PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING			ONSTRUCTION	(X3) DATE COMPL 08/29	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID PREFIX TAG E 0000	(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42  Survey Date: 08/29  Facility Number: 06  Provider Number: 100  At this Emergency Springs, was found Emergency Prepare Medicare and Mediand Suppliers, 42 Co	200491 155495 291230 Preparedness survey, Paddock not in compliance with dness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of us was 54.	E 00	000	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set for the Statement of Deficiencie Plan of Correction is prepared executed solely because it is required it is required by the position of Federal and States. The Plan of Correction is submitted in order to responsite allegation of noncompliancited during the survey visit we exit on August 29, 2022.  E-004 – Develop EP Plan, Review and Update Annual Compliance Date – 9/23/22  Immediate Intervention The Executive Director has updated the Emergency Operations Plan for both location. Nurse station and maintent office. The Executive Director was educated by Facilities Management Support on E0 Develop EP plan, review, an update annually. The facility develop and maintain an emergency preparedness plantation in the Executive Director will at the Emergency preparedness plantation and update annually. The Executive Director will at the Emergency preparedness plantation and update annually. The Executive Director will at the Emergency preparedness	ement facts orth on s. The ed and s e Law. d to nce with  ly  ations ance  04 d must an that ed at udit	

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

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NVXJ21 Facility ID: 000491 If continuation sheet Page 1 of 80

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/22/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G	(X3) DATE SURVEY  COMPLETED  08/29/2022	
	ROVIDER OR SUPPLIER	2	269	EET ADDRESS, CITY, STATE, ZIP COD 95 SHELDON STREET RSAW, IN 46582		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE PROPERTY OF THE PRO	ID PREFI	CROSS-REFERENCED TO THE APPROI	BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		ector to ther tinue. Team eved. the ants.  P  cations nance  s and ty must ergency and  n, risk a)(1) of agraph	
				and procedures must be re		

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

Event ID:

NVXJ21

Facility ID: 000491

and updated at least annually. The Executive Director will audit

If continuation sheet

Page 2 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 08/29/2022			
	PROVIDER OR SUPPLIE	R	2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				the Emergency preparedness communication 1 X per month 12 Months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Te determines substantial compliance has been achieved This deficient practice had the potential to affect all occupants.  E-029 – Development of Communication Plan Compliance Date – 9/23/22  Immediate Intervention The Executive Director has removed out date policies and updated the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E029 Develop EP plan, review, and update annually. The facility medevelop and maintain an emergency preparedness plan must be reviewed and updated least annually. The Executive Director will aud the Emergency preparedness communication 1 X per month 12 Months. Results of this audit will be presented by Executive Direct the QAPI committee for further	or to rule earn d. s

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

Event ID:

NVXJ21

Facility ID: 000491

recommendations and continue

If continuation sheet

Page 3 of 80

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/22/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC					OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	A. BUILDING		COMPLETED	
		155495	B. WIN	G		08/29/	2022
PADDOC	ROVIDER OR SUPPLIER			2695 SH WARSA	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	until the Quality Assurance Te determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.  E-031 – Emergency Officials contact Information Compliance Date – 9/23/22  Immediate Intervention The Executive Director has updated the Emergency Operations Plan to include cor information for ombudsman located at all locations. The Executive Director was educated by Facilities Management Support E031, Emergency Officials Contact Information to include Federal, State, Tribal, Regional, and locemergency preparedness staff. The State Licensing and Certification Agency. The Office the State Long-Term Care Ombudsman, Other sources of assistance. The Executive Director will aud the Emergency preparedness officials contact information 1 of the Emergency preparedness officials contact information 1 of the Emergency preparedness officials contact information 1 of the QAPI committee for further recommendations and continuantil the Quality Assurance Tedetermines substantial	am d. s. cal f. ce of dit X or to r e	DATE
	1				compliance has been achieved	a.	

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

Event ID:

NVXJ21

Facility ID: 000491

This deficient practice had the

If continuation sheet

Page 4 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	ULTIPLE CO	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPLETED	
		155495	B. W	ING		08/29/2022	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
BADDOO	CK SPRINGS		2695 SHELDON STREET WARSAW, IN 46582				
FADDUC	N OFNINGO				TVV, IIN 4000Z		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
IAG	REGULATORT OF	LESC IDENTIFY TING INFORMATION	+	IAG	potential to affect all occupant		
					E-036 – Training and Testing		
					Compliance Date – 9/23/22		
					Immediate Intervention		
					The Executive Director has		
					updated the Training and Test	ting	
					plan for the Emergency		
					Operations Plan located at the	9	
					Nurse station.		
					The Executive Director was educated by Facilities		
					Management Support on E03	6	
					Develop EP plan, review, and		
					update annually to include Tra	aining	
					and Testing (483.73(d). The fa	-	
					must develop and maintain ar		
					emergency preparedness plar must be reviewed and update		
					least annually.	u ai	
					The Executive Director will au	dit	
					the Emergency preparedness		
					training and testing 1 X per me	onth	
					X 12 Months.		
					Results of this audit will be	tor to	
					presented by Executive Direct the QAPI committee for furthe		
					recommendations and continu		
					until the Quality Assurance Te	eam	
					determines substantial		
					compliance has been achieve		
					This deficient practice had the		
					potential to affect all occupant	.5.	
					E-039 -Testing Requirements	s	
					Compliance Date – 10/5/22		
					Immediate Intervention		
	I		1		The Executive Director has		

