	T OF HEALTH AND HU R MEDICARE & MEDIC						TED: 08/23/2024 RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/06/2024	
	PROVIDER OR SUPPLIE	R		6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 42 Survey Dates: 08/ Facility Number: Provider Number: AIM Number: 100 At this Emergency Manor was found a Emergency Prepar Medicare and Medicare and Medicare and Suppliers, 42 0 The facility has 75 the survey, the centy Quality Review control of the requirement at MET as evidenced	05/24 and 08/06/24 000436 155607 0275120 Preparedness survey, Bethel not in compliance with edness Requirements for licaid Participating Providers CFR 483.73. certified beds. At the time of sus was 63. mpleted on 08/09/24 t 42 CFR, Subpart 483.73 is NOT by:	E 000	00	By submitting the enclosed material we are not admitting the truth or accuracy of any specifindings or allegations. We resthe right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect September 4, 2024 to the survicenducted August 5, 2024 – August 6, 2024. We respectfully request a papar compliance/desk review.	ic erve s or illity tive rey	
E 0041	482.15(e), 483.73	3(e), 485.542(e), 485.625(e)					

SS=F Bldg. -- Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.

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

§483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems.

TITLE

(X6) DATE

CEO & Administrator 08/22/2024 Joshua Bowman 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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	UILDING	NSTRUCTION	(X3) DATE COMPL 08/06/	ETED
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	implement emerg systems based or forth in paragraph §482.15(e)(1), §4 §485.625(e)(1) Emergency generator must be the location requirements of the location requirements and TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or buildi 482.15(e)(2), §48 §485.542(e)(2) Emergency generation, testing requirements four Facilities Code, National Code. 482.15(e)(3), §48 (3),§485.542(e)(2) Emergency generation, testing requirements four Facilities Code, National Code. 482.15(e)(3), §48 (3),§485.542(e)(2) Emergency generation LTC facilities source to power end to power systems of emergency, unless *[For hospitals at the control of the co	rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] and in the Health Care IFPA 110, and Life Safety 3.73(e)(3), §485.625(e) 2) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 08/06/2024				
	PROVIDER OR SUPPLIER	₹	6015 K	ADDRESS, CITY, STATE, ZIP CO RATZVILLE RD SVILLE, IN 47710	DD .		
(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 CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION		
	this section are appreference by the EFederal Register in 552(a) and 1 CFF the material from You may inspect a Information Reson Boulevard, Baltim Archives and Recon (NARA). For information this material at NA go to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characteristic (1) National Fire Fatterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (vi) TIA 12-5 to NF 2014. (vii) NFPA 101, Liedition, issued Autoritical Register Autoritical International Internationa	corporated by reference in opproved for incorporation by Director of the Office of the in accordance with 5 U.S.C.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155607	B. WING		08/06/2024
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD	
BETHEL	MANOR			SVILLE, IN 47710	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, S Standby Power Sy including TIAs to or 2009. Based on record rev failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). 1. Based on record facility failed to ens maintenance and tegenerators was main 110, the Standard for Powers Systems, at schedule for routine testing of the EPSS 8.3.4 requires a per inspections, tests, erepairs shall be main Section8.3.4.1 required include the followir (1) The date of the or (2) Identification of (3) Notification of a and the corrective are replaced (4) Testing of any r recommended by the	maintenance report The servicing personnel any unsatisfactory condition action taken, including parts epair for the time as	E 0041	The corrective action taken at those residents found to be affected by the deficient prainclude: No specific residents were identified in the summary statement of deficiencies. Senticket placed with generator service provider and generato have now had annual prevent maintenance, load bank testin and fuel quality test performed Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: Tool developed for maintenant staff to utilize to track required preventive maintenance. Genetesting log updated to assist in accurate data collection. In-seeducation was also provided to maintenance staff. The corrective action taken in	ctice vice vice ors ive og, d. e o into ecur ce derator n ervice o

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	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	r í	UILDING	NSTRUCTION	(X3) DATE COMPL 08/06	ETED
	F PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(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)	λΤΕ	(X5) COMPLETION DATE
	Based on record real.m. and 3:30 p.m. and Maintenance Adocumentation ava emergency generate maintenance during recent routine maintenance are during which was over and the most recent routine maintenance Director has been contacted the end of the week maintenance service. This finding was recently defined a maintenance Assis on 08/06/24. 2. Based on record facility failed to exagenerators annually NFPA 110, 2010 Emergency and State 8.4.2. Section 8.4.3 service shall be exected for a minimum of 3 following methods (1) Loading that magas temperatures as manufacturer (2) Under operating	wiew on 08/05/24 between 9:30 with the Maintenance Director assistant present, there was no illable to show that both for shave had routine at the past 12 months. The most tenance report for the Main by generator was dated 06/27/23, anonth past due, furthermore, tine maintenance report for the generator was dated 05/17/23, anonth past due. Based on the of record review, the tor said the generator vendor and will be at the facility by the top erform routine to no both generators. Viewed with the requirements of dittion, the Standard for and turing the exit conference to meet the requirements of dittion, the Standard for and by Powers Systems, Chapter 2 states diesel generator sets in treised at least once monthly, 0 minutes, using one of the standard by the green generator conditions and at the tent of the EPS (Emergency).			monitor performance to assembliance through quality assurance is: The corrective action implement to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code Emergency Preparedness aud the CEO and the Director of Quality. This audit will ensure timeliness and completeness generator inspections, testing preventive maintenance. Any areas identified through this a will be immediately corrected results reported to the Quality. Assessment and Assurance meeting to determine if any additional interventions are needed.	ented and dit by the of , and udit and	

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155607	B. W	ING		08/06/	2024
NAME OF	PROVIDER OR SUPPLIEI	?	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					RATZVILLE RD		
BETHEL	. MANOR			EVANS	VILLE, IN 47710		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
		es diesel-powered EPS o not meet the requirements of					
		ised monthly with the available					
		Power Supply System) load and					
		nnually with supplemental					
		Γest) at not less than 50 percent					
	1	ate kW rating for 30 continuous					
	_	less than 75 percent of the EPS					
	nameplate kW rating for 1 continuous hour for a						
	total test duration of not less than 1.5 continuous						
	hours.						
	This deficient practice could affect all residents,						
	staff, and visitors.						
	Findings include:						
	Based on record re-	view on 08/05/24 between 9:30					
	a.m. and 3:30 p.m.	with the Maintenance Director					
		Assistant present, the monthly					
		both diesel powered					
	-	umented less than 30% during					
	_	12 months for both generators.					
		at the time of record review,					
		irector acknowledged the					
	-	er load on a monthly basis but 6 of the name plate rating every					
		ly, the Maintenance Director					
		ad bank test for the generator					
		ithin the past 12 month period.					
		ad bank test for the Main					
	Building generator	was dated 06/27/23, which was					
		st due, furthermore, the most					
	recent load bank te	st for the Cottage generator					
	was dated 05/17/23	, which was over two month					
	past due.						
	This finding was re	wiewed with the					
		r, Maintenance Director, and					
		tant during the exit conference					
	on 08/06/24.						

