electric Code, and NF	PA
	This deficient pract	ice could affect all occupants		72, National Fire Alarm and	
	in the facility.			Signaling Code and that	
				documentation is readily availa	ble
	Findings include:			for review. The	
				administrator/designee will	
	Based on record rev	view on 05/10/23 between 9:30		complete a Performance	
	a.m. and 3:30 p.m.	with the Maintenance Director		Improvement Tool monthly to	
	present, the facility	was able to provide a		ensure the testing, recalibration	n as
semi-annual visual fire alarm system inspection			needed, and inspections are		
	report dated 06/24/2	22 performed by the facility's		completed per regulations.	
	_	however, there was no		Non-compliance with required	
	documentation avai	ilable for an annual visual		testing, calibration, and inspec	tion
	inspection and func	tional test of all devices		will result in disciplinary action	l l
	_	e alarm system. Based on		to and including termination.	
		e of record review, this was		How the corrective action (s)	
		faintenance Director.		will be monitored to ensure the	ne
				deficient practice will not	
	This finding was re	viewed with the Executive		recur, i.e., what quality	
		enance Director during the exit		assurance program will be pu	ıt İ
	conference on 05/1			into place?	
				The Quality Assurance Commi	ttee
	3.1-19(b)			will review the Performance	
				Improvement Tool related to Fi	re
	2. Based on record	review and interview, the		Alarm Systems for compliance	
		sure documentation was		and for further recommendation	ns.
	1	nat all smoke detectors were		By what date will the systemi	
		ithin the past 24 months or		changes for each deficiency l	I
		ational Fire Alarm Code, 2010		completed?	
		.4.5.3.1 states detector		6/19/2023	
		checked within 1 year of			
		ery alternate year thereafter.	1		
		quired calibration test, if	1		
		icate that the detector has			
	_	listed and marked sensitivity			
		time between calibration tests	1		
		o be extended to a maximum of			
	1 Pointing		1	1	l

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155770)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 05	COMP	ESURVEY LETED 1/2023
	PROVIDER OR SUPPLIER OF GUERIN WOODS	1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122	•	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE
	5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24 month period. Based on interview at the time of record review, the Maintenance Director confirmed there was no smoke detector sensitivity testing documentation available for the past 24 months.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2023				
NAME OF PROVIDER OR SUPPLIER VILLAS OF GUERIN WOODS			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
K 0353 SS=F Bldg. 05	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This finding was reviewed with the Executive Director and Maintenance Director during the exit conference on 05/11/23. 3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing		K 0353	E 353 What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice?	06/19/2023		
	Edition, Section 5.2 sprinkler systems sl ensure that normal being maintained.			The identified facility's dry sprinkler system gauges and control valve were inspected, maintenance performed as indicated. The documentation readily available.			

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tested, and maintained in accordance with Chapter

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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 05 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 13. Section 13.1.1.2 states Table 13.1.1.2 shall be How will you identify other utilized for inspection, testing and maintenance of residents having the potential valves, valve components and trim. Section 4.3.1 to be affected by the same states records shall be made for all inspections, deficient practice and what tests, and maintenance of the system and its corrective action will be taken? components and shall be made available to the All residents, staff, and visitors authority having jurisdiction upon request. This have the potential to be affected deficient practice could affect all residents, staff, by the alleged deficient practice. and visitors in the facility. An audit was completed on the remainder Villas to identify Findings include: sprinkler system gauges and control valve were not inspected a. Based on record review on 05/10/23 between and lacking maintenance as 9:30 a.m. and 3:30 p.m. with the Maintenance required. The identified areas were Director present, there was no documentation corrected. The documentation is available to show the facility's dry sprinkler readily available. system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at What measures will be put into the time of record review, the Maintenance place or what systemic Director confirmed there was no documentation changes you will make to available to show that the facility's sprinkler ensure that the deficient gauges have been inspected at least weekly practice does not recur? during 41 of the past 52 weeks. Based on The Maintenance Director has observations with the Maintenance Director been educated on the facility's dry during a tour of the facility on 05/11/23 between sprinkler system gauges, control 10:00 a.m. and 12:00 p.m. the facility had three valves, required inspections, and pressure gauges at the sprinkler riser. maintenance. The administrator/designee will b. Based on record review on 05/10/23 between complete a Performance 9:30 a.m. and 3:30 p.m. with the Maintenance Improvement Tool after reviewing Director present, there was no monthly sprinkler the monthly documentation of the system control valves inspection documentation weekly and monthly inspections for 8 of the past 12 months. Based on interview at and maintenance that is performed the time of record review, the Maintenance as required. Non-compliance of Director confirmed the lack of sprinkler system the required weekly and monthly inspections on the control valves during the past inspections and required 12 months. maintenance will result in disciplinary action up to and This finding was reviewed with the Executive including termination Director and Maintenance Director during the exit

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		a. building <u>05</u> b. wing			COMPLETED 05/11/2023		
100770			<u> </u>				12020
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	DS .		l	GETOWN, IN 47122		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	conference on 05/1	R LSC IDENTIFYING INFORMATION 1/23.	+-	TAG	How the corrective action (s)	<u> </u>	DATE
	conference on 63/11/23.			will be monitored to ensure			
	3.1-19(b)				deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place? The Quality Assurance Comm	ittee	
					will review the Performance	iiiee	
					Improvement Tool related to		
					sprinkler system gauges and		
					control valve inspections, and		
					required maintenance for		
					compliance and to make further recommendations.	er	
					By what date will the system	ic	
					changes for each deficiency		
					completed?		
					6/19/2023		
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 05	Fire Drills						
		the transmission of a fire					
	-	simulation of emergency fire					
		rills are held at expected					
	· ·	imes under varying st quarterly on each shift.					
		ar with procedures and is					
		are part of established					
		rills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	10 7 1 7					
	19.7.1.4 through	19.7.1.7 I review and interview, the	$ _{\mathbf{K} 0'}$	712	K 712		06/19/2023
		ovide quarterly fire drill	K U	112	What corrective action(s) wil	ı	00/19/2023
		3 of 3 shifts during 2 of 4			be accomplished for those	-	
		cient practice could affect all			residents found to have beer	า	
	_	s staff and visitors in the			affected by the deficient		
	facility.				practice?		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>05</u>		05	COMPLETED	
		155770	B. WING 05/11/2023			05/11/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	L Company of the Comp			ISTER BARBARA WAY		
VILLAS OF GUERIN WOODS					GETOWN, IN 47122		
	Г		1		, 	(X5)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION		+	IAU	No residents were found to ha		
	Findings include:				been affected by this alleged	ive	
	i manigs metade.				deficient practice. Fire drills ha	ave	
	Based on review of	the facility's fire drill reports			been conducted on both shifts	 	
		n 9:30 a.m. and 3:30 p.m. with			(Days, Nights) in all 8 villas.		
		rector present, the facility			Documentation is readily avai	lable.	
		umentation for the following					
		luring the past 12 month			How will you identify other		
	period:				residents having the potential	al	
	a. Second shift (ev	ening) of the first quarter			to be affected by the same		
	(January, February,	and March) of 2023, and			deficient practice and what		
	second quarter (Apr	ril, May, and June) of 2022 and			corrective action will be take	n?	
	so far in 2023				All residents, staff and visitors		
	b. Third shift (nigh	t) of the first quarter (January,			have the potential to be affect	ed	
	February, and Marc			by the alleged deficient practice.			
		at the time of record review,		Fire drills have been conducted on			
		rector confirmed the lack of		both shifts (Days, Nights) at			
	_	ring the previously mentioned			expected and unexpected time		
	shifts and quarters.				under various conditions in all		
					villas. Documentation includes	3	
	_	viewed with the Executive			employee signatures that		
		enance Director during the exit			participated in each drill and		
	conference on 05/1	1/23.			transmission of the alarm that was		
	2.1.10/1)				received by monitoring compa	iny.	
	3.1-19(b)				NA/Ib of the control		
	2 Resed on massed	review and interview, the			What measures will be put in	ILO	
		wide complete fire drill			place or what systemic changes you will make to		
		of 9 fire drills performed			ensure that the deficient		
		nonth period. This deficient			practice does not recur?		
		t all residents in the facility.		The Maintenance Director has			
	Practice could affect	- an isolating in the laterity.			been educated on the	´	
	Findings include:				requirements of conducting		
	I manigo morado.				monthly fire drills in all 8 Villas	s on	
	Based on review of the facility's fire drill reports				both day shift and night shift a		
on 05/10/23 between 9:30 a.m. and 3:30 p.m. with				expected and unexpected time			
	the Maintenance Di	-			under various conditions and		
		ll report performed on 03/28/23			required documentation of the		
		st quarter) did not include the			that participated in the drills a		
names and signatures of staff that participated in				transmission of the alarm that			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	a. building <u>05</u>		05	COMPLETED	
		155770	B. WING 05/11/2023			2023	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER			1002 SI	ISTER BARBARA WAY		
VILLAS OF GUERIN WOODS				GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		on interview at the time of			received by the monitoring		
	· ·	Maintenance Director			company. The		
	drill report dated 03	of staff signatures on the fire			administrator/designee will		
	driii report dated 03	0/28/23.			complete a Performance	ha	
	This finding was "	viewed with the Executive			Improvement Tool to ensure the monthly fire drills were conductions		
	_	enance Director during the exit			monthly fire drills were conducted at expected and unexpected to		
	conference on 05/1	_			at expected and unexpected tunder various conditions mon		
	conference on 03/1.	1/23.			on both shifts and validate pro	-	
	3.1-19(b)				documentation is completed.	phei	
	3.1 17(0)				Non-compliance with required	fire	
	2. Based on record	review and interview, the			drills and documentation will r		
		sure 3 of 9 fire drill reports			in disciplinary action up to and		
	-	documentation of the			including termination		
		re alarm signal to the					
		y/fire department during the			How the corrective action (s)	۱ ا	
		LSC 19.7.1.4 requires fire			will be monitored to ensure t		
	-	occupancies shall include the			deficient practice will not		
	transmission of the	fire alarm signal and			recur, i.e., what quality		
	simulation of emerg	gency conditions. This			assurance program will be p	ut	
	deficient practice co	ould affect all residents.			into place?		
					The Quality Assurance Comm	nittee	
	Findings include:				will review the Performance		
					Improvement Tool related to t	he	
		the facility's fire drill reports			competition and proper		
		n 9:30 a.m. and 3:30 p.m. with			documentation of the required		
		rector present, fire drill reports			drills for compliance and to ma	ake	
		27/22 and 03/28/23 were not			further recommendations.		
	•	mentation for the transmission			By what date will the system		
		nonitoring company. Based on			changes for each deficiency	be	
		e of record review, the			completed?		
	Maintenance Director acknowledged there was no				6/19/2023		
	information on the previously mentioned fire drill						
	reports to verify that transmission of the alarm						
	was received by the monitoring company. This finding was reviewed with the Executive						
	-	enance Director during the exit					
	conference on 05/11	_					

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 05 B. WING 05/11/2023			
	PROVIDER OR SUPPLIER OF GUERIN WOOD		1002 \$	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 05	Testing Electrical Systems Testing Hospital-grade recolocations and whee anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 mor (LIM), if installed, less than or equal the LIM test switch activates both visually LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3.3 renovation to the Records are main associated repairs	s - Maintenance and s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. Its performed at intervals ented performance data. Its ested as hospital-grade at the tested at intervals not this. Line isolation monitors are tested at intervals of to 1 month by actuating to per 6.3.2.6.3.6, which tal and audible alarm. For tutomated self-testing, this formed at intervals less to months. LIM circuits are a after any repair or electric distribution system. tained of required tests and to or modifications, from or area tested, and			
	Based on observation interview; the facility documentation was nonhospital-grade expression room location NFPA 99, Health Consection 6.3.4.1.3 states hospital-grade, at parallections where deep the facility of the facility	on, record review and ty failed to ensure complete available for all lectrical receptacles in all ons tested at least annually. are Facilities Code 2012 Edition, attes receptacles not listed as attent bed locations and in p sedation or general istered, shall be tested at	K 0914	K 914 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to hat been affected by this alleged deficient practice. Non-hospital grade receptacles in resident.	ve

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 05 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2023				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122	1002 SISTER BARBARA WAY				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG: PREGULATORY OR LSC IDENTIFYING INFORMATION: TAG: PREGULATORY OR L	ATE COMPLETION				
TAG REGULATOR FOR LSC IDENTIFTING INFORMATION TAG	DATE				
intervals not exceeding 12 months. Additionally, rooms have been tested for					
Section 6.3.3.2, Receptacle Testing in Patient Care polarity, continuity of ground					
Rooms requires the physical integrity of each circuit, and retention force of					
receptacle shall be confirmed by visual inspection. grounding blade. Receptacles					
The continuity of the grounding circuit in each were replaced as indicated by	/ tne				
electrical receptacle shall be verified. Correct tests.					
polarity of the hot and neutral connections in					
each electrical receptacle shall be confirmed; and How will you identify other	:-1				
retention force of the grounding blade of each residents having the potential resource of the grounding blade of each residents having the potential resource of the grounding blade of each	lai				
electrical receptacle (except locking-type to be affected by the same receptacles) shall be not less than 115 grams (4 deficient practice and what					
receptacles) shall be not less than 115 grams (4 deficient practice and what ounces). This deficient practice could affect all corrective action will be take	2				
/ / Solution, Stain and / lener					
have the potential to be affect by the alleged deficient practic					
Based on record review on 05/10/23 between 9:30 Non-hospital grade receptacle resident rooms have been tes					
a.m. and 3:30 p.m. with the Maintenance Director for polarity, continuity of grounds.					
present, there was no documentation available of circuit, and retention force of	nu				
an annual resident room receptacle test for non grounding blade. Receptacles					
hospital-grade receptacles. Based on interview at were replaced as indicated by					
the time of record review, the Maintenance tests.	y uie				
Director said all of the electrical receptacles in					
resident rooms were not hospital-grade What measures will be put in	nto				
receptacles as far as he knew. He further said he place or what systemic					
has been the Maintenance Director at the facility has been the Maintenance Director at the facility changes you will make to					
for only four months and could not find ensure that the deficient					
documentation to show that annual testing per practice does not recur?					
NFPA 99, Receptacle Testing requirements was The Maintenance Director was	ıs İ				
met with all pertinent information within the past met with all pertinent information within the past educated on documenting the					
12 month period or prior. Based on observations annual testing of non-hospital					
on 05/11/23 between 10:00 a.m. and 12:00 p.m. grade receptacles in resident					
during a tour of the facility with the Maintenance rooms, to include testing for					
Director, there were at least four electrical polarity, continuity of ground					
receptacles in each resident room.	the				
grounding blade. Receptacles					
This finding was reviewed with the Executive were replaced as indicated by					
Director and Maintenance Director during the exit tests. The administrator/desig					
conference on 05/11/23. will complete a Performance	, l				
Improvement Tool to ensure					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAD SERVICES

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>05</u>		COMPLETED		
		155770	B. WING		05/11/2023	
		100770	B. WING		00/11/2020	
	ROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	S	GEOR	GETOWN, IN 47122		
(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	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	3.1-19(b)			non-hospital grade receptacles tested annually, replace when indicated by testing, and requi documentation. Non-complian with required annual test will rein disciplinary action up to and including termination How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Commowill review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make further recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	ired ired ice result d) the ut nittee er	
K 0918 SS=F Bldg. 05	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro annually confirm to 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 in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer				

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switches are performed in accordance with

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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 05 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the K 0918 K 918 06/19/2023 facility failed to ensure a written record of weekly What corrective action(s) will inspections for 1 of 1 generator was maintained be accomplished for those for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012 residents found to have been NFPA 99 requires batteries for on-site generators affected by the deficient shall be maintained in accordance with NFPA 110, practice? 2010 Edition, Standard for Emergency and No residents were found to have Standby Power Systems. 8.3.7 requires storage been affected by this alleged batteries, including electrolyte levels or battery deficient practice. The facilities five voltage, used in connection with systems shall be generators have the require weekly inspected weekly and maintained in full inspections/tested, monthly load compliance with manufacturer's specifications. toad test, annual maintenance,