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 5 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	LETED
		155495	B. WI	NG	<u> </u>	08/29/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	CR.			HELDON STREET		
PADDOC	CK SPRINGS			l	AW, IN 46582		
17,000	1			VV/ (1 (O/	7,177,177,10002		1
(X4) ID		Y 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 APPROPRIATE DEFICIENCY)	TE	COMPLETION		
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	+	TAG			DATE
					completed the facilities-based		
					tabletop exercise and has		
					scheduled a community-base	a	
					exercise to be completed by 10/5/22.		
					The Executive Director was		
					educated by Facilities		
					Management Support on E03	9	
					Testing Requirements 483.73		
					The facility must conduct	(4)	
					exercises to test the emergen	CV	
					plan at least twice per year,	,	
					including unannounced staff of	Irill	
					using the emergency procedu		
					The Executive Director will au		
					the Emergency preparedness		
					testing requirements 1 X per		
					month X 12 Months.		
					Results of this audit will be		
					presented by Executive Direct		
					the QAPI committee for further		
					recommendations and continu		
					until the Quality Assurance Te	eam	
					determines substantial		
					compliance has been achieve		
					This deficient practice had the		
					potential to affect all occupant	.5.	
					E-041– LTC Emergency Pow	or	
					Compliance Date – 9/23/22	<del>o</del> i	
					Compliance Date - 3/25/22		
					Immediate Intervention		
					The Director of Plant Operation	ns	
					conducted a monthly load for		
					generator		
					The Executive Director and		
					Director of Plant Operations w	/as	
					educated by the Facilities		
					Management Support on E04	1	
					LTC Emergency Power. The I		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 6 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIEF	2	2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Facility must implement the emergency power system inspection, testing, and requirements found in the NFF 110.  The Executive Director will aud the Emergency preparedness emergency power 1 X per mor 12 Months.  Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuantil the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice had the potential to affect all occupant.  K-131 – Multiple Occupancie Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operation has acquired the appropriate documentation showing the window in the 90 – minute fire rated door was provided with a rated – glazing material. The Director of Plant operation was educated by the Executive Director on K131 Multiple Occupancies, LSC 8.3.3 Section 8.3.3.12 states new fire protection—rated glazing shall be marked accordance with Table 8.3.3.1 and Table 8.3.4.2, and such marking shall be permanently	dit LTC nth X  or to r le le lam d. s. s  ns  a fire ns e on ction d in

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

The Director of Plant Operations

Page 7 of 80

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/22/2022 FORM APPROVED

CENTERS FO	AID SERVICES				OM	B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(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
					will audit the deficient window located in the 90-minute rated door for appropriate glazing material 1 X per week X 6 wee Results of this audit will be presented by Executive Direct the QAPI committee for furthe recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved. This deficient practice had the potential to affect 20 residents one smoke compartment.  K-211 – Means of Egress Compliance Date – 9/19/22  Immediate Intervention The Director of Plant Operation removed food serving equipment two soiled linen carts, boxes, a furniture stored in the Service corridor. The Director of Plant Operation was educated by the Executiv Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exit discharges, exit locations, and access are in accordance with Chapter 7 The Director of Plant Operation will audit the Service Hall corrifor obstructions impeding the of egress 1 X per week X 6 weeksults of this audit will be	eks. for to r le eam d. s in ms ent, and Hall ms e	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

presented by Executive Director to the QAPI committee for further recommendations and continue

Page 8 of 80

PRINTED: 09/22/2022

	T OF HEALTH AND HU					RM APPROVED
	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	B NO. 0938-039 SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155495	A. BUILDING B. WING	<del></del>	COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIE	ER	2695 S	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET AW, IN 46582		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  until the Quality Assurance Te determines substantial compliance has been achieve This deficient practice would a staff using the Service Hall ex  K-222 – Egress Doors Compliance Date – 9/19/22  Immediate Intervention The Director of Plant has insta signage indicating that the exi door located on 300 hall could opened in 15 seconds by pust on the doors. The Director of Plant Operatio was educated by the Executiv	eam  d. affect affect it. d be hing ons	(X5) COMPLETION DATE
				Director on K22, Means of Eg LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high not less than 1/8 in stroke wid on a contrasting background t reads as follows shall be located on the door leaf adjacent to the release device in the direction egress. "PUSH UNTIL ALARMSOUNDS. DOOR CAIL OPENED IN 15 SECONDS" The Director of Plant Operation will audit the deficient door on 300 hall for appropreait signary X per week X 6 weeks X 2 more Results of this audit will be	and th that ted ne of N BE ons the ge 1	

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

Event ID:

NVXJ21

Facility ID: 000491

determines substantial

If continuation sheet

presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team

compliance has been achieved.