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	IT OF DEFICIENCIES OF CORRECTION	OF CORRECTION IDENTIFICATION NUMBER A. BU		2) MULTIPLE CONSTRUCTION 3. BUILDING 3. WING		(X3) DATE SURVEY COMPLETED 08/06/2024	
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>		6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	facility failed to easy was performed for 2 generators. NFPA 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power Syst NFPA 110, Section shall be performed approved by ASTM practice could affect and visitors. Findings include: Based on record revalum, and 3:30 p.m. and Maintenance A documentation of a both diesel generated the past 12 month pfuel quality test for dated 05/17/23, which due. Based on interreview, the Mainter generator vendor has at the facility by the sample of fuel for the test. This finding was re CEO/Administrator.	review and interview, the sure an annual fuel quality test 2 of 2 diesel powered 99, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient at all residents, as well as staff with the Maintenance Director saistant present, there was no an annual fuel quality test for personal to the most recent annual both diesel generators was ich was over two months past review at the time of record nance Director said the as been contacted and will be the end of the week to take the the annual diesel fuel quality wiewed with the ty, Maintenance Director, and ant during the exit conference					

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	AN OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING			COMPLETED 08/06/2024	
	OF PROVIDER OR SUPPLIE	2	6015	T ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD			
BETH	EL MANOR		EVAN	ISVILLE, IN 47710			
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
IAU	4. Based on record facility failed to ma written record of m for 2 of 2 emergence months. Chapter 6 requires monthly te the emergency elect accordance with NI Emergency and Sta 8. Chapter 6.4.4.2 record of inspection period, and repairs regularly maintained by the authority has 6-4.4.1.3 of 2012 Non-site generators accordance with NI Standard for Emerg Systems. 8.3.7 requincluding electrolytused in connection inspected weekly accompliance with m 8.3.7.2 states defector replaced immediate defects. Chapter 6. written record of in exercising period, a maintained and ava authority having jupractice could affect visitors. Findings include: Based on review of testing reports on 0 3:30 p.m. with the serior serior of the serio	review and interview, the sintain a complete and accurate onthly generator load testing by generators during the past 12 4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving trical system to be in FPA 110, the Standard for Indby Powers Systems, Chapter of NFPA 99 requires a written in, performance, exercising for the generator to be and available for inspection wing jurisdiction. Chapter IFPA 99 requires batteries for shall be maintained in IFPA 110, 2010 Edition, gency and Standby Power unires storage batteries, we levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. The standard repairs shall be regularly ilable for inspection by the risdiction. This deficient et all residents, staff and the standard repairs shall be regularly ilable for inspection by the risdiction. This deficient et all residents, staff and the standard repairs the following was	IAU			DATE	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILDING B. WING			COMPLETED 08/06/2024		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BETHEL	MANOR				RATZVILLE RD VILLE, IN 47710		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	I -	monthly load testing time was					
	instead of a full 30	r 7 of the past 12 months,					
	Cottage - monthly load testing time for 05/31/24						
		minutes (8:00 a.m. to 8:05					
	a.m.), also, the 07/1						
		list a completed time frame,					
	only 2:20 p.m. to (b	-					
		Transfer time always listed					
	between 30 seconds	s and one minute.					
	Cottage - Transfer time always listed between						
	45 seconds and five minutes.						
	c. Main Building and Cottage - Cool down time						
	always listed as "Yes" under "Cool down period						
	completed?", instead of an amount						
	of time for the co						
		at the time of record review,					
		rector acknowledged the					
		erator documentation and					
	_	erator vendor was coming to					
		nd of the week, and he would vs to correct the monthly load					
	testing documentati						
	This finding was re	viewed with the					
		, Maintenance Director, and					
	Maintenance Assist	ant during the exit conference					
	on 08/06/24.						
K 0000							
Bldg. 01							
-	1	Recertification and State	K 00	000	By submitting the enclosed		
	1	vas conducted by the Indiana			material we are not admitting	the	
	_	th in accordance with 42 CFR			truth or accuracy of any specit		
	483.90(a).				findings or allegations. We res		
		7/04			the right to contest the finding	s or	
	Survey Dates: 08/0	15/24 and 08/06/24			allegations as part of any		
	Facility Number: 0	00436			proceedings and submit these responses pursuant to our	:	
	l actiffy Number. 0	UCTUU			reshouses hargnaur in ont		

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	OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING 01 B. WING		COMPLETED 08/06/2024	
NAME OF P	PROVIDER OR SUPPLIER		601	EET ADDRESS, CITY, STATE, ZIP COD 5 KRATZVILLE RD ANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFII TAG	CROSS-REFERENCED TO THE APPROI	N BE RIATE	(X5) COMPLETION DATE
	was found not in co for Participation in Subpart 483.90(a), I 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility was determined to be construction and was facility has a fire alassmoke detectors in the corridors, and in This facility has a co of 54 at the time of of both buildings was at the time of this subpart of the corridors. All areas where resist were sprinklered and the subpart of the corridors and the time of the subpart of the corridors.	Code survey, Bethel Manor mpliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection (101), Life Safety Code (LSC), as Health Care Occupancies and ty with a walkout lower level be of Type II (111) as fully sprinklered. The arm system with hard wired the corridors, spaces open to all resident sleeping rooms. Apacity of 63 and had a census this survey. The total capacity as 75 and had a census of 63 arrvey. In the control of the contr		regulatory obligations. The requests that the plan of correction be considered or allegation of compliance ef September 4, 2024 to the sconducted August 5, 2024 August 6, 2024. We respectfully request a pcompliance/desk review.	r ective urvey -	
K 0222 SS=E Bldg. 01	be equipped with a requires the use o egress side unless special locking arr	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following angements: S OR SECURITY THREAT				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPLE	TED
		155607	B. W	ING		08/06/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF I	PROVIDER OR SUPPLIEF	R			RATZVILLE RD		
BETHEL	MANOR			1	VILLE, IN 47710		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		king arrangements for the					
	1	eeds of the patient are					
	used, only one locking device shall be						
	1 '	n door and provisions shall					
		apid removal of occupants					
	1 -	l of locks; keying of all					
		ied by staff at all times; or					
	other such reliable means available to the						
	staff at all times.	226 4022254					
	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the						
		ne patient are used, all of					
	1	curity Locking requirements					
		addition, the locks must be					
	_	at fail safely so as to					
		of power to the device; the					
	-	ed by a supervised					
		er system and the locked					
		d by a complete smoke					
		(or is constantly monitored					
	1	cation within the locked					
		the sprinkler and detection					
		nged to unlock the doors					
	upon activation.	-					
		.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT	S					
	Approved, listed of	delayed-egress locking					
	systems installed	in accordance with					
	7.2.1.6.1 shall be	permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2						
	ACCESS-CONTR	ROLLED EGRESS					