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8.3.7.2 states defective batteries shall be repaired

defects. Chapter 6.5.4.2 of NFPA 99 requires a

or replaced immediately upon discovery of

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and 4-hour load test completed

meet NFPA emergency power and

and documented according to

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	r í	JILDING	ONSTRUCTION 05	(X3) DATE : COMPL 05/11/	ETED
	PROVIDER OR SUPPLIER OF GUERIN WOOD			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(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
	written record of in exercising period, a maintained and ava authority having jui	spection, performance, nd repairs shall be regularly ilable for inspection by the isdiction. This deficient t all residents, staff and			standby system requirements How will you identify other residents having the potenti to be affected by the same deficient practice and what	al	
	Findings include:				All residents, staff, and visitor have the potential to be affect	s	
	reports on 05/10/23 p.m. with the Maint was no documentat emergency generate during 31 of the mo (nothing since 10/0) the time of record re Director said he doc emergency generate document the test/in	the generator inspection between 9:30 a.m. and 3:30 enance Director present, there can available to show the for was inspected/tested weekly st recent 52 week period 3/22). Based on interview at eview, the Maintenance est test/inspect of the for weekly but does not always aspection results.			by the alleged deficient practi The facilities five generators if the require weekly inspections/tested, monthly lo toad test, annual maintenance and 4-hour load test complete and documented according to meet NFPA emergency powe standby system requirements What measures will be put in place or what systemic changes you will make to	nave ead ed or and	
	Director and Mainte conference on 05/1 3.1-19(b)	enance Director during the exit 1/23.			ensure that the deficient practice does not recur? The Maintenance Director had been educated on the NFPA's		
	facility failed to ma of monthly generate generator during 6 6 6.4.4.1.1.4(a) of 20 testing of the general electrical system to	review and interview, the intain a complete written record or load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby			LTC emergency and standby power system requirements. administrator/designee will complete the Performance Improvement Tool for 6 month after reviewing the weekly inspections/testing document weekly, the monthly load too	The hs ation	
	Powers Systems, Cl NFPA 99 requires a performance, exerc	napter 8. Chapter 6.4.4.2 of written record of inspection, ising period, and repairs for the alarly maintained and available			documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-ho load test documentation during		

for inspection by the authority having

each Decembers scheduled QA

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE A. BUILDING B. WING	construction <u>05</u>	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002	T ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY RGETOWN, IN 47122	
VILLAS (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR jurisdiction. Chapter requires batteries for maintained in according to the following electroly to used in connection of inspected weekly are compliance with mark 8.3.7.2 states defect or replaced immediatelects. Chapter 6.1 written record of insexercising period, a maintained and available authority having jurpractice could affect visitors. Findings include: Based on record revisitors. Findings include: Based on record revisitors. Findings include: Based on record revisitors. Findings include: This finding was revisited the following since the following	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION er 6-4.4.1.3 of 2012 NFPA 99 or on-site generators shall be dance with NFPA 110, 2010 or Emergency and Standby 3.7 requires storage batteries, e levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. ive batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly idable for inspection by the insidiction. This deficient t all residents, staff and riew on 05/10/23 between 9:30 with the Maintenance Director to monthly generator load test lable for 6 of the past 12 and 12 and 12 and 13 and 14 and 15 and 15 and 16 and 17 and 17 and 18 and 19 and			ation d test the out nittee er ner
	Based on record	review and interview, the			

facility failed to ensure a written record of routine

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	l í	UILDING	nstruction <u>05</u>	(X3) DATE COMPL 05/11/	ETED	
	PROVIDER OR SUPPLIEI DF GUERIN WOOL		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	generator was main 110, the Standard frowers Systems, at schedule for routing testing of the EPSS requires a permane inspections, tests, erepairs shall be main 8.3.4.1 requires the the following: (1) report (2) Identification personnel (3) Notice condition and the	ation that routine maintenance I on the generator either in utside vendor. viewed with the Executive enance Director during the exit						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	l í	UILDING	nstruction 05	(X3) DATE COMPL 05/11/	ETED
	ROVIDER OR SUPPLIEF DF GUERIN WOOD			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTROL OF THE APPROPRIATE DEFICIENCY		(X5) COMPLETION DATE
	4. Based on record facility failed to profor the testing of 5 of System in accordant for Emergency and Section 8.4.9, as rec Facilities Code, Sec Section 8.4.9 states Power Systems sha every three years. Signeater than 4 hours terminate the test at 6.4.1.1.6.1 states the electrical system post at Type 10, Class X 110, Section 8.4.9. or Natural Gas) EPS available EPSS load affect all residents, Findings include: Based on record revalum, and 3:30 p.m. present, the facility documentation of a gas fueled emergen months for the five was confirmed by the time of record revision of the side o	review and interview, the byide complete documentation of 5 Emergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care ction 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency II be tested at least once within Where the assigned class is s, it shall be permitted to fter 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified to Level 1 generator sets. NFPA 5.3 states for spark-ignited (LP S's, loading shall be the d. This deficient practice could staff, and visitors. Friew on 05/10/23 between 9:30 with the Maintenance Director could not provide four hour load test of the LP cy generator within the past 36 emergency generators. This he Maintenance Director at the sw.					
K 0000							
Bldg. 06							

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	T OF HEALTH AND HU R MEDICARE & MEDIO						ORM APPROVED OMB NO. 0938-039	
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
VILLAS OF GUERIN WOODS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECED REGULATORY OR LSC IDENTIFYING I A Life Safety Code Recertification and Licensure Survey was conducted by th Department of Health in accordance w 483.90(a). Survey Dates: 05/10/23 and 05/11/23 Facility Number: 011509 Provider Number: 155770 AIM Number: 200909280 At this Life Safety Code survey, Villas Woods, was found not in compliance w Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 4 Life Safety from Fire and the 2012 edi National Fire Protection Association (1)		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Re Recertification and State was conducted by the Indiana with in accordance with 42 CFR 10/23 and 05/11/23 11509 155770 1909280 Code survey, Villas of Guerin not in compliance with Participation in 1, 42 CFR Subpart 483.90(a), ire and the 2012 edition of the	K 0	ID PREFIX TAG 000	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRICE DEFICIENCY) Plan of Correction for the of Guerin Woods 2023 L. Safety Code with Emerging Preparedness Survey. The creation and submission this Plan of Correction of constitute an admission provider of any conclusifier forth in the statement of deficiencies, or of any vision of regulation. This provider respectfully that the 2567 Plan of Correction deconsidered the Letter of Credible Allegation and repost Certification Desk Relieu of the Post Survey Relieu o	e Villas ife ency ssion of loes not by this on set iolation requests rection of equests a eview in	(X5) COMPLETION DATE	
K 0291 SS=F	1006 was surveyed Health Care Occup This one story faci Type V (111) cons The facility has a f detection in the con corridors, and all re facility has a capac at the time of this v All areas where res were sprinkled and services were sprin	lity was determined to be of truction and fully sprinkled. Fire alarm system with smoke cridors, spaces open to the esident sleeping rooms. The city of 10 and had a census of 9 visit. Sidents have customary access all areas providing facility skled. Impleted on 05/17/23						

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Bldg. 06

Emergency Lighting
Emergency lighting of at least 1-1/2-hour

duration is provided automatically in

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>06</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIEI		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	interview; the facilidocumentation for backup lights that we seconds during 6 or annually for 90 min to ensure the light of periods of power of emergency lighting accordance with Serequires functional monthly, with a min maximum of 5 weet than 30 seconds, (3 conducted annually if the emergency lighting powered and (5) We inspections and test for inspection by the jurisdiction. This contraction is a second of the form of th	view, observation, and ity failed to ensure there was the testing of 5 of 5 battery were tested monthly for 30 of the past 12 months, and nutes during the past 12 months would provide lighting during utages. LSC 19.2.9.1 requires a shall be provided in action 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a acks between tests, for not less a provided in the provided i	K 0291	K 291 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights twere tested for 90 minutes and documented accordingly. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential be affected by the alleged deficient practice. All 5 of the facilities' battery backup lights were test for 90 minutes and documente accordingly.	ve that d n? I to cient
	a.m. and 3:30 p.m. present, the facility maintenance (PM) emergency lights we there was no 30 seed documentation since was no documentate battery powered en annually for 90 min the time of record re	wiew on 05/10/23 between 9:30 with the Maintenance Director did have a preventative report that battery powered were tested monthly, however, and monthly testing the 09/26/22. Furthermore, there ion available to show the five hergency lights were tested nutes. Based on an interview at review, the Maintenance		What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights will tested monthly by the	

powered emergency lights did not include 30

30 seconds and 90 minutes

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>06</u>	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP CO SISTER BARBARA WAY GETOWN, IN 47122	DD .
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION JULD BE PROPRIATE COMPLETION DATE
	light since 09/26/22 was no documentat minute test during t During a tour of the Director on 05/11/2 p.m., the facility wa emergency battery p This finding was re	viewed with the Executive enance Director during the exit		annually with completed documentation. The administrator/designee complete a Performance Improvement Tool mont months after reviewing testing report to ensure will provide lighting durinoutage. Non-compliance emergency battery back testing will result in disc action up to and includin termination. How the corrective act will be monitored to endeficient practice will recur, i.e., what quality assurance program winto place? The Quality Assurance will review Performance Improvement Tool relate emergency battery backlighting's monthly testing compliance and further recommendations durin scheduled monthly meets. By what date will the schanges for each deficient process.	will e thly for 6 the monthly the light ng a power e with kup lighting iplinary ng ion (s) esure the not II be put Committee ed to kup g for g the etting. ystemic
K 0345 SS=F Bldg. 06	NFPA 101 Fire Alarm Systen Maintenance Fire Alarm Systen Maintenance A fire alarm systel	-			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE (A. BUILDING B. WING	O6	(X3) DATE SURVEY COMPLETED 05/11/2023	
VILLAS (PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	complying with the National Electric C National Fire Alari Records of system and testing are respectively. 1. Based on record facility failed to ensign the National Electric Complete States of the Nati	an approved program re requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 review and interview, the cure the annual testing of all to 1 of 1 fire alarm system was	K 0345	K 345 What corrective action(s) wi	06/19/2023	
	performed. NFPA the 2010 Edition, at inspections, testing, provided that including regarding tests and requested in Figure (1) Date (2) Test frequency (3) Name of proper (4) Address (5) Name of person maintenance, tests,	72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be les the following information all the applicable information 14.6.2.4:		residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The components of the identified Alarm System have been test calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.	ave Fire ted,	
	(6) Name, address, approving agency (17) Designation of the (8) Functional test operations (10) Check of all small (11) Loop resistance line-type heat detect (12) Functional test control units (13) Functional test notification systems (14) Functional test system to silence first	he detector(s) tested of detectors of required sequence of noke detectors e for all fixed-temperature, tors of mass notification system of signal transmission to mass		How will you identify other residents having the potentito be affected by the same deficient practice and what corrective action will be take All residents, staff, and visitor have the potential to be affect by the alleged deficient practitor. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm Signaling Code.	en? rs ted ice.	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	06	COMPL	ETED
		155770	B. W	NG		05/11/	2023
NAME OF I	PROVIDER OR SUPPLIEF	8		l	ADDRESS, CITY, STATE, ZIP COD		
		_			ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS .		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i L	DATE
	system speakers				What measures will be put in	ito	
	(16) Other tests as r	required by the equipment			place or what systemic		
	manufacturer's publ	lished instructions			changes you will make to		
	(17) Other tests as r	equired by the authority			ensure that the deficient		
	having jurisdiction				practice does not recur?		
	(18) Signatures of t	ester and approved authority			The Maintenance Director has	;	
	representative				been educated on testing and		
	(19) Disposition of	problems identified during test			maintenance of a fire alarm		
	(e.g., system owner	notified, problem			system accordance with the		
	corrected/successfu	lly retested, device			requirements of NFPA 70,		
	abandoned in place)			National Electric Code, and NI	FPA	
	This deficient practice could affect all occupants				72, National Fire Alarm and		
in the facility.				Signaling Code and that			
	·				documentation is readily availa	able	
	Findings include:				for review. The		
					administrator/designee will		
	Based on record rev	view on 05/10/23 between 9:30			complete a Performance		
	a.m. and 3:30 p.m.	with the Maintenance Director		Improvement Tool monthly to			
	present, the facility	was able to provide a			ensure the testing, recalibration	n as	
	semi-annual visual	fire alarm system inspection			needed, and inspections are		
	report dated 06/24/2	22 performed by the facility's			completed per regulations.		
	maintenance staff, l	nowever, there was no			Non-compliance with required		
	documentation avai	lable for an annual visual			testing, calibration, and inspection		
	inspection and func	tional test of all devices			will result in disciplinary action	up	
	connected to the fir	e alarm system. Based on			to and including termination.		
	interview at the tim	e of record review, this was			How the corrective action (s)		
	confirmed by the M	laintenance Director.			will be monitored to ensure t	he	
					deficient practice will not		
	This finding was re	viewed with the Executive			recur, i.e., what quality		
	Director and Mainto	enance Director during the exit			assurance program will be p	ut	
	conference on 05/1	1/23.			into place?		
					The Quality Assurance Comm	ittee	
	3.1-19(b)				will review the Performance		
					Improvement Tool related to F		
		review and interview, the			Alarm Systems for compliance		
	-	sure documentation was			and for further recommendation		
	available to show that all smoke detectors were				By what date will the system		
		ithin the past 24 months or			changes for each deficiency be		
		ational Fire Alarm Code, 2010			completed?		
	Edition, Section 14.	.4.5.3.1 states detector			6/19/2023		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIEF		<u> </u>	1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	sensitivity shall be installation, and ever After the second reconstruction and ever After the second reconstruction and ever sensitivity tests indifferent and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and the second reconstruction and second reconstru	checked within 1 year of cry alternate year thereafter. quired calibration test, if icate that the detector has listed and marked sensitivity itime between calibration tests to be extended to a maximum of itency is extended, records of sance alarms and subsequent in shall be maintained. In the nuisance alarms show an evious year, calibration tests. To ensure that each smoke is listed and marked sensitivity sted using any of the methods: in the nuisance alarms and subsequent in the properties of the sensitivity test. The ensure that each smoke is listed and marked sensitivity sted using any of the methods: in the detector causes a signal other its sensitivity is outside range. Sensitivity method acceptable in giurisdiction. In ave sensitivity outside the ensitivity range shall be rated, or replaced. Vity cannot be tested or a spray device that administers centration of aerosol into the central practice could affect all visitors in the facility. The view on 05/10/23 between 9:30 with the Maintenance Director		TAG	DEFICIENCY		DATE
	present, the facility	was unable to produce a					

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		IDENTIFICATION NUMBER 155770		JILDING	06	COMPL: 05/11/	ETED
	PROVIDER OR SUPPLIER			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0353 SS=F	detectors for the passinterview at the time Maintenance Directors smoke detector sensiavailable for the passing This finding was revulated Director and Maintenance on 05/11 3.1-19(b) NFPA 101 Sprinkler System -	viewed with the Executive enance Director during the exit 1/23.					
Bldg. 06	Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and	·					
	Provide in REMAR coverage for any nautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record revinterview; the facilit system inspections i for 1 of 1 dry sprink past 52 weeks. NFP	RKS information on non-required or partial er system.	K 03	353	E 353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		06/19/2023