Page 9 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE C A. BUILDING B. WING	construction	(X3) DATE SURVEY COMPLETED 08/29/2022		
	ROVIDER OR SUPPLIEI K SPRINGS	R	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(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)	5.112		
	•			This deficient practice could a 15 residents in the 300 -hall K-324 – Cooking Facilities Compliance Date – 9/19/22  Immediate Intervention The Director of Plant Operation and Kitchen staff have clean kitchen hood removing the ois ludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood system.  The Director of Plant Operation was educated by the Execution Director on K324, Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Contand Fire Protection of Common cooking Operations.  The Director of Plant Operation will audit the kitchen hood for cleanliness 1 X per day X 4w X 1 months.  Results of this audit will be	ons the ly r od ons ve  rol ercial ons eeeks		
				presented by Executive Direct the QAPI committee for further recommendations and continuation until the Quality Assurance To determines substantial compliance has been achieved. This deficient practice could a at least 30 residents in the direct room and kitchen staff.  K-341 – Fire Alarm System - Installation	er ue eam ed. affect ning		
				Compliance Date – 9/23/22			

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 10 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	ETED
		155495	B. WING			08/29/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			HELDON STREET		
PADDOC	CK SPRINGS		WARSAW, IN 46582				
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Immediate Intervention The Director of Plant Operation contacted contractor to move a smoke detector located in the breakroom with a minimum of 36in. from the air supply. The Director of Plant Operation was educated by the Executive Director on K341, Fire Alarm System – installation. A fire also system is installed with system and components approved for purpose in accordance with N 70, National Electrical Code, a NFPA 72, National Fire Alarm Code. The Director of Plant Operation will audit the smoke detector in the breakroom for location 1 X week X 4weeks X 1 months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achiever.	ns e arm ns the FPA and ns n per or to r ie eam d.	DATE
					staff in the breakroom.  K-351 – Sprinkler System - Installation.  Compliance Date – 9/23/22		
					Immediate Intervention The Director of Plant Operatio has contacted Contractor to he the sprinkler head moved and	ave	

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

Event ID:

NVXJ21

Facility ID: 000491

extended.

If continuation sheet

Page 11 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA (X2) MULTIPI		PLE CONSTRUCTION (X3)		3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPLETI	ED	
		155495	B. Wl	NG	_	08/29/20	22	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			HELDON STREET			
PADDOO	CK SPRINGS				AW, IN 46582			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					The Director of Plant Operation			
					was educated by the Executiv	е		
					Director on K351, Sprinkler			
					System – Installation. Building			
					are to be protected throughou			
					an approved automatic sprink system in accordance with NF			
					13, Standard for the installation			
					sprinkler systems.	"1 01		
					The Director of Plant Operation	ins		
					will audit the deficient sprinkle			
					head located in dining room for			
					proper installation 1 X per wee			
					4weeks X 1 months.			
					Results of this audit will be			
					presented by Executive Direct	tor to		
					the QAPI committee for furthe	r		
					recommendations and continu	ie		
					until the Quality Assurance Te	am		
					determines substantial			
					compliance has been achieve			
					This deficient practice could a	ffect		
					all residents.			
					K-353 – Sprinkler System –			
					Maintenance and Testing			
					Compliance Date – 9/23/22			
					Immediate Intervention			
					The Director of Plant Operation	ns		
					has contacted contractor to			
					replace the deficient gauge or	n the		
					sprinkler system.			
					The Director of Plant Operation	ns		
					was educated by the Executiv	e		
					Director on K353, Sprinkler			
					System – Maintenance and			
					Testing Automatic sprinkler ar			
					standpipe systems are inspec	ted		
					tested and maintained in			

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 12 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	==	COMPL	ETED
		155495	B. WI			08/29/	
		1					
NAME OF F	ROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
					HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		тс	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	DEFICIENCY)	
					accordance with NFPA 25.		
					The Director of Plant Operation	ns	
					will audit the sprinkler gauge f	or	
					proper inspection and date 1.2	⊀ per	
					week X 4weeks X 1 months.		
					Results of this audit will be		
					presented by Executive Direct	or to	
					the QAPI committee for furthe	r	
					recommendations and continu	ıe	
					until the Quality Assurance Te	am	
					determines substantial		
					compliance has been achieve	d.	
					This deficient practice could a	ffect	
					all residents, staff, and visitors	in	
					the facility.		
					K-363 – Corridor – Doors		
					Compliance Date – 9/19/22		
					Compliance Date - 9/19/22		
					Immediate Intervention		
					The Director of Plant Operation	ns	
					removed the door wedge prop	ping	
					the Therapy door open.		
					The Director of Plant Operation	ns	
					was educated by the Executiv		
					Director on K363, 18.3.6.3 Th	ere	
					is no impediment to the closin	g of	
					the doors.		
					The Director of Plant Operation		
					will audit Therapy for wedges		
					could prop door open 1 X per	week	
					X 4weeks X 1 months.		
					Results of this audit will be		
					presented by Executive Direct		
					the QAPI committee for furthe	r	
					recommendations and continu	ıe	
					until the Quality Assurance Te	am	
					determines substantial		
			1		compliance has been achieve	d.	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