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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. BUILDING	01	COMPLETED	
		155607	B. WING		08/06/2024	
		<u> </u>	STREET	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	₹		KRATZVILLE RD		
BETHEL	. MANOR		EVAN	SVILLE, IN 47710		
(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		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	LOCKING ARRAI					
		d Egress Door assemblies				
		dance with 7.2.1.6.2 shall				
	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS					
	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an					
approved, supervised automatic sprinkler						
	system.					
	18.2.2.2.4, 19.2.2.2.4					
		on and interview, the facility	K 0222	The corrective action taken	for 09/04/2024	
	failed to ensure 1 o	f 7 delayed egress locking		those residents found to be		
	arrangements were	maintained in accordance with		affected by the deficient pra	ctice	
	LSC 7.2.1.6.1(3) w	hich states an irreversible		include:		
	process shall releas	e the lock in the direction of		No specific residents were		
	egress within 15 se	conds, or 30 seconds where		identified in the summary		
		thority having jurisdiction,		statement of deficiencies. Fac	cility	
		a force to the release device		had already identified door		
	_	10 under all of the following		malfunctioning and a service		
	conditions:			had been placed with service		
	* *	not be required to exceed 15 lbf		provider prior to the survey, b		
	(67 N).			provider was waiting for nece	-	
	` '	not be required to be		parts to arrive so that repair c		
		ed for more than 3 seconds. If the release process shall		be made. Door was able to be		
	1 1	signal in the vicinity of the		unlocked by entering code that		
	door opening.	signal in the vicinity of the		was available to staff and pos next to keypad.	oteu	
		as been released by the		While awaiting part arrival, do	nor	
		to the releasing device,		code was same code used	,01	
		by manual means only.		throughout facility by staff and	d was	
	_	rice could affect at least 24		also displayed next to keypad		
	_	visitors in the North Hall.		it would have been a safety h		
	, , , , , , , , , , , , , , , , , , , ,			to keep door remained unlock		
	Findings include:			24/7 until repair was complete		
				We believe that the measures		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
155607			B. WING 08/06/2024				
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
						<u> </u>	
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		on on 08/06/24 between 10:30			place would be in compliance	with	
		during a tour of the facility			18.2.2.2.5 &018.2.2.2.6 as		
		ce Director and Maintenance			exhibited by the following:		
		Hall exit door was equipped			1 Door was able to be		
		. When the panic bar on the			unlocked by reliable means to	the	
	-	r 15 seconds the door did not			staff at all times		
		ignetic hold located at the top			2 A total (complete) smoke	II	
		ver, the magnetic hold did			detection system was provided	d	
		en the code was pushed on			throughout the locked space		
		next to the door. Based on			3 The building is protected		
		e of observation, the			throughout by an approved,		
		or acknowledged and agreed			supervised automatic sprinkle	r	
		ot release when the panic bar			system		
	-	seconds, furthermore, the			4 The locks are electrical		
		for said the facility was already			locks that fail safely so as to		
	_	gress on this door was not			release upon loss of power to	the	
		nd is waiting on a part from the			device		
	vendor to correct th	e problem.			5 The locks release by		
					independent activation of both		
	This finding was re				smoke detection system and/o	or	
		, Maintenance Director, and			waterflow in the automatic		
		ant during the exit conference			sprinkler system		
	on 08/06/24.				6 Only one locking device	was	
					present on the door		
	3.1-19(b)				Other residents that have the	-	
					potential to be affected have	·	
					been identified by:		
					All residents have the potentia	II TO	
					be affected.		
					The measures or systematic		
					changes that have been put	into	
					place to ensure that the		
					deficient practice does not re	ecur	
					include:		
					Facility systems currently in pl	ace	
					quickly identified the	do	
					malfunctioning door and outside		
					service provider was immedia	-	
					contacted. Service provider wa		
					awaiting ordered part to arrive	so	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE S COMPLE 08/06/2	ETED
NAME OF P	PROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP CO RATZVILLE RD SVILLE, IN 47710	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULID BE PROPRIATE	(X5) COMPLETION DATE
K 0324 SS=E 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 30.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under the commercial commercial conditions under the commercial commercial conditions under the commercial commercial commercial commercial conditions under the commercial commercial commercial commercial commercial conditions under the commercial commercial commercial conditions control conditions are conditions as a condition control conditions are conditions as a condition control condition control conditions are conditions as a condition control condition conditions are conditions as a condition condition condition conditions are conditions as a condition condition condition condition condition condition conditions are conditional conditions.	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under		that repair could be made arrival was outside facilit. The corrective action to monitor performance to compliance through quassurance is: The corrective action im to prevent the recurrence deficient practice include semi-annual Life Safety audit by the CEO and the of Quality. Any areas identificately corrected a reported to the Quality Assessment and Assurate meeting to determine if additional interventions and additional interventions and are possible.	ty control. aken to o assure uality plemented e of the es a Code le Director entified end results ance any	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE A. BUILDING B. WING	e construction 6 <u>01</u>	(X3) DATE SURVEY COMPLETED 08/06/2024	
	PROVIDER OR SUPPLIEF		STRE 6015 EVA		
(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 CROSS-REFERENCED TO THE APPROLIDERICIENCY)	BE COMPLETION
	NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure the in the Physical Theorem within a smoke concommercial cooking prepare meals for 3 permitted, provided complies with all the (1) The space contains not a sleeping room (2) The space contains and 13 are met. 19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, facility that deactive (b) The switch is used or range whenever a supervision. This deficient pract resident, staff and we then the supervision. Findings include: Based on observation a.m. and 11:45 a.m. with the Maintenan Assistant, there was staff and, there was stant, there was stant, there was stant, there was stant, there was stant and the contains a stant and the same and the	are not required to be rdous areas, but shall not ridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility cook top for 1 of 1 stove/oven rapy area was shut off at the use. LSC 19.3.2.5.4 states apartment, residential or gequipment that is used to 0 or fewer persons shall be that the cooking facility e following conditions: ining the cooking equipment tom. ining the cooking equipment rom the corridor by partitions 3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10) A switch meeting all the	K 0324	The corrective action take those residents found to a affected by the deficient pinclude: No specific residents were identified in the summary statement of deficiencies. Other residents that have potential to be affected have been identified by: All residents have the potential to be affected have been identified by: All residents have the potential to be affected. The measures or systemal changes that have been place to ensure that the deficient practice does not include: Stove is not utilized and had deactivated by unplugging removing cord. The corrective action take monitor performance to a compliance through quality assurance is: The corrective action imples to prevent the recurrence of deficient practice includes a semi-annual Life Safety Coaudit by the CEO and the Eduality. Any areas identificately corrected and reported to the Quality Assessment and Assurance meeting to determine if any	en for be practice 09/04/2024 the ave antial to attic aut into at recur and and and and and attice atty mented of the adde objector fied results at the automatic aut

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF P	ROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP COD (RATZVILLE RD SVILLE, IN 47710	
(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. 01	being used at the time power to the stove/or interview at the time. Maintenance Direct stove/oven was not and further said the Therapy area was not switch so Physical Topower off to the sto. This finding was recceo/Administrator Maintenance Assist on 08/06/24. 3.1-19(b) NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are reasonable and testing are reasonable and testing are reasonable and testing are reasonable and record reversalled to maintain 1	ne of observation and the oven was on. Based on e of observation, the or confirmed the cooktop deactivated when not in use, stove/oven in the Physical of equipped with a disconnect Therapy staff could shut the ve/oven when not in use. Viewed with the Maintenance Director, and ant during the exit conference The Testing and The Testing and	K 0345	The corrective action taken to those residents found to be affected by the deficient practice.	For 09/04/2024
	Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual inspec accordance with the more often if requir jurisdiction. Table	and 9.6. NFPA 72, Section less otherwise permitted by ctions shall be performed in schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following pected semi-annually:		include: No specific residents were identified in the summary statement of deficiencies. Other residents that have the potential to be affected have been identified by:	9

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155607		B. W	ING		08/06/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF 1	PROVIDER OR SUPPLIE	R			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
(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 APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	a. Control unit trou	8			All residents have the potenti	al to	
	b. Remote annuncia				be affected.		
		s (e.g. duct detectors, manual			The measures or systematic		
		eat detectors, smoke detectors,			changes that have been put	tinto	
	etc.)				place to ensure that the		
	d. Notification appl				deficient practice does not	recur	
	e. Magnetic hold-o	-			include:		
	This deficient pract	tice could affect all occupants.			Tool developed for maintenar		
					staff to utilize to track require	d	
	Findings include:				preventive maintenance and		
					inspections. Maintenance sta		
		view on 08/05/24 between 9:30			received in-service education		
	-	with the Maintenance Director			regarding required inspection	S.	
		Assistant present, there was			The corrective action taken	to	
	_	vided regarding an annual fire			monitor performance to ass	ure	
		ction dated 06/27/24 by the			compliance through quality		
		inspection vendor, however,			assurance is:		
		annual visual inspection			The corrective action implement	ented	
	_	vided six months prior to the			to prevent the recurrence of t	he	
	_	by either the vendor or			deficient practice includes a		
		nce staff. The prior fire alarm			semi-annual Life Safety Code)	
	system annual insp	ection report available for			audit by the CEO and the Dire	ector	
	review was dated 0	6/20/23. Based on interview at			of Quality. This audit will ensu	ure	
		review, the Maintenance			the timeliness and completen		
		ii-annual visual inspection of			of fire alarm system inspectio		
		m's devices was not performed			Any areas identified through		
	six months prior to	the annual fire alarm inspection			audit will be immediately corr	ected	
	on 06/27/24.				and results reported to the Q	uality	
					Assessment and Assurance		
	This finding was re				meeting to determine if any		
		r, Maintenance Director, and			additional interventions are		
		tant during the exit conference			needed.		
	on 08/06/24.						
	3.1-19(b)						
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
-		er and standpipe systems					