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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 06 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Water-Based Fire Protection Systems, 2011 The identified facility's dry Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler system gauges and sprinkler systems shall be inspected weekly to control valve were inspected, and ensure that normal air and water pressures are maintenance performed as being maintained. Section 5.1.2 states valves and indicated. The documentation is fire department connections shall be inspected, readily available. tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be How will you identify other utilized for inspection, testing and maintenance of residents having the potential valves, valve components and trim. Section 4.3.1 to be affected by the same states records shall be made for all inspections, deficient practice and what tests, and maintenance of the system and its corrective action will be taken? components and shall be made available to the All residents, staff, and visitors authority having jurisdiction upon request. This have the potential to be affected deficient practice could affect all residents, staff, by the alleged deficient practice. and visitors in the facility. An audit was completed on the remainder Villas to identify Findings include: sprinkler system gauges and control valve were not inspected a. Based on record review on 05/10/23 between and lacking maintenance as 9:30 a.m. and 3:30 p.m. with the Maintenance required. The identified areas were Director present, there was no documentation corrected. The documentation is available to show the facility's dry sprinkler readily available. system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at What measures will be put into the time of record review, the Maintenance place or what systemic Director confirmed there was no documentation changes you will make to available to show that the facility's sprinkler ensure that the deficient gauges have been inspected at least weekly practice does not recur? during 41 of the past 52 weeks. Based on The Maintenance Director has observations with the Maintenance Director been educated on the facility's dry during a tour of the facility on 05/11/23 between sprinkler system gauges, control 10:00 a.m. and 12:00 p.m. the facility had three valves, required inspections, and pressure gauges at the sprinkler riser. maintenance. The administrator/designee will b. Based on record review on 05/10/23 between complete a Performance 9:30 a.m. and 3:30 p.m. with the Maintenance Improvement Tool after reviewing Director present, there was no monthly sprinkler the monthly documentation of the system control valves inspection documentation weekly and monthly inspections for 8 of the past 12 months. Based on interview at and maintenance that is performed

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>06</u>	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE		
	Director confirmed inspections on the c 12 months. This finding was re	eview, the Maintenance the lack of sprinkler system ontrol valves during the past viewed with the Executive enance Director during the exit 1/23.		as required. Non-compliance the required weekly and more inspections and required maintenance will result in disciplinary action up to and including termination How the corrective action (will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Comwill review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, an required maintenance for compliance and to make furtirecommendations. By what date will the syste changes for each deficience completed? 6/19/2023	nthly (s) the put mittee d d d ther mic		
K 0712 SS=F Bldg. 06	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			,		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	06	COMPLETED	
		155770	B. W	ING		05/11/2023	
	PROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	J
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	19.7.1.4 through 1						
		review and interview, the	K 0	712	K 712	06/19/202	3
		ovide quarterly fire drill			What corrective action(s) will	I	
		3 of 3 shifts during 2 of 4			be accomplished for those		
	-	cient practice could affect all			residents found to have bee	n	
		s staff and visitors in the			affected by the deficient		
	facility.				practice?		
					No residents were found to ha	ive	
	Findings include:				been affected by this alleged		
					deficient practice. Fire drills ha	II .	
		the facility's fire drill reports			been conducted on both shifts	5	
		en 9:30 a.m. and 3:30 p.m. with			(Days, Nights) in all 8 villas.		
	the Maintenance Director present, the facility lacked fire drill documentation for the following				Documentation is readily avai	lable.	
					11		
		during the past 12 month			How will you identify other		
	period:				residents having the potenti	aı	
	· ·	ening) of the first quarter and March) of 2023, and			to be affected by the same		
		ril, May, and June) of 2022 and			deficient practice and what	2	
	so far in 2023	in, May, and June) of 2022 and			corrective action will be take All residents, staff and visitors		
		t) of the first quarter (January,			have the potential to be affect		
	February, and Marc				by the alleged deficient practic		
	-	at the time of record review,			Fire drills have been conducted		
		rector confirmed the lack of			both shifts (Days, Nights) at	, G 5/1	
		ring the previously mentioned			expected and unexpected tim	es	
	shifts and quarters.				under various conditions in all		
					villas. Documentation include:		
	This finding was re	viewed with the Executive			employee signatures that		
		enance Director during the exit			participated in each drill and		
	conference on 05/1	_			transmission of the alarm that	was	
					received by monitoring compa	ıny.	
	3.1-19(b)						
					What measures will be put in	nto	
		review and interview, the			place or what systemic		
		ovide complete fire drill			changes you will make to		
		1 of 9 fire drills performed			ensure that the deficient		
		nonth period. This deficient			practice does not recur?		
	practice could affec	et all residents in the facility.			The Maintenance Director has	3	
					been educated on the		
	Findings include:				requirements of conducting		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	06	COMPL	ETED
		155770	B. W	ING		05/11/	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	₹			ISTER BARBARA WAY		
VILLAS C	OF GUERIN WOOD	os			GETOWN, IN 47122		
							ī
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					monthly fire drills in all 8 Villas		
		the facility's fire drill reports			both day shift and night shift a		
		en 9:30 a.m. and 3:30 p.m. with			expected and unexpected time		
	the Maintenance Di	-			under various conditions and t		
		ill report performed on 03/28/23			required documentation of tho		
	,	st quarter) did not include the es of staff that participated in			that participated in the drills ar		
	_	on interview at the time of			transmission of the alarm that	was	
		Maintenance Director			received by the monitoring		
	1	of staff signatures on the fire			company. The administrator/designee will		
	drill report dated 03	-			complete a Performance		
	drin report dated 03	7. 20, 23.			Improvement Tool to ensure the	20	
	This finding was re	viewed with the Executive			monthly fire drills were conduc		
		enance Director during the exit			at expected and unexpected to		
	conference on 05/1				under various conditions mont		
					on both shifts and validate pro	-	
	3.1-19(b)				documentation is completed.	P 0.	
					Non-compliance with required	fire	
	2. Based on record	review and interview, the			drills and documentation will re		
		sure 3 of 9 fire drill reports			in disciplinary action up to and	l	
	1	documentation of the			including termination		
	transmission of a fir	re alarm signal to the					
	monitoring compan	y/fire department during the			How the corrective action (s))	
	past twelve months	. LSC 19.7.1.4 requires fire			will be monitored to ensure t	he	
	drills in health care	occupancies shall include the			deficient practice will not		
	transmission of the	fire alarm signal and			recur, i.e., what quality		
	1	gency conditions. This			assurance program will be p	ut	
	deficient practice co	ould affect all residents.			into place?		
					The Quality Assurance Comm	ittee	
	Findings include:				will review the Performance		
					Improvement Tool related to the	ne	
		the facility's fire drill reports			competition and proper	_	
		en 9:30 a.m. and 3:30 p.m. with			documentation of the required		
		irector present, fire drill reports			drills for compliance and to ma	ake	
		27/22 and 03/28/23 were not			further recommendations.	_	
	1 ^	mentation for the transmission			By what date will the system		
		monitoring company. Based on			changes for each deficiency	be	
		e of record review, the			completed?		
		tor acknowledged there was no			6/19/2023		
	L intormation on the i	nreviously mentioned tire drill	ī				1

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 B. WING		COMPLETED 05/11/2023				
	PROVIDER OR SUPPLIER DF GUERIN WOOD			1002 SI	NDDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 06	reports to verify that was received by the This finding was recoived by the This finding was reconference on 05/11 a-1.19(b) NFPA 101 Electrical Systems Testing Electrical Systems Testing Hospital-grade recolocations and whee	t transmission of the alarm monitoring company. viewed with the Executive enance Director during the exit		TAG	DEFICIENCY)		DATE
	initial installation, in Additional testing in defined by document Receptacles not list these locations are exceeding 12 more (LIM), if installed, is less than or equal the LIM test switch activates both visual LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3.	replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at e tested at intervals not of this. Line isolation monitors are tested at intervals of to 1 month by actuating of per 6.3.2.6.3.6, which of all and audible alarm. For outomated self-testing, this formed at intervals less of months. LIM circuits are of a per 6.3.2.6.3.6					
	Records are maint associated repairs containing date, ro results. 6.3.4 (NFPA 99) Based on observation	oom or area tested, and on, record review and ty failed to ensure complete	K 0	914	K 914 What corrective action(s) will be accomplished for those		06/19/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	ľ í	JILDING	onstruction <u>06</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
NAME OF	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	os		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident room locat NFPA 99, Health C	electrical receptacles in all ions tested at least annually. Care Facilities Code 2012 Edition,			residents found to have bee affected by the deficient practice?	:11	
		ates receptacles not listed as			No residents were found to ha	ave	
		atient bed locations and in			been affected by this alleged		
		ep sedation or general			deficient practice. Non-hospit		
		istered, shall be tested at			grade receptacles in resident		
		ding 12 months. Additionally, ceptacle Testing in Patient Care			rooms have been tested for		
		physical integrity of each			polarity, continuity of ground circuit, and retention force of		
	_	confirmed by visual inspection.			grounding blade. Receptacle		
	-	ne grounding circuit in each			were replaced as indicated by		
		e shall be verified. Correct			tests.	y 1110	
	_	and neutral connections in			100.01		
		ptacle shall be confirmed; and			How will you identify other		
	retention force of th	ne grounding blade of each			residents having the potent	ial	
	electrical receptacle	e (except locking-type			to be affected by the same		
	receptacles) shall be	e not less than 115 grams (4			deficient practice and what		
	ounces). This defici	ient practice could affect all			corrective action will be take	en?	
	residents.				All residents, staff and visitors		
					have the potential to be affect		
	Findings include:				by the alleged deficient practi		
					Non-hospital grade receptacl		
		view on 05/10/23 between 9:30			resident rooms have been tes		
	_	with the Maintenance Director no documentation available of			for polarity, continuity of grou		
	1 -	oom receptacle test for non			circuit, and retention force of		
		ptacles. Based on interview at			grounding blade. Receptacle were replaced as indicated by		
		eview, the Maintenance			tests.	y ii i c	
		the electrical receptacles in			icsis.		
		e not hospital-grade			What measures will be put i	nto	
		s he knew. He further said he			place or what systemic		
	_	enance Director at the facility			changes you will make to		
		ns and could not find			ensure that the deficient		
		how that annual testing per			practice does not recur?		
		cle Testing requirements was			The Maintenance Director wa	as	
	_	ent information within the past			educated on documenting the	Э	1
	•	prior. Based on observations			annual testing of non-hospita		

on 05/11/23 between 10:00 a.m. and 12:00 p.m.

during a tour of the facility with the Maintenance

grade receptacles in resident

rooms, to include testing for

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	06	COMPL	ETED
		155770	B. W	ING		05/11/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	₹			STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS .	GEORGETOWN, IN 47122				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROF		CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	e at least four electrical			polarity, continuity of ground		
	receptacles in each	resident room.			circuit, and retention force of t		
					grounding blade. Receptacles		
	_	eviewed with the Executive			were replaced as indicated by		
		enance Director during the exit			tests. The administrator/design	nee	
	conference on 05/1	1/23.			will complete a Performance		
					Improvement Tool to ensure		
	3.1-19(b)				non-hospital grade receptacle		
					tested annually, replace when		
					indicated by testing, and requi		
					documentation. Non-complian		
					with required annual test will r		
					in disciplinary action up to and	i	
					including termination		
					How the corrective action (s))	
					will be monitored to ensure t	.he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					The Quality Assurance Comm	ittee	
					will review the Performance		
					Improvement Tool related to		
					testing non-hospital grade		
					receptacles annually for		
					compliance and to make furth	er	
					recommendations.		
					By what date will the system		
					changes for each deficiency	be	
					completed?		
					6/19/2023		
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 06		s - Essential Electric					
Ū	System Maintena						
		other alternate power					
	_	iated equipment is capable					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	06	COMPLETED	
		155770	B. WING		05/11/2023	
			CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD		
\/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		ne.				
VILLAS (OF GUERIN WOOD	15	GEUR	GETOWN, IN 47122		
(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	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	of supplying service	ce within 10 seconds. If the				
	10-second criterio	n is not met during the				
	monthly test, a pro	ocess shall be provided to				
	annually confirm t	his capability for the life				
	safety and critical	branches. Maintenance				
	and testing of the	generator and transfer				
	switches are perfo	ormed in accordance with				
	NFPA 110.					
	Generator sets are	e inspected weekly,				
	exercised under lo	oad 30 minutes 12 times a				
	year in 20-40 day	intervals, and exercised				
	once every 36 months for 4 continuous hours.					
	Scheduled test un	ider load conditions include				
	a complete simulated cold start and					
	automatic or manı	ual transfer of all EES				
	loads, and are cor	nducted by competent				
	personnel. Mainte	nance and testing of stored				
	energy power sou	rces (Type 3 EES) are in				
	accordance with N	NFPA 111. Main and feeder				
	circuit breakers ar	e inspected annually, and a				
		dically exercising the				
		tablished according to				
		uirements. Written records				
		nd testing are maintained				
	-	ble. EES electrical panels				
		arked, readily identifiable,				
		n normal power circuits.				
		ssibility of damage of the				
		source is a design				
	consideration for r					
		(NFPA 99), NFPA 110,				
	NFPA 111, 700.10					
		review and interview, the	K 0918	K 918	06/19/2023	
	•	sure a written record of weekly		What corrective action(s) wi	II	
	-	1 generator was maintained		be accomplished for those		
		Chapter 6-4.4.1.3 of 2012		residents found to have bee	n	
		patteries for on-site generators		affected by the deficient		
		in accordance with NFPA 110,		practice?		
		lard for Emergency and		No residents were found to ha	ave	
	Standby Power Sys	tems. 8.3.7 requires storage		been affected by this alleged		

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]	DEPARTMENT OF HEALTH AND HUMAN SERVICES								
•	CENTERS FOR MEDICARE & MEDICAID SERVICES								
ĺ	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						
ı	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING 06						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	UILDING	onstruction 06	(X3) DATE SURVEY COMPLETED 05/11/2023		
VILLAS	PROVIDER OR SUPPLIE	os		1002 SI GEORG	ADDRESS, CITY, STATE, ZIP CO ISTER BARBARA WAY GETOWN, IN 47122	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION
TAG	batteries, including voltage, used in co inspected weekly a compliance with m 8.3.7.2 states defect or replaced immed defects. Chapter 6 written record of ir exercising period, a maintained and available and available and available and available are could affect visitors. Findings include: Based on review of reports on 05/10/2; p.m. with the Main was no documental emergency generat during 31 of the me (nothing since 10/0 the time of record in Director said he doemergency generat document the test/in	R LSC IDENTIFYING INFORMATION g electrolyte levels or battery nnection with systems shall be and maintained in full nanufacturer's specifications. It ive batteries shall be repaired iately upon discovery of 1.5.4.2 of NFPA 99 requires a respection, performance, and repairs shall be regularly nilable for inspection by the risdiction. This deficient et all residents, staff and If the generator inspection S between 9:30 a.m. and 3:30 retenance Director present, there tion available to show the or was inspected/tested weekly post recent 52 week period 13/22). Based on interview at review, the Maintenance rese test/inspect of the or weekly but does not always		TAG	deficient practice. The fagenerators have the requirement of toad test, annual mainte and 4-hour load test con and documented accord meet NFPA emergency standby system requirement ob e affected by the sadeficient practice and vorrective action will be have the potential to be by the alleged deficient practice and vorrective extensions for the requirement of the facilities five generative requirement of the re	acilities five uire weekly thly load enance, inpleted ling to power and ments. ther betential ame what e taken? visitors affected practice. ators have thly load enance, inpleted ling to power and ments.	DATE
	Director and Maint conference on 05/1 3.1-19(b)	tenance Director during the exit 1/23.			ensure that the deficier practice does not recur The Maintenance Direct been educated on the N	r? or has FPA's	
	facility failed to may of monthly generate generator during 6 6.4.4.1.1.4(a) of 20	I review and interview, the aintain a complete written record for load testing for 1 of 1 of the past 12 months. Chapter 12 NFPA 99 requires monthly rator serving the emergency			LTC emergency and sta power system requirement administrator/designee was complete the Performan Improvement Tool for 6 after reviewing the week inspections/testing docu	ents. The will ace months kly	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>06</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
VILLAS (PROVIDER OR SUPPLIEF	s	1002 S GEOR	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	electrical system to 110, the Standard for Powers Systems, Cl NFPA 99 requires as performance, exercing generator to be regular for inspection by the jurisdiction. Chaptor requires batteries for maintained in accorn Edition, Standard for Power Systems. 8.3. including electrolyth used in connection inspected weekly and compliance with material states and selection or replaced immedial defects. Chapter 6. written record of in exercising period, a maintained and avain authority having jurn practice could affect visitors. Findings include: Based on record revisions. Findings include: Based on record revisions in the record revision of record revisions for the record revision of th	be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, using period, and repairs for the darly maintained and available end authority having er 6-4.4.1.3 of 2012 NFPA 99 or on-site generators shall be dance with NFPA 110, 2010 or Emergency and Standby 3.7 requires storage batteries, end levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. The active batteries shall be repaired attely upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly itable for inspection by the disdiction. This deficient that all residents, staff and the monthly generator load test lable for 6 of the past 12 are 09/26/22) for the or. Based on interview at the two, the Maintenance Director is no emergency generator load for 6 of the past 12 months for		weekly, the monthly load toad documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-h load test documentation during each Decembers scheduled meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing document weekly, the monthly load toad documentation will result in disciplinary action up to and including termination. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Committed emergency and standby pow system requirements for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	d test our ng QA dation d test the out mittee er ner