This deficient practice could affect

Page 13 of 80

PRINTED: 09/22/2022

DEPARTMENT CENTERS FOI	FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY  COMPLETED  08/29/2022	
NAME OF I	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD		
PADDO	CK SPRINGS		WARS	AW, IN 46582		
PADDOC (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  6 residents in Therapy gym.  K-372 – Subdivision of Build Spaces – Smoke Barrier Construction Compliance Date – 9/19/22  Immediate Intervention The Director of Plant Operation has made repairs to the two penetrations located 100 hall smoke barriers. The Director of Plant Operation was educated by the Executive Director on K363, NFPA 101, 2012 edition Smoke barriers are be constructed to provide at lea 1-hour fire resistance rating constructed in accordance wite a 1-hour fire resistance rating constructed in accordance wite a 1-hour fire resistance rating constructed in accordance wite a 1-hour fire resistance rating constructed in accordance wite 8.5  The Director of Plant Operation will audit smoke barrier locate 100 for penetrations 1 X per with X 4weeks X 1 months. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuantil the Quality Assurance Teacher and the provided substantial substantial	ing ing ins ons e chall east and h ons d on veek tor to r ue eam	
				compliance has been achieve This deficient practice could a 20 residents in two smoke compartments.  K-379 – Smoke Barrier Door		

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

Event ID:

NVXJ21

Facility ID: 000491

Glazing

If continuation sheet

**Immediate Intervention** 

Compliance Date – 9/23/22

Page 14 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVE COMPLETED 08/29/2022	Y	
	ROVIDER OR SUPPLIEI K SPRINGS	₹	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(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 SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE COMI	(X5) PLETION ATE	
				The Director of Plant O has acquired the approdocumentation showing window in 5 of 5 smoke doors with windows waw with a fire rated – glazir The Director of Plant O was educated by the Ex Director on K379, Smole Door Glazing. Windows barrier doors shall be in each cross-corridor swithorizonal-sliding door p fire – rated glazing or by glass panels in approve 18.3.7.9 The Director of Plant O will audit the 5 of 5 smole doors for fire rated glaz week X 4weeks X 1 mo Results of this audit will presented by Executive the QAPI committee for recommendations and o until the Quality Assura determines substantial compliance has been a This deficient practice of all residents.  K-712 – Fire Drills Compliance Date – 9/2:  Immediate Intervention The Director of Plant O has conducted a fire dri shift The Director of Plant O was educated by the Ex Director on K712, Fire of	priate priate priate priate partier partier provided prov		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 15 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155495	A. BUILDING B. WING	onstruction 	COM	e survey PLETED 9/2022
	ROVIDER OR SUPPLIE K SPRINGS	R	2695 S	ADDRESS, CITY, STATE, ZIP CO SHELDON STREET AW, IN 46582	OD	
(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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				NFPA 101, Fire Drills a expected and unexpect under varying condition quarterly on each shift. The Executive Director audit/review each fire of Director of Plant Operation Month X 3 Months Results of this audit will presented by Executive the QAPI committee for recommendations and until the Quality Assurate determines substantial compliance has been at This deficient practice of all staff and residents.  K-754 – Soiled Linen at Containers  Compliance Date – 9/2  Immediate Intervention The Director of Plant Ohas removed the two 3 soiled linen carts that a side in the service hall The Director of Plant Ohas reducated by the EDirector on K754, Soile and Trash Containers, or trash collection recessing the process of the storage of soiled linen of assuring this does not of more than 32 gallons we feet 1 X per day X 4we months.	ted times as, at least  will drill with the ations 1 X  Il be e Director to r further continue ance Team  achieved. could affect  and Trash  13/22  n Deparations 0-gallon are side by corridor. Deparations xecutive ed Linen soiled linen ptacles Illons in Deparations all for the carts exceed vithin 64 sq	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 16 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED  B. WING 08/29/2022				
		155495	B. WI	NG		08/29/	ZUZZ
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
				1	HELDON STREET		
PADDOC	CK SPRINGS			WARS	AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Results of this audit will be presented by Executive Direct	or to	
					the QAPI committee for furthe		
					recommendations and continu		
					until the Quality Assurance Te		
					determines substantial		
					compliance has been achieve	d.	
					This deficient practice could a	ffect	
					all staff in service hall.		
					K-918 – Electrical Systems –		
					Essential Electrical System		
					Maintenance and Testing.		
					Compliance Date – 9/22/22		
					Immediate Intervention		
					The Director of Plant Operation		
					has exercised the generator s		
					for a minimum of 30 minutes a	and	
					documented.		
					The Director of Plant Operation was educated by the Executive		
					Director on K918, NFPA 101	6	
					Electrical System Essential		
					Electrical System Maintenanc	e	
					and Testing. Generator sets a		
					inspected weekly, exercised u		
					load 30 minutes 12 times per	year	
					in 20–40-day intervals, and		
					exercised once every 36 mon	ths	
					for 4 continuous hours.		
					The Executive Director will	rator	
					audit/review the monthly gene set exercise with Director of P		
					Operations 1 X per Months X		
					Months	~	
					Results of this audit will be		
					presented by Executive Direct	or to	
					the QAPI committee for furthe		
					recommendations and continu	ie	

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

Event ID:

NVXJ21

Facility ID: 000491

491

If continuation sheet Page 17 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIE	R	•	2695 SI	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	(X5) COMPLETION
E 0004 SS=F Bldg	403.748(a), 416.5 441.184(a), 482.7 484.102(a), 485.6	54(a), 418.113(a), 15(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a),		TAG	until the Quality Assurance Te determines substantial compliance has been achieve This deficient practice could a all staff in service hall.	d.	DATE
	491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §483 §485.68(a), §485						
	Federal, State an preparedness rec must develop est comprehensive e program that mee section. The eme	t comply with all applicable d local emergency quirements. The [facility] ablish and maintain a mergency preparedness ets the requirements of this ergency preparedness blude, but not be limited to, nents:					
	develop and mair preparedness pla	lan. The [facility] must ntain an emergency in that must be [reviewed], east every 2 years. The plan following:					
	§485.625(a):] Em or CAH] must cor	t §482.15 and CAHs at nergency Plan. The [hospital mply with all applicable nd local emergency					