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

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	ľ	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 08/06/	ETED
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR				6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710		
(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
	accordance with I Inspection, Testin Water-based Fire Records of syster inspection and tessecure location at a) Date sprinkler b) Who provided c) Water system Provide in REMAl coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record refailed to provide we evidence the sprink been inspected and of 1 sprinkler system device, equipment compliance with the accordance with ap Sprinkler systems accordance with NI Inspection, Testing Water-Based Fire I 4.3.1 requires record inspections, tests, a components and she authority having jurequires that record performed (e.g., instead the organization that results, and the date waterflow alarm dequarterly to verify to serify the organization that results are the organization that the organization that results are the organization that the orga	supply source RKS information on non-required or partial er system.	K 0	353	The corrective action taken those residents found to be affected by the deficient prainclude: No specific residents were identified in the summary statement of deficiencies. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. The measures or systematic changes that have been put place to ensure that the deficient practice does not a include: Tool developed for maintenar staff to utilize to track required preventive maintenance and inspections. Maintenance stareceived in-service education regarding required inspections.	netice ne e al to c tinto recur	09/04/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SI COMPLE 08/06/2	TED
NAME OF F	PROVIDER OR SUPPLIER		6015 k	ADDRESS, CITY, STATE, ZIP C KRATZVILLE RD SVILLE, IN 47710	OD	
(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 COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	to, water motor gon 5.3.3.2 requires van switch-type waterflitested semiannually affect all residents, facility. Findings include: Based on review of inspection records of and 3:30 p.m. with Maintenance Assist quarterly sprinkler savailable for the for November, and Decinterview at the tim Maintenance Direct written documentat sprinkler system ha fourth quarter of 20 This finding was re CEO/Administrator	the quarterly sprinkler system on 08/05/24 between 9:30 a.m. the Maintenance Director and ant present, there was no system inspection report arth quarter (October, tember) of 2023. Based on e of record review, the tor confirmed there was no ion available to show the d been inspected during the 23.		The corrective action monitor performance compliance through of assurance is: The corrective action in to prevent the recurrent deficient practice includes emi-annual Life Safety audit by the CEO and the of Quality. This audit we the timeliness and common of sprinkler system inspany areas identified the audit will be immediate and results reported to Assessment and Assurance inguity to determine it additional interventions needed.	to assure quality Implemented on the design of the Director of the Director of the Director of the Director of the Quality of the	
K 0711 SS=F Bldg. 01	patients and for th of an emergency. Employees are pe kept informed with and a copy of the					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
155607		B. W	B. WING 08/06/			/2024	
NAME OF I	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					RATZVILLE RD		
BETHEL	MANOR			EVANS	VILLE, IN 47710		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY (DATE
		e basic response required					
	•	7.2.1.2 and provides for all					
	18/19.2.2.	lan components per					
		18.7.1.3, 18.7.2.1.2,					
		, 19.7.1.1 through 19.7.1.3,					
	19.7.2.1.2, 19.7.2	——————————————————————————————————————					
		view and interview, the facility	K 0	711	The corrective action taken i	for	09/04/2024
		complete and accurate facility	KU	/11	those residents found to be	101	07/04/2024
	•	safety plan for the protection			affected by the deficient pra	ctice	
	^	ccurately address all life safety			include:		
		tem addressing all items			No specific residents were		
		101, 2012 edition, Section			identified in the summary		
		2.2.2 requires a written health care			statement of deficiencies.		
	occupancy fire safe	ty plan that shall provide for			Other residents that have the	е	
	the following:				potential to be affected have)	
	(1) Use of alarms				been identified by:		
	(2) Transmission of	f alarm to fire department			All residents have the potentia	al to	
		ne call to fire department			be affected.		
	(4) Response to ala				The measures or systematic	;	
	(5) Isolation of fire				changes that have been put	into	
	(6) Evacuation of in				place to ensure that the		
	(7) Evacuation of si	-			deficient practice does not r	ecur	
		loors and building for			include:		
	evacuation	c.c			Fire emergency procedures pl	lan	
	(9) Extinguishment				has been updated to address		
		states any required aisle or			evacuation of the smoke	toff	
		e less than 48 inches in clear			compartment and identifying s		
	1	g as means of egress from oms. Projections into the			member responsible for performance	iming	
		l be permitted for wheeled			back-up call to 911. The corrective action taken is	to	
	_	the relocation of wheeled			monitor performance to ass		
		fire or similar emergency is			compliance through quality	uı C	
		itten fire safety plan and			assurance is:		
		or the facility. The wheeled			The corrective action impleme	ented	
	equipment is limite	_			to prevent the recurrence of the		
	i. Equipment in use				deficient practice includes a	.5	
		ncy equipment not in use			semi-annual audit by the CEC) and	
	iii. Patient lift and t				the Director of Quality. This au		
		ice could affect all occupants			will ensure that the facility's		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	:		ADDRESS, CITY, STATE, ZIP COD	
BETHEL	MANOR			RATZVILLE RD SVILLE, IN 47710	
(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
	Procedures on 08/06 10:30 a.m. with the following was noted a. The plan did not smoke compartment b. It was not determ responsible for mak Based on interview the CEO/Administrathat the Fire Emergupdated to include i of the smoke comparesponsible for the based on the smoke comparesponsi	of the facility's Fire Emergency 6/24 between 9:15 a.m. and CEO/Administrator present, the d: address evacuation of the t. nined in the plan who is ing the back up call to 911. at the time of record review, ator acknowledged and agreed ency Procedures needs to be information about evacuation artment and who will be back up call to 911.		evacuation plan is reviewed a updated at least annually. Any areas identified through this a will be immediately corrected results reported to the Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	, udit and
	3.1-19(b)				
K 0712	NFPA 101				
SS=F Bldg. 01	Fire Drills				
ום טועש. U ו	Fire Drills Fire drills include t	he transmission of a fire			
		simulation of emergency fire			
		ills are held at expected			
	and unexpected till	mes under varying t quarterly on each shift.			
		r with procedures and is			
	aware that drills a	re part of established			
		ills are conducted between			
	9:00 PM and 6:00 announcement ma	ay be used instead of			
	audible alarms.				
					1

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Facility ID: 000436

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155607 B. WING 08/06/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER

BETHEL MANOR	EVANSVILLE, IN 47710
	6015 KRATZVILLE RD

BETHEL MANOR			EVANSVILLE, IN 47710		
(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
TAG	19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to ensure 9 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and Maintenance Assistant present, 9 of 12 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director acknowledged there was no information included with 9 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the CEO/Administrator, Maintenance Director, and Maintenance Assistant during the exit conference on 08/06/24. 3-1.19(b) 3.1-51(c)	K 0		The corrective action taken for those residents found to be affected by the deficient practice include: No specific residents were identified in the summary statement of deficiencies. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Fire drill form was updated with prompt to ensure transmission is received by monitoring company. In-service education was provided to maintenance staff on the timing of fire drills. The corrective action taken to monitor performance to assure compliance through quality assurance is: The corrective action implemented to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Director of Quality. This audit will ensure that fire drills are performed and documented appropriately. Any	09/04/2024
	2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all			areas identified through this audit will be immediately corrected and results reported to the Quality Assessment and Assurance	