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	06	COMPL	ETED
		155770	B. W	ING		05/11/	/2023
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS .		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	IE	DATE	
		enance Director during the exit					
	conference on 05/1	_					
	conference on 03/11/25.						
	3.1-19(b)						
	3.1-19(0)						
	3. Based on record	review and interview, the					
		sure a written record of routine					
		sting for 1 of 1 emergency					
		tained and available. NFPA					
	~	or Emergency and Standby					
	Powers Systems, at 8.3.3 requires a written						
	schedule for routine maintenance and operational						
	testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS						
		xercising, operation, and					
	_						
	_	ntained and readily available.					
	_	permanent record shall include					
		The date of the maintenance					
		eation of the servicing					
		fication of any unsatisfactory					
		orrective action taken,					
		aced (4) Testing of any repair					
		mmended by the manufacturer.					
		ice could affect all residents,					
	staff and visitors.						
	Findings include:						
	D 1 .	05/10/221					
		view on 05/10/23 between 9:30					
		with the Maintenance Director					
	-	no documentation available to					
		gency generator has had					
		e during the past 12 months.					
		at the time of record review,					
	the Maintenance Di	irector said he has been the					
	Maintenance Direct	tor at the facility for only four					
	months and has not	seen					
evidence/documentation that routine maintenance							
has been performed on the generator either in							
	house or from an or						
	I		I				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	r í	UILDING	nstruction <u>06</u>	(X3) DATE COMPL 05/11/	ETED
	PROVIDER OR SUPPLIER OF GUERIN WOOD			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Director and Maint conference on 05/1 3.1-19(b) 4. Based on record facility failed to profor the testing of 5 system in accordant for Emergency and Section 8.4.9, as refacilities Code, Section 8.4.9 states Power Systems shate every three years. It is greater than 4 hours terminate the test at 6.4.1.1.6.1 states the electrical system poat Type 10, Class X 110, Section 8.4.9. or Natural Gas) EP available EPSS load affect all residents, Findings include: Based on record refa.m. and 3:30 p.m. present, the facility	review and interview, the ovide complete documentation of 5 Emergency Power Standby ice with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care ction 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency II be tested at least once within Where the assigned class is so, it shall be permitted to fter 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified at Level 1 generator sets. NFPA 5.3 states for spark-ignited (LP S's, loading shall be the d. This deficient practice could staff, and visitors.					
	gas fueled emergen months for the five was confirmed by t time of record revie This finding was re	four hour load test of the LP cy generator within the past 36 emergency generators. This he Maintenance Director at the ew. viewed with the Executive enance Director during the exit					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0000 Bldg. 07	-	Recertification and State	K 0000	Plan of Correction for the Vil	llas	
	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 05/1 Facility Number: 0 Provider Number: 200 At this Life Safety woods, was found requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I 1007 was surveyed Health Care Occupation of the company of th	as conducted by the Indiana th in accordance with 42 CFR 0/23 and 05/11/23 11509 155770 909280 Code survey, Villas of Guerin not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the extion Association (NFPA) 101, asc), and 410 IAC 16.2. Villa with Chapter 19, Existing ancies. ity was determined to be of ruction and fully sprinkled. The alarm system with smoke ridors, spaces open to the sident sleeping rooms. The ty of 10 and had a census of 0	K 0000	of Guerin Woods 2023 Life Safety Code with Emergency Preparedness Survey. The creation and submission this Plan of Correction does constitute an admission by t provider of any conclusion s forth in the statement of deficiencies, or of any violati of regulation. This provider respectfully requ that the 2567 Plan of Correction be considered the Letter of Credible Allegation and reque Post Certification Desk Review lieu of the Post Survey Revisit	n of not this set ion lests on sts a w in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				` ´	3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155770	B. WING 05/11/20.					
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
VILLAS C	OF GUERIN WOOD	S			GETOWN, IN 47122			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
	Quality Review completed on 05/17/23							
K 0291	NFPA 101							
SS=F	Emergency Lightir	na						
Bldg. 07	Emergency Lightin	_						
		g of at least 1-1/2-hour						
	duration is provide							
	accordance with 7.9.							
	18.2.9.1, 19.2.9.1							
		view, observation, and	K 0	291	K 291		06/19/2023	
	interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested monthly for 30				What corrective action(s) wil	I		
					be accomplished for those			
					residents found to have beer	า		
	_	the past 12 months, and			affected by the deficient			
	-	utes during the past 12 months			practice?			
	_	would provide lighting during			No residents were found to ha	ive		
		stages. LSC 19.2.9.1 requires			been affected by this alleged			
		shall be provided in ction 7.9. Section 7.9.3.1.1 (1)			deficient practice. All 5 of the	414		
		testing shall be conducted			facilities battery backup lights were tested for 90 minutes and			
	_	nimum of 3 weeks and a			documented accordingly.	u		
	· ·	ks between tests, for not less			documented accordingly.			
) Functional testing shall be			How will you identify other			
		for a minimum of 1 1/2 hours			residents having the potentia	al		
	-	ghting system is battery			to be affected by the same	-		
		ritten records of visual			deficient practice and what			
		s shall be kept by the owner			corrective action will be take	n?		
	for inspection by the				All residents have the potentia	al to		
		eficient practice could affect all			be affected by the alleged defi	icient		
	•	staff and visitors in the			practice. All 5 of the facilities'			
	facility.				battery backup lights were tes			
					for 90 minutes and documente	ed		
	Findings include:				accordingly.			
	Based on record rev	view on 05/10/23 between 9:30			What measures will be put in	ito		
	a.m. and 3:30 p.m.	with the Maintenance Director			place or what systemic			
	present, the facility	did have a preventative			changes you will make to			
	maintenance (PM) r	report that battery powered			ensure that the deficient			
	emergency lights w	ere tested monthly, however,			practice does not recur?			
there was no 30 second monthly testing		1		The Maintenance Director has	:	I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>07</u>			COMPLETED	
		155770	B. W	ING		05/11/	2023	
NIA 57 67 1	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF	PROVIDER OR SUPPLIE	IK.			ISTER BARBARA WAY			
	OF GUERIN WOOI	DS		GEOR	GETOWN, IN 47122			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		PR LSC IDENTIFYING INFORMATION		TAG		_	DATE	
		ce 09/26/22. Furthermore, there tion available to show the five			been educated on the NFPA's	5		
		nergency lights were tested			emergency battery backup lighting's testing requirements			
		nutes. Based on an interview at			The 5 battery backup lights w			
	1	review, the Maintenance			tested monthly by the	III DC		
		e PM form for the battery			maintenance director/designe	e for		
	_	ey lights did not include 30			30 seconds and 90 minutes			
	1 -	sting for each battery powered			annually with completed			
	light since 09/26/2	2. Furthermore, he said there			documentation. The			
	was no documenta	tion available for an annual 90			administrator/designee will			
	minute test during	the past 12 month period.			complete a Performance			
		e facility with the Maintenance			Improvement Tool monthly fo	r 6		
		23 between 10:00 a.m. and 12:00			months after reviewing the me	•		
		vas equipped with five			testing report to ensure the lig	•		
	emergency battery	powered lights.			will provide lighting during a p			
					outage. Non-compliance with			
	_	eviewed with the Executive			emergency battery backup lig	-		
	conference on 05/1	tenance Director during the exit			testing will result in disciplinar	У		
	conference on 03/1	11/23.			action up to and including termination.			
	3.1-19(b)				termination.			
					How the corrective action (s)		
					will be monitored to ensure	-		
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	out		
					into place?			
					The Quality Assurance Comn	nittee		
					will review Performance			
					Improvement Tool related to			
					emergency battery backup			
					lighting's monthly testing for			
					compliance and further recommendations during the			
					scheduled monthly meeting.			
					By what date will the system	nic		
					changes for each deficiency			
					completed?			
					6/19/2023			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>07</u>	COMPL	ETED
		155770	B. WING 05/11/2023			2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	_	DATE
K 0321 SS=F Bldg. 07	barrier having 1-hd (with 3/4 hour fire automatic fire extinus accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be self automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.					
	Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collectior (exceeding 64 gall f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322	N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops froms (exceeding 64 n Rooms lons) frage Rooms/Spaces eet) classified as Severe					
	failed to ensure 1 of smoke compartmen combustible materia	on and interview, the facility 1 egress corridor in 1 of 2 ts was not used to store al. This deficient practice dents, staff, and visitors.	K 0	321	K 321 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		06/19/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023			
		ROVIDER OR SUPPLIER DF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	TAG	Findings include: Based on observation a.m. and 12:00 p.m. with the Maintenan area of the back hall several plastic draw cardboard boxes, of and a variety of oth was open to the egrinterview at the tim Maintenance Direct way ever since he's This finding was re	ons on 05/11/23 between 10:00 and during a tour of the facility ce Director, the Beauty Shop I was being used to store for type totes full of items, and furniture, and mattresses, er storage items. This area less corridor. Based on e of observation, the tor said this area has been this been at the facility. Viewed with the Executive enance Director during the exit 1/23.	TAG	practice? No residents were found to heen affected by this alleged deficient practice. The combustible materials that we beauty shop were removed. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take All residents have the potent be affected by the alleged depractice. The facility conduct audit to ensure combustible materials are not stored in egocorridors in smoke comparting Identified items were removed.	ere in ial en? ial to eficient ed an gress ents.		
		3.1-19(b)			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director has been educated on proper stored of combustible materials and combustible materials must be moved if they are identified a being stored appropriately. The maintenance director/designed complete daily rounds to identify combustible materials and complete in mediately. The administration complete a weekly Performal Improvement tool to identify continued non-compliance. Non-compliance with daily	as brage that be is he ee will htify brrect for will		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/07/2023 FORM APPROVED

ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING <u>07</u>	COMPLETED		
	155770	B. WI	NG	05/11/2023		
			CERTET ADDRESS OF A CEATE TIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
			1002 SISTER BARBARA WAY			
VILLAS OF GUERIN WOODS			GEORGETOWN, IN 47122			

VILLAS	OF GUERIN WOODS	GEORGETOWN, IN 47122					
(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			
K 0324 SS=C Bldg. 07	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.		environmental rounds and combustible material storage will result in disciplinary action up to and including termination. 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? The Quality Assurance Committee will review the Performance Improvement Tool and make further recommendations or changes as needed during the scheduled monthly meeting. By what date will the systemic changes for each deficiency be completed? 6/19/2023				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE A. BUILDING B. WING	e construction 6 07	(X3) DATE SURVEY COMPLETED 05/11/2023				
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) D BE COMPLETION DATE			
	NFPA 96 per 9.2. enclosed as haza be open to the co 18.3.2.5.1 through through 19.3.2.5.8 Based on record refailed to ensure 1 o was inspected semi Edition, Standard for Protection of Command Section 11.4 states be inspected for great trained, qualified, and acceptable to the authority and in accordance with the seminant of the experience of the encount of the experience of the experienc	n 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 view and interview, the facility f 1 kitchen exhaust systems annually. NFPA 96, 2011 or Ventilation Control and Fire mercial Cooking Operations, the entire exhaust system shall case buildup by a properly and certified person(s) atthority having jurisdiction with Table 11.4. Table 11.4, ction for Grease Buildup, rving moderate volume shall be inspected PA 96, 11.6.1 states, upon chaust system is found to be deposits from grease laden inated portions of the exhaust aned by a properly trained, fied person(s) acceptable to the risdiction. Hoods, grease ans, ducts, and other I be cleaned to remove minants prior to surfaces contaminated with grease or the exhaust system is cleaned, and with powder or other n exhaust cleaning service is howing the name of the the name of the person or interval and the date of inspection or aintained on the premises. ince could affect all residents,	K 0324	E 324 What corrective action(s) be accomplished for thos residents found to have to affected by the deficient practice? No residents were found to been affected by this alleg deficient practice. The kitc exhaust system in the ider Villa has been inspected a cleaned. How will you identify other residents having the potento be affected by the same deficient practice and who corrective action will be to the affected by the alleged practice. The kitchen exhaust systems in the other 7 villabeen inspected and cleaned indicated by the inspection. What measures will be puplace or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director been educated on the Stat Ventilation Control and Fir Protection of Commercial of the stat	been co have ed hen nitified and er ential lee lat late late late late late late			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>0</u> 7	(X3) DATE SURVEY COMPLETED 05/11/2023				
	PROVIDER OR SUPPLIER OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Operations requirements as		(X5) COMPLETION DATE		
	Based on record revalues. Based on record revalues. Based on record revalues. Based on respect to the old/20/23 date time of record revies aid he could not fit system inspection vold/20/23 date. This finding was re	riew on 05/10/23 between 9:30 with the Maintenance Director spection documentation past twelve months for the system was dated 04/20/23. hood exhaust system ailable within six months prior. Based on interview at the w, the Maintenance Director and a range hood exhaust within six months prior to the viewed with the Executive enance Director during the exit 1/23.		related to required inspected inspected in proceedings of the ventilation. The inspection will be so by the maintenance director/designee for manual inspections/clea administrator/designee complete a Performance Improvement Tool montensure the inspections completed and the finding addressed as needed. Non-compliance with retesting inspections and will result in disciplinary to and including terminate How the corrective act will be monitored to endeficient practice will recur, i.e., what quality assurance program with into place? The Quality Assurance will review the Performate Improvement Tool related kitchen ventilation inspections and to make recommendations as not be supported. The compliance and to make recommendations as not be supported to the supported of the supported	ections and on system. cheduled on system. cheduled onthly and ning. The will e thly to were ngs were equired cleanings action up ation. ion (s) nsure the not Il be put Committee ance ed to ections for e further eeded. ystemic			
K 0345 SS=F Bldg. 07	NFPA 101 Fire Alarm Systen Maintenance Fire Alarm Systen Maintenance A fire alarm systel	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		STREET 1002 S GEOR			
(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)	(X5) COMPLETION DATE	
	complying with the National Electric C National Fire Alarn Records of system and testing are readed to the State of the St	review and interview, the sure the annual testing of all to 1 of 1 fire alarm system was 72, National Fire Alarm Code, 14.6.2.4 requires a record of all and maintenance shall be dest the following information all the applicable information 14.6.2.4: Ty performing inspection, or combination thereof, and address, and telephone and representative of detectors of required sequence of the detectors of required sequence of the detectors of mass notification system of signal transmission to mass	K 0345	K 345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. The components of the identified F Alarm System have been test calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be take All residents, staff, and visitors have the potential to be affect by the alleged deficient practice. The facilities other Fire Alarm Systems have been tested, calibrated as needed, and inspected per the NFPA 70, National, Electric Code, and NFPA 72, National Fire Alarm Signaling Code.	n ave Fire ed, al en? s ed ce.	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	07	COMPL	ETED
		155770	B. W	ING _		05/11/	2023
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R	1002 SISTER BARBARA WAY				
VILLAS	OF GUERIN WOOD	ns			GETOWN, IN 47122		
	T		_				
(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
	system speakers				What measures will be put in	nto	
	1 1	required by the equipment			place or what systemic		
	manufacturer's publ				changes you will make to		
	(17) Other tests as required by the authority				ensure that the deficient		
	having jurisdiction				practice does not recur?		
		ester and approved authority			The Maintenance Director has		
	representative	11 11 26 11 1			been educated on testing and		
	(19) Disposition of problems identified during test				maintenance of a fire alarm		
	(e.g., system owner notified, problem				system accordance with the		
	corrected/successfully retested, device				requirements of NFPA 70,	ED A	
	abandoned in place)				National Electric Code, and N	FPA	
	This deficient practice could affect all occupants				72, National Fire Alarm and		
	in the facility.				Signaling Code and that		
					documentation is readily avail	able	
	Findings include:				for review. The		
	D 1 1	. 05/10/221 4 0.20			administrator/designee will		
		view on 05/10/23 between 9:30	complete a Performance				
		with the Maintenance Director			Improvement Tool monthly to		
		was able to provide a			ensure the testing, recalibration	on as	
		fire alarm system inspection			needed, and inspections are		
	1 -	22 performed by the facility's			completed per regulations.		
		nowever, there was no lable for an annual visual			Non-compliance with required		
					testing, calibration, and inspec		
	_	tional test of all devices			will result in disciplinary action	ı up	
		e alarm system. Based on e of record review, this was			to and including termination.		
			How the corrective action (s)				
	commind by the ly	Iaintenance Director.			will be monitored to ensure t	ıne	
	This finding was ra	viewed with the Executive			deficient practice will not		
	I -	enance Director during the exit			recur, i.e., what quality assurance program will be p	+	
	conference on 05/1	_				ut	
	conference on 03/1	1/20.			into place? The Quality Assurance Comm	nittee	
	3.1-19(b)				will review the Performance	III.LEE	
	J.1-17(0)				Improvement Tool related to F	-iro	
	2 Based on record	review and interview, the			Alarm Systems for compliance		
		sure documentation was			and for further recommendation		
	· ·	nat all smoke detectors were			By what date will the system		
		ithin the past 24 months or			changes for each deficiency		
	1	ational Fire Alarm Code, 2010				Ne	
	_	.4.5.3.1 states detector			completed? 6/19/2023		
I	Landon, Section 14	T.J.J.1 States detector	1		0/13/2023		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BUILDING <u>07</u> COM			(X3) DATE : COMPL 05/11/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(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	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	checked within 1 year of ery alternate year thereafter.					
		quired calibration test, if					
		icate that the detector has					
	-	listed and marked sensitivity					
		time between calibration tests					
		o be extended to a maximum of					
	_	uency is extended, records of					
		sance alarms and subsequent					
	trends of these alarr	ns shall be maintained. In					
	zones or areas where nuisance alarms show an						
	increase over the previous year, calibration tests						
	shall be performed. To ensure that each smoke						
	detector is within its listed and marked sensitivity						
	range, it shall be tested using any of the methods:						
	(1) Calibrated test n						
		calibrated sensitivity test					
	instrument.						
		quipment arranged for the					
	purpose.	fire alarm control unit					
	` '	by the detector causes a signal					
	_	where its sensitivity is outside					
	its listed sensitivity						
	-	sensitivity method acceptable					
	to the authority hav	-					
	-	have sensitivity outside the					
		ensitivity range shall be					
	cleaned and recalib	rated, or replaced.					
	The detector sensiti	vity cannot be tested or					
		spray device that administers					
		centration of aerosol into the					
		eient practice could affect all					
	residents, staff, and	visitors in the facility.					
	Findings include:						
	Based on record rev	view on 05/10/23 between 9:30					
	a.m. and 3:30 p.m.	with the Maintenance Director					
	_	was unable to produce a					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770			JILDING	07	COMPL: 05/11/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0353 SS=F	detectors for the passinterview at the time Maintenance Directors smoke detector sensiavailable for the passing This finding was revulated by Director and Maintenance on 05/11 3.1-19(b) NFPA 101	viewed with the Executive enance Director during the exit					
Bldg. 07	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location an	- Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. In system last checked					
	coverage for any nautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record revinterview; the facilit system inspections if for 1 of 1 dry sprink past 52 weeks. NFP		K 03	353	E 353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		06/19/2023