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 18 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155495		A. BUILDING  B. WING	onstruction 	COMPLETED  08/29/2022	
	ROVIDER OR SUPPLIER		2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582	
(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
120	preparedness required CAH] must develor comprehensive en program that meet section, utilizing at * [For LTC Facilities Emergency Plan. develop and mainting preparedness plar and updated at least * [For ESRD Facilities Emergency Plan. develop and mainting preparedness plar and updated at least test of the program of the preparedness plar and updated at least test of the program of the preparedness Plan (accordance with 42 practice could affect Findings include:	uirements. The [hospital or p and maintain a nergency preparedness is the requirements of this in all-hazards approach.  Ses at §483.73(a):]  The LTC facility must itain an emergency in that must be reviewed, ast annually.  Ities at §494.62(a):]  The ESRD facility must itain an emergency in that must be [evaluated], ast every 2 years.  Ities at every 2 years.  Ities and interview, the facility in update the Emergency in the Emergency in the every 2 years.  Ities and interview, the facility in update the Emergency in the every 2 years.	E 0004	E-004 – Develop EP Plan, Review and Update Annually Compliance Date – 9/23/22 Immediate Intervention The Executive Director has updated the Emergency	09/23/2022
	Facility Maintenance Director on 08/29/2 nurses' station had a EPP from the maint	e Support, and Maintenance 2 at 10:41 a.m., the EEP from the review date of 11/01/18. The enance office had a review date		Operations Plan for both locat  - Nurse station and maintenal office.  The Executive Director was educated by Facilities	nce
	not properly updated information was fro Lakeland Nursing a Springs. Based on a review, the Adminis	m a different facility named nd did not pertain to Paddock n interview during records strator and Maintenance EPP books were not properly		Management Support on E00- Develop EP plan, review, and update annually. The facility n develop and maintain an emergency preparedness plar must be reviewed and update least annually. The Executive Director will au	nust n that d at

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 19 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155495	A. BU B. WI	JILDING NG	<del></del>	COMPL 08/29/	
		100+00	В. 111		DDDFGG CITY OTATE ZID COD	00/20/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD HELDON STREET		
PADDOC	K SPRINGS				AW, IN 46582		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	This finding was rev	viewed with the Administrator, see Support, and Maintenance exit conference.		TAG	the Emergency preparedness communication 1 X per month 12 Months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Te determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.	or to r e am d.	DATE
E 0013 SS=C Bldg	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).  (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must						
	-	s at §483.73(b):] Policies he LTC facility must ement emergency					

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 20 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155495	B. W.	ING	_	08/29/	/2022
NAME OF F	DROWIDED OF CLIEBT ICE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		2695 SI	HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		icies and procedures, based					
		plan set forth in paragraph risk assessment at					
	` ,						
	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this						
	section. The policies and procedures must						
	be reviewed and updated at least annually.						
	be reviewed and updated at least annually.						
	*Additional Requirements for PACE and						
	ESRD Facilities:						
	*(Ear DACE at \$4)	20 94/h):1 Deligion and					
	*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must						
	develop and imple						
	· ·	icies and procedures, based					
		plan set forth in paragraph					
		risk assessment at					
	' '	of this section, and the					
		an at paragraph (c) of this					
	· ·	cies and procedures must					
	-	nent of medical and					
	_	gencies, including, but not					
		uipment, power, or water					
		ed emergencies; and natural					
		threaten the health or					
		cipants, staff, or the public.					
		procedures must be					
		ated at least every 2 years.					
	*[For ESPD Facili	ties at §494.62(b):] Policies					
	_	The dialysis facility must					
	develop and imple						
	· ·	icies and procedures, based					
		plan set forth in paragraph					
		risk assessment at					
	' '	of this section, and the					
		an at paragraph (c) of this					
	· ·	cies and procedures must					
	-	updated at least every 2					
		ergencies include, but are					
	1 , 54.5. 111000 01110	g = 5100 11101000, Dut 010	1				I

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 21 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIF A. BUILDIN B. WING	LE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED 08/29/2022	
	OF PROVIDER OR SUPPLIED	₹	26	REET ADDRESS, CITY, STATE, ZIP COD 95 SHELDON STREET ARSAW, IN 46582	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	CROSS-REFERENCED TO THE APPR	TION (X5)  LD BE COMPLETION  COMPLETION  DATE
	failures, care-rela supply interruption likely to occur in tarea.  Based on record refailed to review and Preparedness Pland at least annually in 483.73(a). This defoccupants.  Findings include:  Based on records refacility Maintenand Director on 08/29/2 and Procedures from review date of 11/0 during records review date of 11/0 during records reviewed and updataths finding was refacility maintenance Director on the reviewed and updataths.	viewed with the Administrator, ce Support, and Maintenance	E 0013	E-013 – Development of policies and procedures Compliance Date – 9/23/2 Immediate Intervention The Executive Director has updated the Policies and Procedures to include emservices in the Emergence Operations Plan for both I – Nurse station and maint office. The Executive Director was educated by Facilities Management Support on Development of EP Polici Procedures. The LTC facing develop and implement expreparedness and polices procedures, based on the emergency plan set forth paragraph (a) of this section assessment at paragraph this section, and the communication plan at passessment at paragraph this section. The position and procedures must be reand updated at least annual The Executive Director with Emergency preparedrommunication 1 X per model 12 Months. Results of this audit will be presented by Executive Director for the CAPI committee for furecommendations and control of the communication and control of the communication and control of the CAPI committee for furecommendations and control of the communication and control of the commun	dergency y locations tenance as E013 les and illity must mergency s and in ion, risk (a)(1) of licies reviewed ually. ill audit ness lonth X e liciector to urther