PRINTED: 08/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155607		l í	UILDING	onstruction 01	(X3) DATE COMPL 08/06/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	3		6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
					,		
(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		R LSC IDENTIFYING INFORMATION		TAG			DATE
	residents in the faci Findings include:	additional interve		meeting to determine if any additional interventions are needed.	• I		
	Bosed on review of	the facility's fire drill reports					
		en 9:30 a.m. and 3:30 p.m. with					
		rector and Maintenance					
		ne following was noted:					
	_	(day) fire drills were performed					
	between 9:30 a.m. a						
		ift (evening) fire drills were					
		2:58 p.m. and 3:51 p.m.					
	c. 3 of 4 third shift (night) fire drills were						
	performed between 4:02 a.m. and 4:52 a.m.						
	Based on interview at the time of record review,						
		rector acknowledged the times					
		and third shift fire drills were					
		ed the times were not varied					
	enough.						
	This finding was re	viewed with the					
	_	; Maintenance Director, and					
		ant during the exit conference					
	on 08/06/24.	and coming the control control					
	3.1-19(b)						
	3.1-51(c)						
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01	Electrical Systems	s - Essential Electric					
	System Maintena						
	The generator or	other alternate power					
	source and assoc	iated equipment is capable					
	of supplying servi	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					
		branches. Maintenance					
	and testing of the	generator and transfer					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155607	B. W	ING		08/06	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	₹			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
(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	.ΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ormed in accordance with					
	NFPA 110.						
		e inspected weekly,					
		oad 30 minutes 12 times a					
	1 -	intervals, and exercised					
		onths for 4 continuous hours.					
		nder load conditions include					
	a complete simula	ated cold start and ual transfer of all EES					
		nducted by competent					
		enance and testing of stored					1
	I -	rces (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					
	and readily availa	ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate fron	n normal power circuits.					
		ssibility of damage of the					
		source is a design					1
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1	` ,	17.0	010	The comment of the section to	6 ~	00/04/2024
		review and interview, the	K 0	918	The corrective action taken to	or	09/04/2024
	-	sure a written record of routine			those residents found to be	otios	
		sting for 1 of 1 emergency stained and available. NFPA			affected by the deficient practinclude:	cace	
	_	or Emergency and Standby			No specific residents were		1
		8.3.3 requires a written			identified in the summary		
		e maintenance and operational			statement of deficiencies. Ser	vice	
		shall be established. 8.3.4			ticket placed with generator		
	_	nt record of the EPSS			service provider and generato	rs	
		xercising, operation, and			have now had annual prevent		
	_	intained and readily available.			maintenance, load bank testin		
	-	permanent record shall include			and fuel quality test performed	-	
	the following:	-			Other residents that have the		
	_	maintenance report			potential to be affected have		

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2024	
NAME OF	PROVIDER OR SUPPLIEF	· {		ADDRESS, CITY, STATE, ZIP COD		
BETHEL	. MANOR			KRATZVILLE RD SVILLE, IN 47710		
(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		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	(2) Identification of (3) Notification of and the corrective a replaced (4) Testing of any recommended by the This deficient pract staff and visitors. Findings include: Based on record revalum, and 3:30 p.m. and Maintenance A documentation avaigenerator has had repast 12 months. The maintenance report was dated 06/27/23 due. Based on intereview, the Maintengenerator vendor has at the facility by the routine maintenance. This finding was received. This finding was received. The finding was received. This finding was received. The f	of the servicing personnel any unsatisfactory condition action taken, including parts are pair for the time as the manufacturer. The could affect all residents, which was not eliable to show the emergency outline maintenance during the the most recent routine for the emergency generator, which was over a month past review at the time of record mance Director said the the end of the week to perform th	TAG	been identified by: All residents have the potential be affected. The measures or systematic changes that have been put place to ensure that the deficient practice does not include: Tool developed for maintenar staff to utilize to track required preventive maintenance. Gentesting log updated to assist i accurate data collection. In-seeducation was also provided maintenance staff. The corrective action taken monitor performance to assist compliance through quality assurance is: The corrective action implement to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code Emergency Preparedness authe CEO and the Director of Quality. This audit will ensure timeliness and completeness generator inspections, testing preventive maintenance. Any areas identified through this a will be immediately corrected results reported to the Quality	al to c sinto recur nce d herator n ervice to to sure ented he e and dit by e the of g, and audit and	
		review and interview, the		Assessment and Assurance		
		ercise 1 of 1 emergency to meet the requirements of		meeting to determine if any additional interventions are		
	-	dition, the Standard for		needed.		
	Emergency and Sta	ndby Powers Systems, Chapter				

8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILDING 01 B. WING		COMPLETED 08/06/2024			
	F PROVIDER OR SUPPLIEF	3		6015 KF	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	gas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) nam Section 8.4.2.3 statinstallations that do 8.4.2 shall be exerc EPSS (Emergency shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not nameplate kW ratin total test duration or hours. This deficie residents, staff, and Findings include: Based on record reviaum. and Maintenance A load percentage for was documented lethe past 12 months. time of record reviaucknowledged the generating emaintenance Direct test for the generate past 12 month period test for the generate was over one month.	aintains the minimum exhaust a recommended by the green the EPS (Emergency heplate kW rating. He diesel-powered EPS on the most power of the EPS (Emergency heplate kW rating. He diesel-powered EPS on the most power of the EPS on the most power of the EPS of the most power of the EPS of the text power of the text					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE COMPL 08/06	ETED
NAME OF P	ROVIDER OR SUPPLIER		6015 H	CADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710		
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	Maintenance Assist on 08/06/24.	ant during the exit conference				
	facility failed to ensume was performed for 10 NFPA 99, Health C Section 6.5.4.1.1.2 Electrical System) goinspected and tested 6.4.4.1.1.3. Section shall be performed Standard for Emerg Systems, 2010 Edit Section 8.3.8 states performed at least a by ASTM standards.	review and interview, the sure an annual fuel quality test I of 1 diesel powered generator. are Facilities Code, 2012 Edition states Type 2 EES (Essential generator sets shall be I in accordance with Section 6.4.4.1.1.3 states maintenance in accordance with NFPA 110, ency and Standby Power ion, Chapter 8. NFPA 110, a fuel quality test shall be nnually using tests approved s. This deficient practice dents, as well as staff and				
	a.m. and 3:30 p.m. and Maintenance A documentation of at the diesel powered during the past 12 mannual fuel quality generator was dated months past due. Bof record review, the generator vendo be at the facility by	view on 08/05/24 between 9:30 with the Maintenance Director ssistant present, there was no an annual fuel quality test for generator available for review month period. The most recent test for the diesel powered 1 05/17/23, which was over two ased on interview at the time e Maintenance Director said or has been contacted and will the end of the week to take the me annual diesel fuel quality wiewed with the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILDING 01 COM B. WING 08/		COMPI 08/06	LETED		
NAME OF P	ROVIDER OR SUPPLIER	3		6015 KF	NDDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
		r, Maintenance Director, and ant during the exit conference					
	3.1-19(b)						
	facility failed to may written record of m for 1 of 1 emergency months. Chapter 6. requires monthly te the emergency election accordance with NE Emergency and Sta 8. Chapter 6.4.4.2 record of inspection period, and repairs regularly maintaine by the authority have 6-4.4.1.3 of 2012 N on-site generators is accordance with NE Standard for Emerg Systems. 8.3.7 requincluding electrolytused in connection inspected weekly and compliance with may 8.3.7.2 states defect or replaced immediate defects. Chapter 6. written record of in exercising period, a maintained and availanted and availanted could affect	review and interview, the intain a complete and accurate onthly generator load testing by generator during the past 12 4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving trical system to be in FPA 110, the Standard for andby Powers Systems, Chapter of NFPA 99 requires a written and available for inspection wing jurisdiction. Chapter IFPA 99 requires batteries for thall be maintained in IFPA 110, 2010 Edition, generator storage batteries, are levels or battery voltage, with systems shall be and maintained in full anufacturer's specifications. The batteries shall be repaired attely upon discovery of 5.4.2 of NFPA 99 requires a spection, performance, and repairs shall be regularly ilable for inspection by the disdiction. This deficient at all residents, staff and					
	visitors. Findings include:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/06/2024	
NAME OF F	PROVIDER OR SUPPLIEF		6015 K	ADDRESS, CITY, STATE, ZIP COD (RATZVILLE RD SVILLE, IN 47710	
(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)	(X5) COMPLETION DATE
	testing reports on 0: 3:30 p.m. with the Maintenance Assist noted: a. Monthly load test for 7 of the past 12 minutes. b. Transfer time also seconds and one mic. Cool down time "Cool down period amount of time for the compassed on interview the Maintenance Dissues with the general further said the general the facility by the eask them about way testing documentati This finding was re CEO/Administrator	always listed as "Yes" under completed?", instead of an cool down. at the time of record review, rector acknowledged the crator documentation and crator vendor was coming to and of the week and he would be to correct the monthly load on.			
K 0000					
Bldg. 02	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000	By submitting the enclosed material we are not admitting truth or accuracy of any speci findings or allegations. We rethe right to contest the finding allegations as part of any proceedings and submit these	fic serve s or