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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 07 COMPLETED B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Water-Based Fire Protection Systems, 2011 The identified facility's dry Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler system gauges and sprinkler systems shall be inspected weekly to control valve were inspected, and ensure that normal air and water pressures are maintenance performed as being maintained. Section 5.1.2 states valves and indicated. The documentation is fire department connections shall be inspected, readily available. tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be How will you identify other utilized for inspection, testing and maintenance of residents having the potential valves, valve components and trim. Section 4.3.1 to be affected by the same states records shall be made for all inspections, deficient practice and what tests, and maintenance of the system and its corrective action will be taken? components and shall be made available to the All residents, staff, and visitors authority having jurisdiction upon request. This have the potential to be affected deficient practice could affect all residents, staff, by the alleged deficient practice. and visitors in the facility. An audit was completed on the remainder Villas to identify Findings include: sprinkler system gauges and control valve were not inspected a. Based on record review on 05/10/23 between and lacking maintenance as 9:30 a.m. and 3:30 p.m. with the Maintenance required. The identified areas were Director present, there was no documentation corrected. The documentation is available to show the facility's dry sprinkler readily available. system gauges were inspected weekly during 41 of the past 52 week period. Based on interview at What measures will be put into the time of record review, the Maintenance place or what systemic Director confirmed there was no documentation changes you will make to available to show that the facility's sprinkler ensure that the deficient gauges have been inspected at least weekly practice does not recur? during 41 of the past 52 weeks. Based on The Maintenance Director has observations with the Maintenance Director been educated on the facility's dry during a tour of the facility on 05/11/23 between sprinkler system gauges, control 10:00 a.m. and 12:00 p.m. the facility had three valves, required inspections, and pressure gauges at the sprinkler riser. maintenance. The administrator/designee will b. Based on record review on 05/10/23 between complete a Performance 9:30 a.m. and 3:30 p.m. with the Maintenance Improvement Tool after reviewing Director present, there was no monthly sprinkler the monthly documentation of the system control valves inspection documentation weekly and monthly inspections for 8 of the past 12 months. Based on interview at and maintenance that is performed

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 07	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Director confirmed inspections on the c 12 months. This finding was re	eview, the Maintenance the lack of sprinkler system ontrol valves during the past viewed with the Executive enance Director during the exit 1/23.		as required. Non-compliance the required weekly and more inspections and required maintenance will result in disciplinary action up to and including termination. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Commuil review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	the put mittee d ner
K 0712 SS=F Bldg. 07	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	lì í	JILDING	07	COMPL	ETED
		155770	B. WI			05/11/	
				CED FEE	A DEDEGG COMMA CTATE THE COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\/		ne.		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
VILLAS (OF GUERIN WOOD	15	GEORG		3E I OWN, IN 47 122		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	19.7.1.4 through 1	19.7.1.7					
	Based on record review and interview, the facility failed to provide quarterly fire drill		K 0	712	K 712		06/19/2023
					What corrective action(s) wi	II	
	documentation for 2	2 of 3 shifts during 2 of 4			be accomplished for those		
	quarters. This defic	cient practice could affect all			residents found to have bee	n	
	residents, as well as	s staff and visitors in the			affected by the deficient		
	facility.				practice?		
					No residents were found to ha	ave	
	Findings include:				been affected by this alleged		
					deficient practice. Fire drills h	ave	
		the facility's fire drill reports			been conducted on both shifts	3	
	on 05/10/23 between 9:30 a.m. and 3:30 p.m. with				(Days, Nights) in all 8 villas.		
	the Maintenance Director present, the facility				Documentation is readily avai	lable.	
		rumentation for the following					
	-	during the past 12 month			How will you identify other		
	period:				residents having the potenti	al	
		of the first quarter (January,			to be affected by the same		
	February, and Marc				deficient practice and what		
	· ·	ening) of the first quarter			corrective action will be take		
		and March) of 2023, and			All residents, staff and visitors		
		ril, May, and June) of 2022 and			have the potential to be affect		
	so far in 2023				by the alleged deficient practi		
		at the time of record review,			Fire drills have been conducted	ed on	
		rector confirmed the lack of			both shifts (Days, Nights) at		
		ring the previously mentioned			expected and unexpected tim		
	shifts and quarters.				under various conditions in al		
	751 ' C' 1'	t tala p			villas. Documentation include	S	
	_	viewed with the Executive			employee signatures that		
		enance Director during the exit			participated in each drill and	ı	
	conference on 05/1	1/23.			transmission of the alarm that		
	2.1.10/1-)				received by monitoring compa	any.	
	3.1-19(b)				NA//	-4-	
	2 Dagad an man1	raviary and interview the			What measures will be put in	110	
		review and interview, the ovide complete fire drill			place or what systemic		
		-			changes you will make to ensure that the deficient		
	documentation for 1 of 9 fire drills performed						
	during the past 12 month period. This deficient practice could affect all residents in the facility.				practice does not recur? The Maintenance Director has	•	
	practice could affect	an residents in the facility.			been educated on the	5	
	Findings include:						
	r manigs metade:		1		requirements of conducting		1

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 07 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 monthly fire drills in all 8 Villas on Based on review of the facility's fire drill reports both day shift and night shift at on 05/10/23 between 9:30 a.m. and 3:30 p.m. with expected and unexpected times the Maintenance Director present, the under various conditions and the documented fire drill report performed on 03/28/23 required documentation of those (third shift of the first quarter) did not include the that participated in the drills and names and signatures of staff that participated in transmission of the alarm that was the fire drill. Based on interview at the time of received by the monitoring record review, the Maintenance Director company. The confirmed the lack of staff signatures on the fire administrator/designee will drill report dated 03/28/23. complete a Performance Improvement Tool to ensure the This finding was reviewed with the Executive monthly fire drills were conducted Director and Maintenance Director during the exit at expected and unexpected times conference on 05/11/23. under various conditions monthly on both shifts and validate proper 3.1-19(b) documentation is completed. Non-compliance with required fire 2. Based on record review and interview, the drills and documentation will result facility failed to ensure 3 of 9 fire drill reports in disciplinary action up to and included complete documentation of the including termination transmission of a fire alarm signal to the monitoring company/fire department during the How the corrective action (s) past twelve months. LSC 19.7.1.4 requires fire will be monitored to ensure the drills in health care occupancies shall include the deficient practice will not transmission of the fire alarm signal and recur, i.e., what quality simulation of emergency conditions. This assurance program will be put deficient practice could affect all residents. into place? The Quality Assurance Committee Findings include: will review the Performance Improvement Tool related to the Based on review of the facility's fire drill reports competition and proper on 05/10/23 between 9:30 a.m. and 3:30 p.m. with documentation of the required fire the Maintenance Director present, fire drill reports drills for compliance and to make dated 08/27/22, 10/27/22 and 03/28/23 were not further recommendations.

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provided with documentation for the transmission

of the alarm to the monitoring company. Based on

Maintenance Director acknowledged there was no

information on the previously mentioned fire drill

interview at the time of record review, the

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completed?

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By what date will the systemic

changes for each deficiency be

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		07	COMPL	
		155770	B. WINC	э —		05/11/	2023
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	s	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	1	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		at transmission of the alarm emonitoring company.					
V 0014	Director and Mainte conference on 05/11 3-1.19(b)	viewed with the Executive enance Director during the exit 1/23.					
K 0914 SS=F Bldg. 07	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and						
		on, record review and ty failed to ensure complete available for all	K 091	14	K 914 What corrective action(s) will be accomplished for those	l	06/19/2023

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DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 07			COMPL	ETED
		155770	B. WI	NG		05/11/	/2023
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
		_	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
VILLAS C	OF GUERIN WOOD	S					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	nonhospital-grade e	lectrical receptacles in all			residents found to have been	1	

resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents.

Findings include:

Based on record review on 05/10/23 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles. Based on interview at the time of record review, the Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. He further said he has been the Maintenance Director at the facility for only four months and could not find documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period or prior. Based on observations on 05/11/23 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance

affected by the deficient practice?

No residents were found to have been affected by this alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Non-hospital grade receptacles in resident rooms have been tested for polarity, continuity of ground circuit, and retention force of grounding blade. Receptacles were replaced as indicated by the tests.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

The Maintenance Director was educated on documenting the annual testing of non-hospital grade receptacles in resident rooms, to include testing for

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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. B	UILDING	07	COMPL	ETED
		155770	B. W	ING		05/11/	2023
				CTREET	ADDRESS SITU STATE ZID SOD		
NAME OF I	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD		
\/II I A C (.c			ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	15		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	Director, there were	e at least four electrical			polarity, continuity of ground		
	receptacles in each	resident room.			circuit, and retention force of t	he	
					grounding blade. Receptacles		
	This finding was re	viewed with the Executive			were replaced as indicated by		
		enance Director during the exit			tests. The administrator/desig		
	conference on 05/1	_			will complete a Performance		
					Improvement Tool to ensure		
	3.1-19(b)				non-hospital grade receptacle	s are	
					tested annually, replace when		
					indicated by testing, and requi		
					documentation. Non-complian		
					with required annual test will r		
					in disciplinary action up to and		
					including termination		
					How the corrective action (s))	
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					The Quality Assurance Comm	ittee	
					will review the Performance		
					Improvement Tool related to		
					testing non-hospital grade		
					receptacles annually for		
					compliance and to make furth	er	
					recommendations.		
					By what date will the system	ic	
					changes for each deficiency		
					completed?		
					6/19/2023	ļ	
						ļ	
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste				ļ	
Bldg. 07		s - Essential Electric				ļ	
•	System Maintena					ļ	
		other alternate power				ļ	
	-	iated equipment is capable					

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	ENT OF HEALTH AND HU FOR MEDICARE & MEDIC				FO	RM APPROVED 1B NO. 0938-039	
	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 07	COMPI	(X3) DATE SURVEY COMPLETED 05/11/2023	
	OF PROVIDER OR SUPPLIE		1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	: NATE	(X5) COMPLETION DATE	
	10-second criteri monthly test, a prannually confirm safety and critical and testing of the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are program for performed in the switches are performed in th	rice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance is generator and transfer formed in accordance with re inspected weekly, load 30 minutes 12 times a y intervals, and exercised onths for 4 continuous hours. Inder load conditions include lated cold start and inual transfer of all EES onducted by competent enance and testing of stored urces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and a odically exercising the established according to quirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, in normal power circuits. Desibility of damage of the er source is a design new installations. 4 (NFPA 99), NFPA 110, lo (NFPA 70) dereview and interview, the	K 0918	K 918		06/19/2023	

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facility failed to ensure a written record of weekly

inspections for 1 of 1 generator was maintained

NFPA 99 requires batteries for on-site generators

Standby Power Systems. 8.3.7 requires storage

shall be maintained in accordance with NFPA 110,

for 31 of 52 weeks. Chapter 6-4.4.1.3 of 2012

2010 Edition, Standard for Emergency and

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practice?