09/22/2022 PRINTED: FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155495	A. BUI B. WIN	LDING IG	<del></del>	COMPL 08/29/	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8	2695 SHELDON STREET				
PADDO	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION DATE
1110	REGUENTURY G			1110	until the Quality Assurance Te	am	Dille
					determines substantial		
					compliance has been achieved		
					This deficient practice had the		
					potential to affect all occupant	S.	
E 0029	403.748(c), 416.5	4(c), 418,113(c).					
SS=C	` '	5(c), 483.475(c), 483.73(c),					
Bldg	484.102(c), 485.6						
	485.727(c), 485.9	20(c), 486.360(c),					
	491.12(c), 494.62						
	· ·	Communication Plan					
	` , , .	6.54(c), §418.113(c),					
	- , , -	).84(c), §482.15(c),					
	- , , -	475(c), §484.102(c), 625(c), §485.727(c),					
	- , , -	6.360(c), §491.12(c),					
	§494.62(c).						
	. ,	ust develop and maintain					
		eparedness communication s with Federal, State and					
		ist be reviewed and updated					
		ears [annually for LTC					
	facilities].	. ,					
	Based on record rev	view and interview, the facility	E 00	29	E-029 – Development of		09/23/2022
		l update the Emergency			Communication Plan		
		(EPP) Communication Plan at			Compliance Date – 9/23/22		
	1	cordance with 42 CFR					
	* *	icient practice could affect all			Immediate Intervention		
	occupants.				The Executive Director has removed out date policies and	l	
	Findings include:				updated the Emergency		
	- manage merade.				Operations Plan located at the	<b>;</b>	
	Based on records re	eview with the Administrator,			Nurse station.		
		ce Support, and Maintenance			The Executive Director was		
	Director on 08/29/2	22 at 10:41 a.m., the EEP			educated by Facilities		

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

Communication Plan from the nurses' station had

a review date of 11/01/18. Based on an interview during records review, the Administrator and

Event ID:

NVXJ21

Facility ID: 000491

Management Support on E029 Develop EP plan, review, and

update annually. The facility must

If continuation sheet

Page 23 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED 9/2022
	PROVIDER OR SUPPLIER		2695 S	ADDRESS, CITY, STATE, ZIP CO HELDON STREET AW, IN 46582	D D	_
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE
E 0031 SS=C Bldg	Maintenance Direct Communication Planot been reviewed at This finding was refacility Maintenance Director during the Director during the 403.748(c)(2), 416, 441.184(c)(2), 482, 483.73(c)(2), 484.485.68(c)(2), 485.486.360(c)(2), 485.486.373(c)(2), 485.486.373(c)(2), 485.485.68(c)(2), 485.485.68(c)(2), 485.485.920(c)(2), 485.485.920(c)(	or agreed the EPP on from the nurses' station has and updated annually.  viewed with the Administrator, see Support, and Maintenance	IAG	develop and maintain ar emergency preparednes must be reviewed and u least annually.  The Executive Director of the Emergency prepared communication 1 X per 12 Months.  Results of this audit will presented by Executive the QAPI committee for recommendations and countil the Quality Assurant determines substantial compliance has been as This deficient practice has potential to affect all occurrence.	ss plan that pdated at will audit dness month X be Director to further ontinue nce Team chieved.	DATE
	facilities]. The con include all of the fo	ears [annually for LTC nmunication plan must ollowing: ation for the following:				

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 24 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	LETED
		155495	B. WI	NG		08/29/	/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HELDON STREET		
	CK SPRINGS				AW, IN 46582		
PADDOC	JN SENINGS			WARSA	4VV, IIV 40302		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(i) Federal, State,	tribal, regional, and local					
	emergency prepa	redness staff.					
	(ii) Other sources of assistance.  *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman.						
	(iv) Other sources	of assistance.					
	*[For ICF/IIDs at §	3483.475(c):] (2) Contact					
	information for the	e following:					
	(i) Federal, State,	tribal, regional, and local					
	emergency prepa						
	(ii) Other sources						
	(iii) The State Lice	ensing and Certification					
	Agency.						
	l ' '	tection and Advocacy					
	Agency.						
		view and interview, the facility	E 00	)31	E-031 – Emergency Officials		09/23/2022
		emergency preparedness			contact Information		
		n includes (2) Contact			Compliance Date – 9/23/22		
		following: (i) Federal, State,					
	T	ocal emergency preparedness			Immediate Intervention		
		Licensing and Certification			The Executive Director has		
	1	ffice of the State Long-Term			updated the Emergency		
		(iv) Other sources of assistance			Operations Plan to include con	ntact	
		42 CFR 483.73(c) (2). This			information for ombudsman		
	deficient practice could affect all occupants.  Findings include:				located at all locations.		
					The Executive Director was		
					educated by Facilities		
	, , , , , , , , , , , , , , , , , , ,	the state of the state of			Management Support E031,		
		view with the Administrator,			Emergency Officials Contact		
	1	ce Support, and Maintenance			Information to include Federal	•	
		22 at 10:45 a.m., the emergency			State, Tribal, Regional, and lo		
	preparedness comm	nunication plan for Federal,			emergency preparedness staf	f.	