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	COMP	E SURVEY LETED 5/2024
NAME OF F	PROVIDER OR SUPPLIER	2	6015 K	ADDRESS, CITY, STATE, ZIP C (RATZVILLE RD SVILLE, IN 47710	OD	
(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
	Bethel Manor was a Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Care Occupancies a This one story facil Type V (111) const sprinklered. The fa with hard wired sm spaces open to the sleeping rooms. The certified beds and he this survey. The to was 75 and had a consurvey. All areas where res were sprinklered ar services were sprinklered are ser	Code survey, the Cottage at Found not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 18, New Health and 410 IAC 16.2. The ity was determined to be of ruction and was fully cility has a fire alarm system to be detectors in the corridors, corridors, and all resident the facility has a capacity of 12 and a census of 9 at the time of that capacity of both buildings the ensus of 63 at the time of this defents have customary access did all areas providing facility		responses pursuant to regulatory obligations. requests that the plan of correction be considered allegation of compliant September 4, 2024 to conducted August 5, 2000 August 6, 2024. We respectfully request compliance/desk reviews	The facility of ed our se effective the survey 024 – et a paper	
K 0211 SS=E Bldg. 02	discharges, exit lo in accordance wit of egress is contir all obstructions to	- General ays, corridors, exit cations, and accesses are n Chapter 7, and the means accussly maintained free of full use in case of s modified by 18/19.2.2				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 02 COMPLETE B. WING 08/06/202			
NAME OF F	PROVIDER OR SUPPLIEF		60 ²	EET ADDRESS, CITY, STATE, ZIP COD 15 KRATZVILLE RD ANSVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPRO	ON (X5) DBE COMPLETION DATE
	failed to ensure 1 of corridors were controbstructions. This of up to 6 residents, as Findings include: Based on observation a.m. and 12:30 p.m. with the Maintenant Assistant, there was egress corridor outst wheelchair scale was observation. Based observation, the Markenowledged the varieties of the control of the cont	on and interview, the facility of 3 exit means of egress inuously maintained free of deficient practice could affect well as staff and visitors. Ons on 08/06/24 between 11:45 during a tour of the facility ce Director and Maintenance as a wheelchair scale in the ide the Laundry Room. The as not in use at the time of on interview at the time of cintenance Director wheelchair scale being stored or and not in use at the time of	K 0211	The corrective action take those residents found to affected by the deficient include: No specific residents were identified in the summary statement of deficiencies. Other residents that have potential to be affected in been identified by: All residents and staff local the east smoke compartment the potential to be affected. The measures or system changes that have been include: Scale was moved to newly identified location for usage storage. The corrective action take monitor performance to a compliance through quality assurance is: The corrective action implet to prevent the recurrence of deficient practice includes semi-annual Life Safety Collection and the lof Quality. Any areas identified to the Quality Assessment and Assurance meeting to determine if an additional interventions are needed.	be practice e the ave ted in ent have atic cout into ot recur e and en to assure lity emented of the a code Director cified I results be the ave

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG 02	(X3) DATE SURV COMPLETEI 08/06/202	D
NAME OF E	PROVIDER OR SUPPLIER	R	60 ⁻	REET ADDRESS, CITY, STATE, ZIP COD 15 KRATZVILLE RD 'ANSVILLE, IN 47710)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE APP	TION JLD BE ROPRIATE CO	(X5) OMPLETION DATE
K 0345 SS=F Bldg. 02	in accordance with complying with the National Electric Contional Fire Alari Records of system and testing are respected on record revisited to maintain 1 accordance with NF Sections 18.3.4.5.1 14.3.1 states that un 14.3.2, visual inspector often if requirifurisdiction. Table must be visually instance of the inference of the in	m is tested and maintained in an approved program is requirements of NFPA 70, Code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available. IFPA 70, NFPA 72 view and interview, the facility of 1 fire alarm system in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by etions shall be performed in the eschedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors in the control of the c	K 0345	The corrective action ta those residents found to affected by the deficient include: No specific residents were identified in the summary statement of deficiencies. Other residents that have potential to be affected been identified by: All residents have the pope affected. The measures or system changes that have been place to ensure that the deficient practice does include: Tool developed for maint staff to utilize to track recompliance inspections. Maintenance inspections. Maintenance received in-service educated regarding required inspections. The corrective action to the compliance through quassurance is:	to be t practice re / s. ve the have tential to matic n put into e not recur tenance quired and e staff ation ctions. eken to o assure	0/04/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 02 B. WING			(X3) DATE SURVEY COMPLETED 08/06/2024			
NAME OF P	ROVIDER OR SUPPLIER		6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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)	ΓE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 02	documentation provannual inspection by in-house maintenant system annual inspective was dated 00 the time of record red Director said a semithe fire alarm system six months prior to on 06/27/24. This finding was received the fire alarm system on 08/07/24. This finding was received the fire alarm system on 08/06/24. 3.1-19(b) NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkler are inspected, test accordance with New Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system - Provide in REMAF	Maintenance Director, and ant during the exit conference Maintenance and Testing Maintenance and Testing ar and standpipe systems ted, and maintained in MFPA 25, Standard for the g, and Maintaining of Protection Systems. Maintenance, sting are maintained in a maintenance, sting are maintained in a maintenance		The corrective action impleme to prevent the recurrence of the deficient practice includes a semi-annual Life Safety Code audit by the CEO and the Dire of Quality. This audit will ensure the timeliness and completenes of fire alarm system inspection. Any areas identified through the audit will be immediately correand results reported to the Quantity Assessment and Assurance meeting to determine if any additional interventions are needed.	e ctor re ess es. nis cted	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155607	B. W	NG		08/06/	2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			RATZVILLE RD		
BETHEL	MANOR				SVILLE, IN 47710		
	1717/114011			LVANS	· v · L L L , N T / / U		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
		view and interview, the facility	K 0	353	The corrective action taken	-	09/04/2024
	_	ritten documentation or other			those residents found to be		
	_	xler system components had			affected by the deficient pra	ctice	
	_	tested for 1 of 4 quarters for 1			include:		
		em. LSC 4.6.12.1 requires any			No specific residents were		
	device, equipment or system required for				identified in the summary statement of deficiencies.		
	compliance with this Code be maintained in					10	
	accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in				Other residents that have the	-	
	accordance with NFPA 25, Standard for the				potential to be affected have been identified by:	,	
	Inspection, Testing, and Maintenance of				All residents have the potential	al to	
	Water-Based Fire Protection Systems. NFPA 25,				be affected.	ui to	
	4.3.1 requires records shall be made for all				The measures or systematic	•	
	_	and maintenance of the system			changes that have been put		
	-	all be made available to the			place to ensure that the		
	_	risdiction upon request. 4.3.2			deficient practice does not	recur	
		ls shall indicate the procedure			include:		
	-	spection, test, or maintenance),			Tool developed for maintenar	nce	
		at performed the work, the			staff to utilize to track require		
	_	e. NFPA 25, 5.2.5 requires that			preventive maintenance and		
		evices shall be inspected			inspections. Maintenance sta	ff	
	quarterly to verify	they are free of physical			received in-service education		
	damage. NFPA 25	, 5.3.3.1 requires the mechanical			regarding required inspection	s.	
	waterflow alarm de	evices including, but not limited			The corrective action taken		
	to, water motor gor	ngs, shall be tested quarterly.			monitor performance to ass	ure	
	-	ne-type and pressure			compliance through quality		
		low alarm devices shall be			assurance is:		
		y. This deficient practice could			The corrective action implement		
		staff, and visitors in the			to prevent the recurrence of t	he	
	facility.				deficient practice includes a		
					semi-annual Life Safety Code		
	Findings include:				audit by the CEO and the Dire		
					of Quality. This audit will ensu		
		f the quarterly sprinkler system			the timeliness and completen		
	inspection records on 08/05/24 between 9:30 a.m. and 3:30 p.m. with the Maintenance Director and				of sprinkler system inspection		
					Any areas identified through t		
		tant present, there was no			audit will be immediately corr		
		system inspection report			and results reported to the Qu	uality	
		urth quarter (October,			Assessment and Assurance		
	November, and De	cember) of 2023. Based on			meeting to determine if any		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/06/2024	
NAME OF P	ROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Direct written documentati sprinkler system had fourth quarter of 20. This finding was rev CEO/Administrator Maintenance Assista on 08/06/24.			additional interventions are needed.	
K 0711 SS=F Bldg. 02	patients and for the of an emergency. Employees are pekept informed with and a copy of the with telephone opeplan addresses the of staff per 18/19.7 of the fire safety pl 18/19.2.2. 18.7.1.1 through 1 18.7.2.2, 18.7.2.3, 19.7.2.1.2, 19.7.2. Based on record rev	elocation Plan plan for the protection of all eir evacuation in the event riodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3,	K 0711	The corrective action taken f	for 09/04/2024
	specific written fire of all residents to ac systems, plus a syste required by NFPA 1 18.7.2.2. LSC 18.7.	safety plan for the protection ecurately address all life safety em addressing all items 101, 2012 edition, Section .2.2 requires a written health care ty plan that shall provide for		affected by the deficient practinclude: No specific residents were identified in the summary statement of deficiencies. Other residents that have the potential to be affected have been identified by:	3