What corrective action(s) will

residents found to have been

No residents were found to have

been affected by this alleged

be accomplished for those

affected by the deficient

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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 07 COMPLETED 155770 B. WING 05/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY VILLAS OF GUERIN WOODS GEORGETOWN, IN 47122 (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 batteries, including electrolyte levels or battery deficient practice. The facilities five voltage, used in connection with systems shall be generators have the require weekly inspected weekly and maintained in full inspections/tested, monthly load compliance with manufacturer's specifications. toad test, annual maintenance, 8.3.7.2 states defective batteries shall be repaired and 4-hour load test completed or replaced immediately upon discovery of and documented according to defects. Chapter 6.5.4.2 of NFPA 99 requires a meet NFPA emergency power and written record of inspection, performance, standby system requirements. exercising period, and repairs shall be regularly maintained and available for inspection by the How will you identify other authority having jurisdiction. This deficient residents having the potential practice could affect all residents, staff and to be affected by the same visitors. deficient practice and what corrective action will be taken? Findings include: All residents, staff, and visitors have the potential to be affected Based on review of the generator inspection by the alleged deficient practice. reports on 05/10/23 between 9:30 a.m. and 3:30 The facilities five generators have p.m. with the Maintenance Director present, there the require weekly was no documentation available to show the inspections/tested, monthly load emergency generator was inspected/tested weekly toad test, annual maintenance, during 31 of the most recent 52 week period and 4-hour load test completed (nothing since 10/03/22). Based on interview at and documented according to the time of record review, the Maintenance meet NFPA emergency power and Director said he does test/inspect of the standby system requirements. emergency generator weekly but does not always document the test/inspection results. What measures will be put into place or what systemic This finding was reviewed with the Executive changes you will make to Director and Maintenance Director during the exit ensure that the deficient conference on 05/11/23. practice does not recur? The Maintenance Director has 3.1-19(b) been educated on the NFPA's LTC emergency and standby 2. Based on record review and interview, the power system requirements. The facility failed to maintain a complete written record administrator/designee will of monthly generator load testing for 1 of 1 complete the Performance generator during 6 of the past 12 months. Chapter Improvement Tool for 6 months

6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly

testing of the generator serving the emergency

after reviewing the weekly

inspections/testing documentation

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	MENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155770	UILDING	07	COMPL 05/11/	ETED
	OF PROVIDER OR SUPPLIER		1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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 BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		(X5) COMPLETION DATE
	110, the Standard for Powers Systems, Control of Powers Systems, Control of Powers Systems, Control of Power Systems of Power	er 6-4.4.1.3 of 2012 NFPA 99 or on-site generators shall be redance with NFPA 110, 2010 or Emergency and Standby 3.7 requires storage batteries, ee levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. tive batteries shall be repaired ately upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly ilable for inspection by the risdiction. This deficient of all residents, staff and view on 05/10/23 between 9:30 with the Maintenance Director to monthly generator load test lable for 6 of the past 12 ance 09/26/22) for the or. Based on interview at the two, the Maintenance Director as no emergency generator load for 6 of the past 12 months for		weekly, the monthly load toad documentation during the scheduled monthly Quality Assurance meeting and the annual maintenance and 4-ho load test documentation during each Decembers scheduled Great meeting to ensure the requirements are met. This practice will be ongoing. Non-compliance of weekly inspections/testing documentation will result in disciplinary action up to and including termination. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Committed emergency and standby power system requirements for compliance and to make further recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	ur g AA ation test he ittee r er	

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STATEMENT C		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	 JILDING	nstruction <u>0</u> 7	(X3) DATE COMPL 05/11/	ETED
	OVIDER OR SUPPLIER		1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(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)	TE	(X5) COMPLETION DATE
D		enance Director during the exit				
3	3.1-19(b)					
fann g 1 P so te re in re 8 8 th re co in fan in fan co in in fan in in fan in in fan in in fa in in fa in in fa in in fa in in fa in in in fa in in in fa in in in in in in in in in in in in in	acility failed to ensinaintenance and test penerator was main. 10, the Standard for Powers Systems, at chedule for routine esting of the EPSS equires a permaner inspections, tests, exepairs shall be main. 3.3.4.1 requires the the following: (1) 'eport (2) Identification and the concluding parts replator the time as recon-	review and interview, the ure a written record of routine sting for 1 of 1 emergency tained and available. NFPA or Emergency and Standby 8.3.3 requires a written emaintenance and operational shall be established. 8.3.4 at record of the EPSS sercising, operation, and intained and readily available. permanent record shall include The date of the maintenance ation of the servicing fication of any unsatisfactory prrective action taken, aced (4) Testing of any repair mmended by the manufacturer. Ice could affect all residents,				
F	Findings include:					
a. p sl rc B tt M m	n.m. and 3:30 p.m. who because there was no how that the emergoutine maintenance Based on interview the Maintenance Direct months and has not evidence/documental	on the generator either in				

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	OF CORRECTION	IDENTIFICATION NUMBER 155770	l í	JILDING	07	COMPI 05/11	LETED
	PROVIDER OR SUPPLIER DF GUERIN WOOD			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	This finding was rev Director and Mainte conference on 05/11 3.1-19(b) 4. Based on record facility failed to pro for the testing of 5 of System in accordance for Emergency and Section 8.4.9, as rec Facilities Code, Sec Section 8.4.9 states Power Systems shale every three years. Very greater than 4 hours terminate the test aff 6.4.1.1.6.1 states that electrical system po at Type 10, Class X 110, Section 8.4.9.3 or Natural Gas) EPS available EPSS load affect all residents, so Findings include: Based on record rev a.m. and 3:30 p.m. very present, the facility documentation of a gas fueled emergence months for the five	viewed with the Executive enance Director during the exit 1/23. review and interview, the vide complete documentation of 5 Emergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care tion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 1 be tested at least once within Where the assigned class is , it shall be permitted to the 4 hours. NFPA 99 Section at Type 1 and Type 2 essential wer sources shall be classified , Level 1 generator sets. NFPA 5.3 states for spark-ignited (LP 6's, loading shall be the 1. This deficient practice could staff, and visitors.					
	-	w. viewed with the Executive enance Director during the exit					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	î ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING 07			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CURRECTION	IDENTIFICATION NUMBER 155770	B. W		07	05/11		
		133770	В. W.			05/11/	12023	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
VILLAS C	OF GUERIN WOOD	S		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	conference on 05/11	1/23.						
	3.1-19(b)							
K 0923	NFPA 101							
SS=F	Gas Equipment - 0	Cylinder and Container						
Bldg. 07	Storag	•						
	Gas Equipment - 0	Cylinder and Container						
	Storage							
	Greater than or eq	qual to 3,000 cubic feet						
	Storage locations	are designed, constructed,						
	and ventilated in a	accordance with 5.1.3.3.2						
	and 5.1.3.3.3.							
	>300 but <3,000 c							
	-	are outdoors in an						
		n an enclosed interior						
	-	mited- combustible						
		door (or gates outdoors)						
		ed. Oxidizing gases are not						
		ables, and are separated						
		by 20 feet (5 feet if						
		closed in a cabinet of						
		onstruction having a						
		re protection rating.						
	Less than or equa							
		compartment, individual						
		e for immediate use in						
	·	with an aggregate volume						
	-	ual to 300 cubic feet are not						
	-	red in an enclosure. handled with precautions						
	as specified in 11.	· · · · · · · · · · · · · · · · · · ·						
		gn readable from 5 feet is						
		ate of a cylinder storage						
	_	ign includes the wording as						
		FION: OXIDIZING GAS(ES)						
	STORED WITHIN	` ,						
		d so cylinders are used in						
		y are received from the						
		vlinders are segregated						

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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 07 B. WING 05/11/2023 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 VILLAS OF GUERIN WOODS (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 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 Based on observation and interview, the facility K 0923 K 923 06/19/2023 failed to ensure cylinders of nonflammable gases What corrective action(s) will such as oxygen were properly secured from falling be accomplished for those in 1 of 2 smoke compartments. NFPA 99, Health residents found to have been Care Facilities Code, 2012 Edition, Section 11.3.3 affected by the deficient states storage for nonflammable gases with a total practice? volume equal to or less than greater than 8.5 cubic No residents were found to have meters (300 cubic feet) shall comply with 11.3.3.1 been affected by this alleged and 11.3.3.2. NFPA 99, Section 11.3.3.2 states deficient practice. Oxygen precautions in handling cylinders specified in cylinders have been placed in 11.3.3.1 shall be in accordance with 11.6.2. Section proper carts and secured with the 11.6.2.3(11) states freestanding cylinders shall be thumb screw. properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect How will you identify other all residents, staff, and visitors. residents having the potential to be affected by the same Findings include: deficient practice and what corrective action will be taken? Based on observations on 05/11/23 between 10:00 All residents, staff and visitors a.m. and 12:00 p.m. during a tour of the facility have the potential to be affected with the Maintenance Director, there was one by the alleged deficient practice. medium sized oxygen cylinder freestanding on the An audit was conducted to identify floor in the back hall. The oxygen cylinder was oxygen cylinders that were not not supported in a proper cylinder stand or properly secured. The identified otherwise secured from falling. Based on unsecured cylinders were secured interview at the time of the observation, the immediately. Maintenance Director acknowledged the oxygen cylinder freestanding on the floor in the back hall What measures will be put into and not supported in a cylinder stand or place or what systemic otherwise secured from falling. changes you will make to

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This finding was reviewed with the Executive

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ensure that the deficient

practice does not recur?

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>0</u> 7	(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER		STREET 1002 S GEOR			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0000		enance Director during the exit		The Maintenance Director had been educated on securing oxygen cylinders in the proper cylinder stand and will comple environmental rounds in all 8 5 days a week for 4 weeks and then weekly x 5 months to environmental rounds in all 8 5 days a week for 4 weeks and then weekly x 5 months to environmental rounds are being secured. The administrator were complete a Performance Improvement Tool after reviet the environmental round sheweekly for 6 months to ensure compliance. Non-compliance daily environmental rounds were sult in disciplinary action up and including termination. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Committed in the Performance improvement Tool for compliant to make further recommendations. By what date will the systemic changes for each deficiency in completed? 6/19/2023	er ete Villas nd ssure afely rill wing ets e with rill o to s) the put mittee ance	
Bldg. 08	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	Plan of Correction for the V of Guerin Woods 2023 Life Safety Code with Emergenc Preparedness Survey.		

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i i		r í				DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BU B. WI		08	COMPL 05/11/	
		100110	D. W			03/11/	12020
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	os		1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Survey Dates: 05/1	0/23 and 05/11/23			The creation and submission this Plan of Correction does	not	
	Facility Number: 011509				constitute an admission by to provider of any conclusion s		
	Provider Number:				forth in the statement of	G.	
	AIM Number: 200				deficiencies, or of any violat	ion	
					of regulation.		
	-	Code survey, Villas of Guerin			This provider respectfully requ	ıests	
		not in compliance with			that the 2567 Plan of Correcti	on	
	Requirements for P	•			be considered the Letter of		
		, 42 CFR Subpart 483.90(a),			Credible Allegation and reque		
	Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,				Post Certification Desk Review		
		LSC), and 410 IAC 16.2. Villa			lieu of the Post Survey Revisi		
		with Chapter 19, Existing					
	Health Care Occupa	-					
	Transm cure o coup.						
	This one story facil:	ity was determined to be of					
	Type V (111) const	ruction and fully sprinkled.					
	The facility has a fir	re alarm system with smoke					
		ridors, spaces open to the					
		sident sleeping rooms. The					
		ity of 8 and had a census of 8					
	at the time of this v	ısıt.					
	All areas where resi	idents have customary access					
		all areas providing facility					
	services were sprinl						
	•						
	Quality Review con	mpleted on 05/17/23					
IX 0204	NEDA 464						
K 0291 SS=F	NFPA 101						
33-г Bldg. 08	Emergency Lightin Emergency Lightin	-					
Diag. 00		g of at least 1-1/2-hour					
		ed automatically in					
	accordance with 7	•					
	18.2.9.1, 19.2.9.1						
		view, observation, and	K 0.	291	K 291		06/19/2023
	interview; the facili	ty failed to ensure there was			What corrective action(s) will	ıl.	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	r í	UILDING	onstruction 08	(X3) DATE COMPL 05/11 /	ETED
	PROVIDER OR SUPPLIER OF GUERIN WOOD			STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documentation for backup lights that we seconds during 6 of annually for 90 mir to ensure the light we periods of power or emergency lighting accordance with Se requires functional monthly, with a mir maximum of 5 weethan 30 seconds, (3 conducted annually if the emergency lighting powered and (5) We inspections and test for inspection by the jurisdiction. This design is a second of the secon	the testing of 5 of 5 battery were tested monthly for 30 The past 12 months, and nutes during the past 12 months would provide lighting during ntages. LSC 19.2.9.1 requires shall be provided in ection 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less Functional testing shall be for a minimum of 1 1/2 hours whiting system is battery ritten records of visual s shall be kept by the owner			be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. All 5 of the facilities battery backup lights were tested for 90 minutes and documented accordingly. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be take All residents have the potentiate be affected by the alleged definantice. All 5 of the facilities' battery backup lights were tested for 90 minutes and documented accordingly.	that d al en? al to icient	
	a.m. and 3:30 p.m. present, the facility maintenance (PM) emergency lights w there was no 30 sec documentation sinc was no documentat battery powered emanually for 90 mir the time of record r Director agreed the powered emergency second monthly tes light since 09/26/22 was no documentat	with the Maintenance Director did have a preventative report that battery powered ere tested monthly, however, ond monthly testing e 09/26/22. Furthermore, there ion available to show the five tergency lights were tested tutes. Based on an interview at eview, the Maintenance PM form for the battery y lights did not include 30 ting for each battery powered to available for an annual 90 he past 12 month period.			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director has been educated on the NFPA's emergency battery backup lighting's testing requirements. The 5 battery backup lights wittested monthly by the maintenance director/designe 30 seconds and 90 minutes annually with completed documentation. The administrator/designee will complete a Performance	s s Il be	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 08	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER DF GUERIN WOOD		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	
(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)	(X5) COMPLETION DATE
Direct p.m., t emerg This fi Direct confer	Director on 05/11/2 p.m., the facility was emergency battery. This finding was re	viewed with the Executive enance Director during the exit		Improvement Tool monthly for months after reviewing the metesting report to ensure the limit will provide lighting during a poutage. Non-compliance with emergency battery backup light testing will result in disciplinate action up to and including termination.	onthly ght power ghting
	3.1-19(b)			How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? The Quality Assurance Commill review Performance Improvement Tool related to emergency battery backup lighting's monthly testing for compliance and further recommendations during the scheduled monthly meeting. By what date will the system changes for each deficiency completed? 6/19/2023	the put mittee
K 0321 SS=F Bldg. 08	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automa				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPL	
		155770	B. W	ING		05/11/	/2023
	PROVIDER OR SUPPLIER OF GUERIN WOOD			1002 SI	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas t REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K32: Based on observation	and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) hance, and Paint Shops boms (exceeding 64 In Rooms lons) brage Rooms/Spaces eet) classified as Severe	K 0	321	K 321 What corrective action(s) wil	I	06/19/2023
	smoke compartmen	ts was not used to store			be accomplished for those		
		al. This deficient practice			residents found to have beer	1	
	Findings include: Based on observation	dents, staff, and visitors. ons on 05/11/23 between 10:00			affected by the deficient practice? No residents were found to ha been affected by this alleged deficient practice. The		
		during a tour of the facility			combustible materials that we	re in	
		ce Director, the Beauty Shop			beauty shop were removed.		
		l was being used to store					
	_	ver type totes full of items,			How will you identify other		
		d furniture, and mattresses,			residents having the potentia	ai	
	and a variety of oth	er storage items. This area			to be affected by the same		

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	OF CORRECTION	IDENTIFICATION NUMBER 155770	A. BUILDING B. WING	08	COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		1002 S	ADDRESS, CITY, STATE, ZIP COD SISTER BARBARA WAY GETOWN, IN 47122	_
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE RIATE COMPLETION DATE
	interview at the time Maintenance Direct way ever since he's This finding was re-	viewed with the Executive enance Director during the exit		deficient practice and what corrective action will be tate All residents have the potent be affected by the alleged of practice. The facility conduct audit to ensure combustible materials are not stored in ecorridors in smoke comparts Identified items were removed. What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director heen educated on proper store of combustible materials and combustible materials must moved if they are identified being stored appropriately, maintenance director/design complete daily rounds to idenon-compliance with storing combustible materials and cimmediately. The administration complete a weekly Performation in the provenent tool to identify continued non-compliance. Non-compliance with daily environmental rounds and combustible material storage result in disciplinary action of and including termination. How the corrective action will be monitored to ensur deficient practice will not recur, i.e., what quality assurance program will be into place?	ken? Itial to deficient de

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPL	ETED
		155770	B. W	ING		05/11/	/2023
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIEF	₹	1002 SISTER BARBARA WAY				
\/II I AS (OF GUERIN WOOD	19			GETOWN, IN 47122		
VILLAG	O GOLINIA WOOL			OLOIK			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					The Quality Assurance Comm	ittee	
					will review the Performance		
					Improvement Tool and make		
					further recommendations or		
					changes as needed during the	;	
					scheduled monthly meeting.		
					By what date will the system		
					changes for each deficiency	be	
					completed?		
					6/19/2023		
K 0324	NFPA 101						
SS=C	Cooking Facilities						
Bldg. 08	Cooking Facilities						
Diag. 00	Cooking equipme						
		NFPA 96, Standard for					
		ol and Fire Protection of					
		ring Operations, unless:					
		ng equipment (i.e., small					
		as microwaves, hot plates,					
	* *	d for food warming or limited					
		ance with 18.3.2.5.2,					
	19.3.2.5.2	and with 10.0.2.0.2,					
		open to the corridor in					
	-	ents with 30 or fewer					
		rith the conditions under					
	18.3.2.5.3, 19.3.2						
		in smoke compartments					
		eatients comply with					
	·	18.3.2.5.4, 19.3.2.5.4.					
		protected according to					
	-	3 are not required to be					
	·	rdous areas, but shall not					
	be open to the co	•					
		n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
	•	view and interview, the facility	KO	324	F 324		06/19/2023