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 25 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO	NSTRUCTION 	(X3) DATE : COMPL	
155495			B. WI			08/29/	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	State, Tribal emerge contact information State Long-Term Conterview at the time Administrator, Faci Maintenance Direct the Ombudsman phe This finding was refacility Maintenance Director during the	ency preparedness staff was missing the Office of the are Ombudsman. Based on e of record review, the lity Maintenance Support, and for stated the plan was missing one number.  wiewed with the Administrator, the Support, and Maintenance exit conference.		TAG	The State Licensing and Certification Agency. The Office the State Long-Term Care Ombudsman, Other sources of assistance.  The Executive Director will aude the Emergency preparedness officials contact information 1.2 per month X 12 Months.  Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved. This deficient practice had the potential to affect all occupant	or to ree am	DAIL
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §485. §485.68(d), §485. §485.920(d), §486 §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)					

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 26 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155495	A. BU B. W.	JILDING ING	<del></del>	COMPL 08/29/		
		100430	D. W	_		00/29/	U	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD HELDON STREET			
PADDOC	CK SPRINGS				NEEDON STREET NW, IN 46582			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		tain an emergency	+	IAG			DATE	
		ning and testing program						
	1 ' '	ne emergency plan set forth						
	in paragraph (a) o	- · ·						
		ragraph (a)(1) of this						
	section, policies a	nd procedures at paragraph						
	1 ' '	and the communication						
		(c) of this section. The						
	"	g program must be						
	reviewed and upd	ated at least every 2 years.						
	*[For LTC facilities	s at §483.73(d):] (d) Training						
	_	LTC facility must develop						
	and maintain an e	mergency preparedness						
		g program that is based on						
		an set forth in paragraph (a)						
		k assessment at paragraph						
		on, policies and procedures						
		of this section, and the an at paragraph (c) of this						
		ing and testing program						
		and updated at least						
	annually.	•						
	*!5 !05/!!5-	2400 475/4\-1 T						
		3483.475(d):] Training and D must develop and						
		gency preparedness training						
		am that is based on the						
	1	et forth in paragraph (a) of						
		ssessment at paragraph						
		on, policies and procedures						
		of this section, and the						
		an at paragraph (c) of this						
		ing and testing program						
		and updated at least every						
	2 years. The ICF/							
	requirements for eat §483.470(i).	evacuation drills and training						
	at 3400.470(i).							
	*[For ESRD Facili	ties at §494.62(d):]						

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 27 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155495	A. BUILDING B. WING	construction	COMPLETED 08/29/2022
	PROVIDER OR SUPPLIER CK SPRINGS		2695	ET ADDRESS, CITY, STATE, ZIP COD 5 SHELDON STREET RSAW, IN 46582	
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
	dialysis facility mu emergency prepar and patient orienta on the emergency (a) of this section, paragraph (a)(1) o procedures at para and the communic of this section. The orientation prograr updated at every 2 Based on record reversited to review and Preparedness Plan (Plan at least annuall 483.73(a). This definition occupants.  Findings include:  Based on records reversited facility Maintenance Director on 08/29/2. Training and Testing had a review date of interview during record and Maintenance Director on the program of t	iew and interview, the facility update the Emergency EPP) Training and Testing y in accordance with 42 CFR cient practice could affect all view with the Administrator, e Support, and Maintenance 2 at 10:41 a.m., the EEP g Plan from the nurses' station f 11/01/18. Based on an cords review, the Administrator frector agreed the EPP g Plan from the nurses' station ed and updated annually.	E 0036	E-036 – Training and Testic Compliance Date – 9/23/22  Immediate Intervention The Executive Director has updated the Training and Teplan for the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on ECD Develop EP plan, review, and update annually to include If and Testing (483.73(d). The must develop and maintain emergency preparedness per must be reviewed and update least annually. The Executive Director will at the Emergency preparedness training and testing 1 X per X 12 Months. Results of this audit will be presented by Executive Director further commendations and continutil the Quality Assurance.	esting the  036 nd Fraining e facility an lan that ted at audit ss month  ector to her nue

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 28 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155495	B. W	NG		08/29/	/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0039 SS=F Bldg	403.748(d)(2), 416 441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §47 §485.625(d)(2), §47 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.9 §491.12, and ESR (2) Testing. The [filters	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 184.102(d)(2), §485.68(d)(2), 185.727(d)(2), §485.920(d) 184.102(d)(2). 6.54, CORFs at §485.68, 185.727(d)(2), §485.68, 185.727(d)(2). 6.54, CORFs at §485.68, 185.727, 185.7		TAG		d.	DATE
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:  (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.						