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u> COMPLETED		
		155607	B. W	B. WING 08/06/20		
				CTD FET	ADDRESS STEW STATE ZID COD	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD	
DETLIEL	MANOD				RATZVILLE RD	
BETHEL	WANOR			EVANS	VILLE, IN 47710	
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	(2) Transmission of	f alarm to fire department			All residents have the potentia	l to
	(3) Emergency pho	ne call to fire department			be affected.	
	(4) Response to ala	rms			The measures or systematic	
	(5) Isolation of fire				changes that have been put	into
	(6) Evacuation of in	nmediate area			place to ensure that the	
	(7) Evacuation of si	moke compartment			deficient practice does not re	ecur
	(8) Preparation of f	loors and building for			include:	
	evacuation				Fire emergency procedures pl	an
	(9) Extinguishment	of fire			has been updated to address	
	Section 18.2.3.4(4)	states any required aisle or			evacuation of the smoke	
	corridor shall not be	e less than 48 inches in clear			compartment and identifying s	taff
	width where serving	g as means of egress from			member responsible for perfor	ming
	patient sleeping rooms. Projections into the				back-up call to 911.	
	required width shal	l be permitted for wheeled			The corrective action taken t	o
	equipment provided	l the relocation of wheeled			monitor performance to assu	ıre
	equipment during a	fire or similar emergency is			compliance through quality	
	addressed in the wr	itten fire safety plan and			assurance is:	
	training program fo	r the facility. The wheeled			The corrective action impleme	nted
	equipment is limite	d to:			to prevent the recurrence of th	e
	i. Equipment in use	and carts in use			deficient practice includes a	
	ii. Medical emerger	ncy equipment not in use			semi-annual audit by the CEO	and
	iii. Patient lift and t				the Director of Quality. This au	ıdit
		ice could affect all occupants			will ensure that the facility's	
	in the event of an er	mergency.			evacuation plan is reviewed ar	nd
					updated at least annually. Any	
	Findings include:				areas identified through this a	
					will be immediately corrected a	and
		of the facility's Fire Emergency			results reported to the Quality	
		6/24 between 9:15 a.m. and			Assessment and Assurance	
		CEO/Administrator present, the			meeting to determine if any	
	following was noted				additional interventions are	
	_	address evacuation of the			needed.	
	smoke compartmen					
		nined in the plan who is				
	_	ting the back up call to 911.				
		at the time of record review,				
		ator acknowledged and agreed				
	_	ency Procedures needs to be				
	updated to include	information about evacuation				
	of the smoke compa	artment and who will be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUII	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 02 COMPLETED B. WING 08/06/2024			ETED	
NAME OF I	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 02	Maintenance Assist on 08/06/24. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include alarm signal and sconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills a routine. Where draware that drills a routine audible alarms. 18.7.1.4 through and 1. Based on record facility failed to ensincluded complete of transmission of a firmonitoring compant past twelve months drills in health care transmission of the simulation of emergate deficient practice of the simulation of emergate findings include: Based on review of on 08/05/24 between	the transmission of a fire simulation of emergency fire fills are held at expected mes under varying at quarterly on each shift. For with procedures and is repart of established fills are conducted between AM, a coded ay be used instead of 18.7.1.7 review and interview, the sure 9 of 12 fire drill reports documentation of the re alarm signal to the py/fire department during the LSC 18.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This build affect all residents.	K 07	12	The corrective action taken in those residents found to be affected by the deficient practiculus. No specific residents were identified in the summary statement of deficiencies. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. The measures or systematic changes that have been put place to ensure that the	e ll to	09/04/2024
	the Maintenance Di	rector and Maintenance			deficient practice does not re	ecur	

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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. BU	UILDING	02	COMPLETED	
		155607	B. WING 08/06/2024			08/06/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
OV O ID	CID B (A DV)	OTATEMENT OF DEFICIENCIE	1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOLL)		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	_	of 12 fire drill reports			include:	Ha	
	performed during the past 12 month period were not provided with documentation for the				Fire drill form was updated with		
	_	alarm to the monitoring			prompt to ensure transmission		
		n interview at the time of			received by monitoring compa	-	
					In-service education was prov		
		Maintenance Director e was no information included			to maintenance staff on the tir of fire drills.	ıllığ	
		ill reports to verify that				₄₀	
		alarm was received by the			The corrective action taken		
		-			monitor performance to ass	ure	
	monitoring company.				compliance through quality assurance is:		
	This finding was reviewed with the				The corrective action impleme	ontod	
	CEO/Administrator, Maintenance Director, and				to prevent the recurrence of the		
	Maintenance Assistant during the exit conference				deficient practice includes a	ie	
	on 08/06/24.				semi-annual Life Safety Code		
	011 00/00/24.				audit by the CEO and the Dire		
	3-1.19(b)				of Quality. This audit will ensu		
	3.1-51(c)				that fire drills are performed a		
	3.1-31(c)				documented appropriately. Ar		
	2 Based on record	review and interview, the			areas identified through this a	-	
		sure fire drills were held at			will be immediately corrected		
	1	of 3 employee shifts during 4 of			results reported to the Quality		
		ficient practice could affect all			Assessment and Assurance		
	residents in the faci	-			meeting to determine if any		
		,			additional interventions are		
	Findings include:				needed.		
]		
	Based on review of	the facility's fire drill reports					
		en 9:30 a.m. and 3:30 p.m. with					
		irector and Maintenance					
	Assistant present, the	he following was noted:					
	_	(day) fire drills were performed					
	between 10:13 a.m.	and 10:47 a.m.					
	b. 3 of 4 second sh	ift (evening) fire drills were					
	performed between	3:16 p.m. and 4:00 p.m.					
	_	(night) fire drills were					
		4:12 a.m. and 5:08 a.m.					
		at the time of record review,					
		irector acknowledged the times					
		and third shift fire drills were					