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failed to ensure 1 of 1 kitchen exhaust systems

was inspected semiannually. NFPA 96, 2011

Edition, Standard for Ventilation Control and Fire

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What corrective action(s) will

residents found to have been

be accomplished for those

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	ULTIPLE CO UILDING	08	COMPL		
		155770	B. W	ING		05/11/	/2023
	PROVIDER OR SUPPLIER		•	1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Protection of Comn	nercial Cooking Operations,			affected by the deficient		
		the entire exhaust system shall			practice?		
	-	ease buildup by a properly			No residents were found to ha	ive	
	_	nd certified person(s)			been affected by this alleged		
	_	thority having jurisdiction			deficient practice. The kitchen		
		with Table 11.4. Table 11.4,			exhaust system in the identifie	ed	
	_	edule for Inspection for Grease Buildup,			Villa has been inspected and		
		uires systems serving moderate volume			cleaned.		
	cooking operations	-					
		A 96, 11.6.1 states, upon			How will you identify other	_	
	_	haust system is found to be			residents having the potentia	al	
		deposits from grease laden			to be affected by the same		
	_	nated portions of the exhaust			deficient practice and what	•	
	_ ·	aned by a properly trained,			corrective action will be take		
	_	ried person(s) acceptable to the			All residents have the potentia		
		risdiction. Hoods, grease			be affected by the alleged def		
	removal devices, fa				practice. The kitchen exhaust		
		be cleaned to remove ninants prior to surfaces			systems in the other 7 villas h		
		ontaminated with grease or			been inspected and cleaned if indicated by the inspection.		
	-	he exhaust system is cleaned,			indicated by the inspection.		
		d with powder or other			What measures will be put in	nto	
		n exhaust cleaning service is			place or what systemic	110	
		howing the name of the			changes you will make to		
		the name of the person			ensure that the deficient		
		k, and the date of inspection or			practice does not recur?		
		aintained on the premises.			The Maintenance Director has	3	
		ice could affect all residents,			been educated on the Standa		
	staff, and visitors in				Ventilation Control and Fire		
					Protection of Commercial Cod	king	
	Findings include:				Operations requirements as	J	
					related to required inspections	and	
	Based on record rev	view on 05/10/23 between 9:30			cleaning of the ventilation sys	tem.	
	_	with the Maintenance Director			The inspection will be schedul	ed	
	_	spection documentation			by the maintenance		
		e past twelve months for the			director/designee for monthly	and	
		system was dated 04/20/23.			annual inspections/cleaning.	he	
		hood exhaust system			administrator/designee will		
	_	vailable within six months prior			complete a Performance		
	to the 04/20/23 date	e. Based on interview at the			Improvement Tool monthly to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	08	COMPL	ETED
		155770	B. W	ING		05/11/	/2023
		1			-		
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
				1002 SI	STER BARBARA WAY		
VILLAS (OF GUERIN WOOD	OS		GEORG	GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	time of record revie	ew, the Maintenance Director			ensure the inspections were		
	said he could not fir	nd a range hood exhaust			completed and the findings we	ere	
	system inspection v	vithin six months prior to the			addressed as needed.		
	04/20/23 date.	•			Non-compliance with required	t	
					testing inspections and cleani		
	This finding was re	viewed with the Executive			will result in disciplinary action	-	
	Director and Maintenance Director during the exit				to and including termination.	чР	
	conference on 05/1	_			How the corrective action (s)	١	
	conference on og/1	1,23.			will be monitored to ensure t		
	3.1-19(b)				deficient practice will not	.116	
	3.1 17(0)				recur, i.e., what quality		
					assurance program will be p		
					into place?	ut	
						ittoo	
					The Quality Assurance Comm	illee	
					will review the Performance		
					Improvement Tool related to	4	
					kitchen ventilation inspections		
					compliance and to make furth	er	
					recommendations as needed.	_	
					By what date will the system		
					changes for each deficiency	be	
					completed?		
					6/19/2023		
K 0345	NFPA 101						
SS=F	Fire Alarm Systen	n - Testing and					
Bldg. 08	Maintenance						
	Fire Alarm Systen	n - Testing and					
	Maintenance						
	-	m is tested and maintained					
		h an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
	Records of system	n acceptance, maintenance					
	and testing are re	adily available.					
	9.6.1.3, 9.6.1.5, N	IFPA 70, NFPA 72					
	1. Based on record	review and interview, the	K 0	345	K 345		06/19/2023
	facility failed to ens	sure the annual testing of all			What corrective action(s) wil	I	

devices connected to 1 of 1 fire alarm system was

be accomplished for those

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	08	COMPL	LETED
		155770	B. WING	j.	<u> </u>	05/11	/2023
					_		
NAME OF	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
		-			STER BARBARA WAY		
VILLAS	of Guerin Wood)S		GEORG	GETOWN, IN 47122		
(V4) ID	CUMMARY	STATEMENT OF DEFICIENCIE		ID			(V5)
(X4) ID					PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	1 -	72, National Fire Alarm Code,			residents found to have been	n	
		t 14.6.2.4 requires a record of all			affected by the deficient		
	inspections, testing	, and maintenance shall be			practice?		
	provided that include	des the following information			No residents were found to ha	ive	
	regarding tests and	all the applicable information			been affected by this alleged		
	requested in Figure	14.6.2.4:			deficient practice. The		
	(1) Date				components of the identified F	ire	
	(2) Test frequency				Alarm System have been test		
	(3) Name of proper	ty			calibrated as needed, and	,	
	(4) Address				inspected per the NFPA 70,		
	` ′	performing inspection,			National, Electric Code, and		
		or combination thereof, and			NFPA 72, National Fire Alarm		
					and Signaling Code.		
	affiliation, business address, and telephone number				and Signaling Code.		
		and manuscratative of			Hannill was identify athen		
	1 1	and representative of			How will you identify other	-1	
	approving agency (residents having the potentia	aı	
		the detector(s) tested			to be affected by the same		
	(8) Functional test				deficient practice and what	_	
		of required sequence of			corrective action will be take		
	operations				All residents, staff, and visitors		
	(10) Check of all sr				have the potential to be affect		
		e for all fixed-temperature,			by the alleged deficient praction	ce.	
	line-type heat detec				The facilities other Fire Alarm		
	(12) Functional test	t of mass notification system			Systems have been tested,		
	control units				calibrated as needed, and		
	(13) Functional test	t of signal transmission to mass			inspected per the NFPA 70,		
	notification system	s			National, Electric Code, and		
	(14) Functional test	t of ability of mass notification			NFPA 72, National Fire Alarm	and	
	system to silence fi	re alarm notification appliances			Signaling Code.		
	1 -	gibility of mass notification			3 3		
	system speakers	-			What measures will be put ir	nto	
		required by the equipment			place or what systemic		
	manufacturer's pub				changes you will make to		
	_	required by the authority			ensure that the deficient		
	having jurisdiction	required by the authority			practice does not recur?		
		ester and approved authority			•		
	_ · · · -	esier and approved authority			The Maintenance Director has		
	representative	11			been educated on testing and		
		problems identified during test			maintenance of a fire alarm		
	(e.g., system owner	notified, problem	1		system accordance with the		

corrected/successfully retested, device

requirements of NFPA 70,

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	ì í	UILDING	onstruction 08	(X3) DATE COMPL 05/11/	ETED
	PROVIDER OR SUPPLIEF			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	abandoned in place This deficient pract in the facility. Findings include: Based on record rev a.m. and 3:30 p.m. present, the facility semi-annual visual report dated 06/24/ maintenance staff, I documentation avai inspection and func connected to the fir interview at the tim confirmed by the M This finding was re Director and Maint conference on 05/1 3.1-19(b) 2. Based on record facility failed to ens available to show th sensitivity tested w prior. NFPA 72, N Edition, Section 14 sensitivity shall be installation, and eve After the second re- sensitivity tests ind remained within its range, the length of shall be permitted t 5 years. If the frequetector caused nui	view on 05/10/23 between 9:30 with the Maintenance Director was able to provide a fire alarm system inspection 22 performed by the facility's however, there was no ilable for an annual visual ctional test of all devices a alarm system. Based on the of record review, this was faintenance Director.		TAG	National Electric Code, and N 72, National Fire Alarm and Signaling Code and that documentation is readily avail for review. The administrator/designee will complete a Performance Improvement Tool monthly to ensure the testing, recalibration needed, and inspections are completed per regulations. Non-compliance with required testing, calibration, and inspective action, and including termination. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Commwill review the Performance Improvement Tool related to Falarm Systems for compliance and for further recommendation By what date will the system changes for each deficiency completed? 6/19/2023	FPA able on as ction up che ut iittee cons. ic	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER OF GUERIN WOOD		•	1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
IAU	zones or areas when increase over the probability shall be performed. detector is within it range, it shall be test (1) Calibrated test rows (2) Manufacturer's dinstrument. (3) Listed control expurpose. (4) Smoke detectors arrangement whereast the control unit with the control unit wit	re nuisance alarms show an revious year, calibration tests. To ensure that each smoke is listed and marked sensitivity sted using any of the methods: method. calibrated sensitivity test quipment arranged for the fire alarm control unit by the detector causes a signal where its sensitivity is outside range. Is sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be rated, or replaced. Vity cannot be tested or repray device that administers centration of aerosol into the stent practice could affect all visitors in the facility. Fiew on 05/10/23 between 9:30 with the Maintenance Director was unable to produce a sitivity report for all smoke set 24 month period. Based on e of record review, the cor confirmed there was no sitivity testing documentation		IAU			DATE
	conference on 05/1						

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	EFARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE		
K 0353 SS=F Bldg. 08	Sprinkler System Automatic sprinkle are inspected, tes accordance with I Inspection, Testir Water-based Fire Records of syster inspection and tes secure location and a) Date sprinkles b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record re interview; the facil system inspections for 1 of 1 dry sprin past 52 weeks. NF Inspection, Testing Water-Based Fire I Edition, Section 5.3 sprinkler systems s ensure that normal being maintained.	supply source RKS information on non-required or partial er system.	K 0353	E 353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The identified facility's dry sprinkler system gauges and control valve were inspected, a maintenance performed as indicated. The documentation i readily available.	nd		

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tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be

utilized for inspection, testing and maintenance of

valves, valve components and trim. Section 4.3.1

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How will you identify other

to be affected by the same

residents having the potential

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	08	COMPLETED	
		155770	B. W	ING	_	05/11/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD	s			GETOWN, IN 47122		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	states records shall	be made for all inspections,			deficient practice and what		
	tests, and maintenar	nce of the system and its			corrective action will be take	en?	
	components and sha	all be made available to the			All residents, staff, and visitors	s	
	authority having jur	risdiction upon request. This			have the potential to be affect	ed	
	deficient practice co	ould affect all residents, staff,			by the alleged deficient practic	ce.	
	and visitors in the fa	acility.			An audit was completed on th	e	
		ings include:			remainder Villas to identify		
	Findings include:				sprinkler system gauges and		
		acad on record raview on 05/10/23 between			control valve were not inspect	ed	
	a. Based on record	review on 05/10/23 between			and lacking maintenance as		
	9:30 a.m. and 3:30	a. Based on record review on 05/10/23 between 0:30 a.m. and 3:30 p.m. with the Maintenance			required. The identified areas	were	
	Director present, the	ere was no documentation			corrected. The documentation	is	
	available to show th	ne facility's dry sprinkler			readily available.		
	system gauges were	e inspected weekly during 41					
	of the past 52 week	period. Based on interview at			What measures will be put in	nto	
	the time of record re	eview, the Maintenance			place or what systemic		
	Director confirmed	there was no documentation			changes you will make to		
	available to show th	nat the facility's sprinkler			ensure that the deficient		
	gauges have been ir	nspected at least weekly			practice does not recur?		
	during 41 of the pas	st 52 weeks. Based on			The Maintenance Director has	3	
	observations with the	ne Maintenance Director			been educated on the facility's	s dry	
	during a tour of the	facility on 05/11/23 between			sprinkler system gauges, cont	rol	
		00 p.m. the facility had three			valves, required inspections, a	and	
	pressure gauges at t	he sprinkler riser.			maintenance. The		
					administrator/designee will		
		review on 05/10/23 between			complete a Performance		
		p.m. with the Maintenance			Improvement Tool after review	-	
	_	ere was no monthly sprinkler			the monthly documentation of		
	1 *	es inspection documentation			weekly and monthly inspection		
		months. Based on interview at			and maintenance that is perfo		
		eview, the Maintenance			as required. Non-compliance		
		the lack of sprinkler system			the required weekly and mont	hly	
	_	control valves during the past			inspections and required		
	12 months.				maintenance will result in		
					disciplinary action up to and		
	_	viewed with the Executive			including termination		
		enance Director during the exit					
	conference on 05/1	1/23.			How the corrective action (s		
					will be monitored to ensure	the	
	3.1-19(b)				deficient practice will not		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 08	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER OF GUERIN WOOD		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0712 SS=F Bldg. 08	NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and sometions. Fire drand unexpected ticonditions, at least	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift.		recur, i.e., what quality assurance program will be pinto place? The Quality Assurance Commwill review the Performance Improvement Tool related to sprinkler system gauges and control valve inspections, and required maintenance for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	ut nittee er nic		
	aware that drills a routine. Where dr 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1. Based on record facility failed to prodocumentation for a quarters. This defice	re part of established ills are conducted between AM, a coded ay be used instead of	K 0712	K 712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by this alleged deficient practice. Fire drills have been affected by the deficient practice.	n ave		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	08	COMPLETED	
		155770	B. Wl	NG _		05/11/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	٤			ISTER BARBARA WAY		
VILLAS	OF GUERIN WOOD	S		GEORGETOWN, IN 47122			
					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		the facility's fire drill reports			been conducted on both shifts	S	
		n 9:30 a.m. and 3:30 p.m. with			(Days, Nights) in all 8 villas.		
		rector present, the facility			Documentation is readily avail	lable.	
		umentation for the following					
	_	luring the past 12 month			How will you identify other	_1	
	period:				residents having the potentia	aı	
	,	ening) of the first quarter			to be affected by the same		
		and March) of 2023, and			deficient practice and what	0	
		ril, May, and June) of 2022 and			corrective action will be take		
	so far in 2023	t) of the first quarter (January,			All residents, staff and visitors		
					have the potential to be affect		
	February, and March) of 2023 Based on interview at the time of record review,				by the alleged deficient practic		
		rector confirmed the lack of			Fire drills have been conducted	ed on	
		rector commined the tack of			both shifts (Days, Nights) at		
	shifts and quarters.	mg the previously mentioned			expected and unexpected time under various conditions in all		
	shirts and quarters.					-	
	This finding was ro	viewed with the Executive			villas. Documentation includes		
	_	enance Director during the exit			employee signatures that		
	conference on 05/1	_			participated in each drill and transmission of the alarm that	W00	
	conference on 03/1	1/23.			received by monitoring compa		
	3.1-19(b)				l received by monitoring compa	arry.	
	3.1 17(0)				What measures will be put in	nto	
	2. Based on record	review and interview, the			place or what systemic		
		vide complete fire drill			changes you will make to		
		of 9 fire drills performed			ensure that the deficient		
		nonth period. This deficient			practice does not recur?		
		t all residents in the facility.			The Maintenance Director has	,	
	1	,			been educated on the		
	Findings include:				requirements of conducting		
					monthly fire drills in all 8 Villas	son	
	Based on review of	the facility's fire drill reports			both day shift and night shift a		
		n 9:30 a.m. and 3:30 p.m. with			expected and unexpected time		
	the Maintenance Di	_			under various conditions and		
		ll report performed on 03/28/23			required documentation of the		
		st quarter) did not include the			that participated in the drills a		
	`	es of staff that participated in			transmission of the alarm that		
	_	on interview at the time of			received by the monitoring		
		Maintenance Director			company. The		
	confirmed the lack of staff signatures on the fire				administrator/designee will		