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>			COMPLETED	
		155607	B. W	ING		08/06/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				RATZVILLE RD			
BETHEL	MANOR				VILLE, IN 47710			
(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	
		ed the times were not varied						
	enough.							
	This finding was no	viouved with the						
	This finding was rev	, Maintenance Director, and						
		ant during the exit conference						
	on 08/06/24.	ant during the exit conference						
	011 00/00/24.							
	3.1-19(b)							
	3.1-51(c)							
K 0918	NFPA 101							
SS=F	Electrical Systems	s - Essential Electric Syste						
Bldg. 02	Electrical Systems	s - Essential Electric						
	System Maintenar	nce and Testing						
	_	other alternate power						
		ated equipment is capable						
		ce within 10 seconds. If the						
		n is not met during the						
		ocess shall be provided to						
	_	his capability for the life						
	-	branches. Maintenance						
	_	generator and transfer						
	-	ormed in accordance with						
	NFPA 110.	inapacted weekly						
		e inspected weekly, pad 30 minutes 12 times a						
		intervals, and exercised						
	, ·	nths for 4 continuous hours.						
		der load conditions include						
	a complete simula							
	-	ual transfer of all EES						
		nducted by competent						
		nance and testing of stored						
		rces (Type 3 EES) are in						
	accordance with N	IFPA 111. Main and feeder						
	circuit breakers ar	e inspected annually, and a						
	program for period	lically exercising the						
	components is est	ablished according to						
	manufacturer requ	irements. Written records						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE C A. BUILDING B. WING	B. WING 08/06/20			
NAME OF I	PROVIDER OR SUPPLIER		6015 k	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710		
(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	
	and readily availal and circuits are m and separate from Minimizing the pose emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 1. Based on record facility failed to ensimal testing of the EPSS requires a permaner inspections, tests, experies shall be main 8.3.4.1 requires the the following: (1) The date of the (2) Identification of and the corrective a replaced (4) Testing of any recommended by the This deficient pract staff and visitors. Findings include: Based on record revalum and 3:30 p.m. and Maintenance A documentation avain generator has had recommended by the commended by the	(NFPA 99), NFPA 110, O (NFPA 70) review and interview, the sure 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 exercising, operation, and intained and readily available. permanent record shall include emaintenance report of the servicing personnel any unsatisfactory condition ction taken, including parts	K 0918	The corrective action taken those residents found to be affected by the deficient prainclude: No specific residents were identified in the summary statement of deficiencies. Seticket placed with generator service provider and generate have now had annual preven maintenance, load bank testin and fuel quality test performe Other residents that have the potential to be affected have been identified by: All residents have the potentibe affected. The measures or systematic changes that have been put place to ensure that the deficient practice does not include: Tool developed for maintenant staff to utilize to track require preventive maintenance. Gentesting log updated to assist in accurate data collection. In-seeducation was also provided maintenance staff. The corrective action taken monitor performance to assisting actions.	rvice provice provi	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u> COMPLETED		
		155607	B. W	B. WING 08/06/2024		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIEF	8			RATZVILLE RD	
BETHEL	MANOR			EVANSVILLE, IN 47710		
(X4) ID	CHMMADN	STATEMENT OF DEFICIENCIE	1	ID		(V5)
PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG		for the emergency generator		IAG	compliance through quality	DATE
		, which was over two months			assurance is:	
		interview at the time of record			The corrective action impleme	ented
	_	nance Director said the			to prevent the recurrence of the	
		as been contacted and will be			deficient practice includes a	
	-	e end of the week to perform			semi-annual Life Safety Code	and
		e service on the generator.			Emergency Preparedness aud	
		e service on the generator.			the CEO and the Director of	an by
	This finding was re	viewed with the			Quality. This audit will ensure	the
		, Maintenance Director, and			timeliness and completeness	
		ant during the exit conference			generator inspections, testing	
	on 08/06/24.	5			preventive maintenance. Any	, 44
	68 00.00.2.1				areas identified through this a	udit
	3.1-19(b)				will be immediately corrected	
					results reported to the Quality	
	2. Based on record	review and interview, the			Assessment and Assurance	
	facility failed to exe	ercise 1 of 1 emergency			meeting to determine if any	
	generator annually	to meet the requirements of			additional interventions are	
	NFPA 110, 2010 E	dition, the Standard for			needed.	
	Emergency and Sta	ndby Powers Systems, Chapter				
	8.4.2. Section 8.4.2	2 states diesel generator sets in				
	service shall be exe	rcised at least once monthly,				
	for a minimum of 3	0 minutes, using one of the				
	following methods:					
	(1) Loading that ma	nintains the minimum exhaust				
		recommended by the				
	manufacturer					
		temperature conditions and at				
	_	cent of the EPS (Emergency				
	Power Supply) nam					
		es diesel-powered EPS				
		not meet the requirements of				
		ised monthly with the available				
		Power Supply System) load and				
		nnually with supplemental				
		Test) at not less than 50 percent				
	_	tte kW rating for 30 continuous				
		less than 75 percent of the EPS				
	-	ag for 1 continuous hour for a				
	total test duration o	f not less than 1.5 continuous				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		î í	UILDING	02	COMPL 08/06/	ETED	
NAME OF F	PROVIDER OR SUPPLIER	t		6015 KF	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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 APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	hours. This deficient residents, staff, and	nt practice could affect all visitors.					
	Findings include:						
	a.m. and 3:30 p.m. and Maintenance A load percentage for was documented less the past 12 months. time of record revie acknowledged the gmonthly basis but dname plate rating evidentest for the generate past 12 month period test for the generate was over two month. This finding was re CEO/Administrator						
	3.1-19(b)	. 1:4 . 4					
	facility failed to ens was performed for NFPA 99, Health C Section 6.5.4.1.1.2 Electrical System) g inspected and tested 6.4.4.1.1.3. Section shall be performed Standard for Emerg Systems, 2010 Edit	review and interview, the sure an annual fuel quality test 1 of 1 diesel powered generator. The facilities Code, 2012 Edition states Type 2 EES (Essential generator sets shall be 1 in accordance with Section 16.4.4.1.1.3 states maintenance in accordance with NFPA 110, tency and Standby Power ion, Chapter 8. NFPA 110, a fuel quality test shall be					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		r í	UILDING	02	COMPL 08/06/	ETED	
NAME OF P	PROVIDER OR SUPPLIER			6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	performed at least a by ASTM standards could affect all residuisitors. Findings include: Based on record revalues and 3:30 p.m. and Maintenance A documentation of atthe diesel powered during the past 12 manual fuel quality generator was dated months past due. Bof record review, the generator vendo be at the facility by sample of fuel for the test. This finding was received. This finding was received. This finding was received. This finding was received. Assist on 08/06/24. 3.1-19(b) 4. Based on record facility failed to mawritten record of months. Chapter 6. requires monthly te	view on 08/05/24 between 9:30 with the Maintenance Director ssistant present, there was no an annual fuel quality test for generator available for review month period. The most recent test for the diesel powered 1 05/17/23, which was over two cased on interview at the time the Maintenance Director said or has been contacted and will the end of the week to take the the annual diesel fuel quality		TAG			DATE
	Emergency and Sta 8. Chapter 6.4.4.2	FPA 110, the Standard for ndby Powers Systems, Chapter of NFPA 99 requires a written n, performance, exercising					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 02	(X3) DATE SURVEY COMPLETED 08/06/2024		
	PROVIDER OR SUPPLIE		STRE 6015	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE	N SHOULD BE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		
	period, and repairs	for the generator to be				
		ed and available for inspection				
	by the authority ha	ving jurisdiction. Chapter				
	6-4.4.1.3 of 2012 1	NFPA 99 requires batteries for				
	on-site generators	shall be maintained in				
	accordance with N	FPA 110, 2010 Edition,				
		gency and Standby Power				
		quires storage batteries,				
	including electroly	rte levels or battery voltage,				
		with systems shall be				
	inspected weekly a	and maintained in full				
	compliance with m	nanufacturer's specifications.				
	8.3.7.2 states defec	ctive batteries shall be repaired				
	or replaced immed	liately upon discovery of				
	defects. Chapter 6	5.5.4.2 of NFPA 99 requires a				
	written record of in	nspection, performance,				
	exercising period,	and repairs shall be regularly				
	maintained and ava	ailable for inspection by the				
		risdiction. This deficient				
		ct all residents, staff and				
	visitors.					
	Findings include:					
		f the generator inspection and 08/05/24 between 9:30 a.m. and				
	3:30 p.m. with the	Maintenance Director and				
	Maintenance Assis	stant present, the following was				
		esting time for 05/31/24 was				
	1	nutes (8:00 a.m. to 8:05 a.m.),				
	also, the 07/18/24					
		t list a completed time frame,				
	only 2:20 p.m. to (-				
		lways listed between 45				
	seconds and five m					
		e always listed as "Yes" under				
		d completed?", instead of an				
	amount	r,				
	of time for the	cool down.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		X2) MULTIPLE CONSTRUCTION A. BUILDING D2 B. WING		(X3) DATE SURVEY COMPLETED 08/06/2024			
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR				6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
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