CENTERS FOR	WIEDICAKE & WIEDIC	AID SERVICES			UMB	NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	li i	A. BUILDING 08		COMPLETED	
ANDILAN	or connection					05/11/2023	
		155770	B. WING		05/11/2	:023	
			STREET	ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF F	PROVIDER OR SUPPLIER	R		SISTER BARBARA WAY			
\/ \/\	JE CHEDINI WOOD	10					
VILLAS	OF GUERIN WOOD		I GEOR	GETOWN, IN 47122			
(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		COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
IAG			IAG			DATE	
	drill report dated 03	0/28/23.		complete a Performance			
				Improvement Tool to ensure t			
	This finding was re	viewed with the Executive		monthly fire drills were condu	cted		
	Director and Mainte	enance Director during the exit		at expected and unexpected	times		
	conference on 05/1	1/23.		under various conditions mon			
				on both shifts and validate pro	-		
	3.1-19(b)			documentation is completed.	- POI		
	J.1-17(0)			The state of the s	l fire		
				Non-compliance with required			
		review and interview, the		drills and documentation will i			
	1	sure 3 of 9 fire drill reports		in disciplinary action up to an	d		
	included complete documentation of the			including termination			
	transmission of a fire alarm signal to the						
	monitoring compan	y/fire department during the		How the corrective action (s)		
		LSC 19.7.1.4 requires fire		will be monitored to ensure			
	1 ~	occupancies shall include the					
		-		deficient practice will not			
		fire alarm signal and		recur, i.e., what quality			
		gency conditions. This		assurance program will be p	out		
	deficient practice co	ould affect all residents.		into place?			
				The Quality Assurance Comn	nittee		
	Findings include:			will review the Performance			
				Improvement Tool related to t	he		
	Based on review of	the facility's fire drill reports		competition and proper			
		-		1	d fire		
		on 9:30 a.m. and 3:30 p.m. with		documentation of the required			
		rector present, fire drill reports		drills for compliance and to m	аке		
	1	27/22 and 03/28/23 were not		further recommendations.			
	1 ~	mentation for the transmission		By what date will the system	nic		
	of the alarm to the r	nonitoring company. Based on		changes for each deficiency	be		
	interview at the tim	e of record review, the		completed?			
		for acknowledged there was no		6/19/2023			
		previously mentioned fire drill		5. 75,2525			
		t transmission of the alarm					
	was received by the	monitoring company.					
	This finding was reviewed with the Executive						
	Director and Mainte	enance Director during the exit					
	conference on 05/1	_					
	3-1.19(b)						
	~(0)		1	Ť.	ı		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		A. BU	A. BUILDING <u>08</u> COM			ATE SURVEY MPLETED /11/2023	
	PROVIDER OR SUPPLIEF			1002 SI	ADDRESS, CITY, STATE, ZIP COD STER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	REFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
K 0914 SS=F Bldg. 08	Testing Electrical Systems Testing Hospital-grade recolocations and whee anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visit LIM circuits with a manual test is per than or equal to 1: tested per 6.3.3.3 renovation to the Records are main associated repairs	s - Maintenance and s - Maintenance and ceptacles at patient bed are deep sedation or general ainistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not noths. Line isolation monitors are tested at intervals of to 1 month by actuating to per 6.3.2.6.3.6, which that and audible alarm. For the performed at intervals less to months. LIM circuits are the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the company or the case and the case and the company or the case and the case and the company or the case and the case					
	Based on observation interview; the facility documentation was nonhospital-grade expression of the section of t	on, record review and ty failed to ensure complete available for all electrical receptacles in all ions tested at least annually. Fare Facilities Code 2012 Edition, ates receptacles not listed as atient bed locations and in the sedation or general istered, shall be tested at ling 12 months. Additionally, the septacle Testing in Patient Care	K 0	914	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to hat been affected by this alleged deficient practice. Non-hospitat grade receptacles in resident rooms have been tested for polarity, continuity of ground	n ve	06/19/2023

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Event ID:

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>08</u>		COMPLETED	
		155770	B. W	NG		05/11/	2023
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			ISTER BARBARA WAY		
VILLAS	OF GUERIN WOOD	ıs.			GETOWN, IN 47122		
					JE 1 O VVIIV, 114 77 122		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Rooms requires the physical integrity of each				circuit, and retention force of		
	_	confirmed by visual inspection.			grounding blade. Receptacles		
	_	ne grounding circuit in each			were replaced as indicated by	the	
	_	shall be verified. Correct			tests.		
		and neutral connections in					
		ptacle shall be confirmed; and			How will you identify other		
		ne grounding blade of each			residents having the potentia	al	
	_	e (except locking-type			to be affected by the same		
	- '	e not less than 115 grams (4			deficient practice and what		
	· · · · · · · · · · · · · · · · · · ·	ent practice could affect all			corrective action will be take		
	residents.				All residents, staff and visitors		
	Findings include:				have the potential to be affect		
					by the alleged deficient praction		
	,				Non-hospital grade receptacle		
		view on 05/10/23 between 9:30			resident rooms have been tes		
		with the Maintenance Director			for polarity, continuity of grour	nd	
	_	o documentation available of			circuit, and retention force of		
		oom receptacle test for non			grounding blade. Receptacles		
		otacles. Based on interview at			were replaced as indicated by	the	
		eview, the Maintenance			tests.		
		the electrical receptacles in			l		
	resident rooms were				What measures will be put in	nto	
	_	s he knew. He further said he			place or what systemic		
		enance Director at the facility			changes you will make to		
	-	s and could not find			ensure that the deficient		
		now that annual testing per			practice does not recur?		
		ele Testing requirements was			The Maintenance Director was		
	_	nt information within the past			educated on documenting the		
	•	prior. Based on observations			annual testing of non-hospital		
		on 10:00 a.m. and 12:00 p.m.			grade receptacles in resident		
	_	facility with the Maintenance			rooms, to include testing for		
	· ·	e at least four electrical			polarity, continuity of ground	h a	
	receptacles in each	resident room.			circuit, and retention force of t		
	This finding was	viewed with the Executive			grounding blade. Receptacles		
	_	viewed with the Executive			were replaced as indicated by		
		enance Director during the exit			tests. The administrator/desig	nee	
	conference on 05/1	1/23.			will complete a Performance		
	2.1.10/1-)				Improvement Tool to ensure		
	3.1-19(b)				non-hospital grade receptacle		
					tested annually, replace when		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	F CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER OF GUERIN WOOD			1002 S	ADDRESS, CITY, STATE, ZIP COD ISTER BARBARA WAY GETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					indicated by testing, and required documentation. Non-compliar with required annual test will rin disciplinary action up to and including termination How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? The Quality Assurance Committed will review the Performance Improvement Tool related to testing non-hospital grade receptacles annually for compliance and to make furth recommendations. By what date will the system changes for each deficiency completed? 6/19/2023	nce result d) the out nittee	
K 0918 SS=F Bldg. 08	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 and testing of the	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with					

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NFPA 110.

Generator sets are inspected weekly,

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r '	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>08</u>		COMPLETED	
		155770	B. WING		05/11/2023	
NAME OF P	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD		
VILLAS (OF GUERIN WOOD	os .		SISTER BARBARA WAY RGETOWN, IN 47122		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		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 APPROPR		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		oad 30 minutes 12 times a				
		intervals, and exercised				
	once every 36 months for 4 continuous hours.					
	Scheduled test ur	nder load conditions include				
	a complete simula	ated cold start and				
		ual transfer of all EES				
	· ·	nducted by competent				
	•	enance and testing of stored				
		ırces (Type 3 EES) are in				
		NFPA 111. Main and feeder				
		re inspected annually, and a				
	. •	dically exercising the				
		tablished according to				
		uirements. Written records				
		nd testing are maintained				
	-	ble. EES electrical panels				
		arked, readily identifiable,				
		n normal power circuits.				
		ssibility of damage of the				
		r source is a design				
	consideration for					
		(NFPA 99), NFPA 110,				
	NFPA 111, 700.1	` ,	TT 0010		0.5/4.0/2.02.5	
		review and interview, the	K 0918	K 918	06/19/2023	
	-	sure a written record of weekly		What corrective action(s) w	III	
	-	1 generator was maintained		be accomplished for those		
		Chapter 6-4.4.1.3 of 2012 batteries for on-site generators		residents found to have bee	en	
	•	l in accordance with NFPA 110,		affected by the deficient		
		dard for Emergency and		practice? No residents were found to h	21/0	
		stems. 8.3.7 requires storage				
		electrolyte levels or battery		been affected by this alleged deficient practice. The facilitie		
	_	nnection with systems shall be		generators have the require		
	-	nd maintained in full		inspections/tested, monthly le	-	
		anufacturer's specifications.		toad test, annual maintenand		
	-	tive batteries shall be repaired		and 4-hour load test complet		
		ately upon discovery of		and documented according to		
	-	5.4.2 of NFPA 99 requires a		meet NFPA emergency power		
	-	spection, performance,		standby system requirements		
		and repairs shall be regularly		January System requirements	J.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	08	COMPL	ETED
		155770	B. W	ING		05/11/	2023
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
TURNE OF I	THO VIDER OR SOLVER			1002 S	SISTER BARBARA WAY		
VILLAS (OF GUERIN WOOD)S		GEOR	GETOWN, IN 47122		
(VA) ID	CLDOLADY	CTATEMENT OF DEPLOYENCE		ID.			(7/5)
(X4) ID		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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintained and ava	ilable for inspection by the			How will you identify other		
	authority having jur	risdiction. This deficient			residents having the potent	ial	
	practice could affect	et all residents, staff and			to be affected by the same		
	visitors.	•			deficient practice and what		
					corrective action will be tak	on?	
	Findings includes					_	
	Findings include:				All residents, staff, and visitor		
		Sat			have the potential to be affect		
		the generator inspection			by the alleged deficient pract		
	_	3 between 9:30 a.m. and 3:30			The facilities five generators	have	
	p.m. with the Main	tenance Director present, there			the require weekly		
	was no documentat	ion available to show the			inspections/tested, monthly lo	oad	
	emergency generator was inspected/tested weekly				toad test, annual maintenance	e,	
	during 31 of the most recent 52 week period				and 4-hour load test complete		
	(nothing since 10/03/22). Based on interview at				and documented according to		
		review, the Maintenance			meet NFPA emergency power		
		es test/inspect of the					
		-			standby system requirements	5.	
		or weekly but does not always					
	document the test/in	nspection results.			What measures will be put i	nto	
					place or what systemic		
		eviewed with the Executive			changes you will make to		
	Director and Maint	enance Director during the exit			ensure that the deficient		
	conference on 05/1	1/23.			practice does not recur?		
					The Maintenance Director ha	ıs	
	3.1-19(b)				been educated on the NFPA'	S	
					LTC emergency and standby		
	2. Based on record	review and interview, the			power system requirements.		
		aintain a complete written record			1 -		
	1	or load testing for 1 of 1			administrator/designee will		
					complete the Performance		
		of the past 12 months. Chapter			Improvement Tool for 6 mont	ns	
	` '	12 NFPA 99 requires monthly			after reviewing the weekly		
		ator serving the emergency			inspections/testing document		
		be in accordance with NFPA	1		weekly, the monthly load toad	d test	
		or Emergency and Standby			documentation during the		
	Powers Systems, C	hapter 8. Chapter 6.4.4.2 of			scheduled monthly Quality		
	NFPA 99 requires a	a written record of inspection,			Assurance meeting and the		
	_	ising period, and repairs for the			annual maintenance and 4-he	our	
	_	ularly maintained and available			load test documentation during		
	for inspection by th					•	
					each Decembers scheduled	ŲA	
	jurisaiction. Chapt	er 6-4.4.1.3 of 2012 NFPA 99			meeting to ensure the		

requires batteries for on-site generators shall be

MB9521

requirements are met. This

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>08</u>		COMPLETED	
		155770	B. W	ING		05/11/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			STER BARBARA WAY		
VILLAS	OF GUERIN WOOD)S			GETOWN, IN 47122		
				OLONG			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dance with NFPA 110, 2010			practice will be ongoing.		
		or Emergency and Standby			Non-compliance of weekly		
	· ·	3.7 requires storage batteries,			inspections/testing documenta		
		e levels or battery voltage,			weekly, the monthly load toad	test	
		with systems shall be			documentation will result in		
	inspected weekly and maintained in full				disciplinary action up to and		
		anufacturer's specifications.			including termination.		
	8.3.7.2 states defective batteries shall be repaired				How the corrective action (s)		
	or replaced immediately upon discovery of				will be monitored to ensure t	ne	
	defects. Chapter 6.5.4.2 of NFPA 99 requires a				deficient practice will not		
	written record of inspection, performance,				recur, i.e., what quality		
	exercising period, and repairs shall be regularly				assurance program will be p	ut	
	maintained and available for inspection by the authority having jurisdiction. This deficient				into place?		
					The Quality Assurance Comm	ittee	
		et all residents, staff and			will review the Performance		
	visitors.				Improvement Tool related		
	F' 1' ' 1 1				emergency and standby powe	r	
	Findings include:				system requirements for		
	D 1 1	. 05/10/221 4 0.20			compliance and to make furth	er	
		view on 05/10/23 between 9:30			recommendations.		
	_	with the Maintenance Director			By what date will the system		
	_	no monthly generator load test			changes for each deficiency	be	
		lable for 6 of the past 12			completed?		
	, -	or. Based on interview at the			6/19/2023		
		ew, the Maintenance Director					
		s no emergency generator load					
	the emergency gene	for 6 of the past 12 months for					
	inc emergency gene	nator.					
	This finding was re	viewed with the Executive					
	_	enance Director during the exit					
	conference on 05/1						
	3.1-19(b)						
	3.1 17(0)						
	3. Based on record	review and interview, the					
		sure a written record of routine					
		sting for 1 of 1 emergency					
		tained and available. NFPA					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155770		l í	UILDING	nstruction <u>08</u>	(X3) DATE (COMPL 05/11/	ETED
	F PROVIDER OR SUPPLIE S OF GUERIN WOOL			1002 SI	DDRESS, CITY, STATE, ZIP COD STER BARBARA WAY SETOWN, IN 47122		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Powers Systems, at schedule for routine testing of the EPSS requires a permane inspections, tests, e repairs shall be mai 8.3.4.1 requires the the following: (1) report (2) Identific personnel (3) Not condition and the c including parts repl for the time as reconstructed the following: (1) report (2) Identific personnel (3) Not condition and the c including parts repl for the time as reconstructed the time as reconstructed to the following: (2) Identific personnel (3) Not condition and the c including parts repl for the time as reconstructed to the time as reconstructed to the following include: Based on record real a.m. and 3:30 p.m. present, there was a show that the emer routine maintenance Based on interview the Maintenance Direct months and has not evidence/document has been performed house or from an or This finding was reducted by the finding was reducted by the finding was reducted and Maintenance on 05/1 3.1-19(b)	ation that routine maintenance I on the generator either in utside vendor. viewed with the Executive enance Director during the exit					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
inc	for the testing of 5 of System in accordant for Emergency and Section 8.4.9, as rec Facilities Code, Sec Section 8.4.9 states Power Systems shall every three years. An accordant to the test of 6.4.1.1.6.1 states the electrical system poat Type 10, Class X 110, Section 8.4.9.3 or Natural Gas) EPS available EPSS load affect all residents, Findings include: Based on record review. Based on record review a.m. and 3:30 p.m. An accordant present, the facility documentation of a gas fueled emergence months for the five was confirmed by the time of record review.	of 5 Emergency Power Standby the With NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care tion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 1 be tested at least once within Where the assigned class is quired to the task of					

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