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

(ii) Conduct an additional exercise at least

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 29 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

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	<del></del>	COMPL	
		155495	B. W	ING		08/29/	/2022
NAME OF T	DROLUDED OF CURRY TO		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	¢ .		2695 SI	HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
	' '	scale exercise that is or individual, facility-based					
	functional exercise	<del>-</del>					
	(B) A mock disast						
	' '	ercise or workshop that is					
		and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta	- ·					
		pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					
	(2) Testing for ho	spices that provide care in					
	the patient's home	e. The hospice must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	community based						
	, ,	nunity based exercise is not					
		ct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
	_	ency that requires activation					
	,	plan, the hospital is					
		aging in its next required full					
	scale community-based exercise or individual						
	facility-based functional exercise following the						
	onset of the emergency event.						
	' '	dditional exercise every 2					
	years, opposite th	e year the full-scale or					

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 30 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155495	B. W	ING		08/29/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	,	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					HELDON STREET		
PADDO	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	, ,	scale exercise that is					
		or a facility based					
	functional exercise						
	(B) A mock disas						
	1 ' '	ercise or workshop that is					
	discussion using a	and includes a group					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	<del>-</del>					
	to challenge an ch	nergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					
	1 ' '	spice must do the following:					
		an annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not					
		ict an annual individual					
	•	ctional exercise; or					
	, ,	experiences a natural or					
	_	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
		dditional annual exercise but is not limited to the					
	following:	but is not innited to the					
	_	scale exercise that is					
	` '	or a facility based					
	functional exercise	_					
	(B) A mock disas						
	` '	ercise or workshop led by a					
	1 ' '	udes a group discussion					

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 31 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155495	B. W	ING		08/29/	/2022
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(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		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	using a narrated,						
		rio, and a set of problem					
	questions designe	ed messages, or prepared					
	emergency plan.	to challerige an					
		ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	*[For PRFTs at §4	l41.184(d), Hospitals at					
	§482.15(d), CAHs	at §485.625(d):]					
	(2) Testing. The [F	PRTF, Hospital, CAH] must					
		to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	_					
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund						
		Hospital, CAH] experiences					
		or man-made emergency					
	-	ation of the emergency is exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
		et of the emergency event.					
	•	an [additional] annual					
		at may include, but is not					
	limited to the follo						
		scale exercise that is					
	community-based						
	-	ctional exercise; or					
	I -	ock disaster drill; or					
	` '	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	~ .					
	_	emergency scenario, and a					

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 32 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		ì	UILDING	NSTRUCTION	(X3) DATE COMP: 08/29			
	PROVIDER OR SUPPLIEI CK SPRINGS	<b>.</b>	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION ID BE OPRIATE	(X5) COMPLETION DATE	
	set of problem sta messages, or pre to challenge an et (iii) Analyze t and maintain doct tabletop exercises and revise the [faineeded.	ntements, directed pared questions designed mergency plan. he [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as						
	conduct exercises plan at least annuorganization must (i) Participate in a that is community (A) When a commaccessible, condufacility-based func (B) If the PACE exor man-made emactivation of the experience of the conduction of the exercises of the conduction of the exercises of the conduction of the exercises of the exercises of the conduction of the exercises	PACE organization must as to test the emergency cally. The PACE and othe following: an annual full-scale exercise e-based; or nunity-based exercise is not act an annual individual, citional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE						
	full-scale communifacility-based functionset of the emerical Conduct and 2 years opposite of functional exercise of this section is community-based functional exercise of this section is community-based functional exercise (B) A mock disased (C) A tabletop exeled by a facilitator discussion, using	an additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is for individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated,						
	clinically-relevant set of problem sta	emergency scenario, and a stements, directed						

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 33 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155495		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022		
	PROVIDER OR SUPPLIEI	<b>\</b>	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY)		BE	(X5) COMPLETION DATE	
	to challenge an et (iii) Analyze the F maintain document exercises, and en the PACE's emergence and the PACE's emergence are the test the emergency proposed to test the emergency propos	PACE's response to and intation of all drills, tabletop bergency events and revise gency plan, as needed.  Be at §483.73(d):]  ity] must conduct exercises ency plan at least twice per sannounced staff drills using occdures. The [LTC facility, the following: an annual full-scale exercise elased; or nunity-based exercise is not act an annual individual, etional exercise.  Itility] facility experiences an man-made emergency plan, the empt from engaging its next alle community-based or elased functional exercise et of the emergency event. In an exercise et of the emergency event. It is not limited to the exercise that is a or an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed						

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 34 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155495	B. W	NG		08/29/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			HELDON STREET		
P∆DDOC	CK SPRINGS				AW, IN 46582		
17,0000				VV/ (1 (O/	(VV, IIV 40002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		naintain documentation of					
	-	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*r= 10=#15 / 0	1400 475/ N					
	*[For ICF/IIDs at §	• • •					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						
		n annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not act an annual individual,					
		etional exercise; or.					
	' '	experiences an actual					
		ade emergency that requires mergency plan, the ICF/IID					
		gaging in its next required					
	-	nity-based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		ditional annual exercise					
	, ,	but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
	-	ctional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is					
	, ,	and includes a group					
	discussion, using	• .					
		emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an emergency plan.						
	(iii) Analyze the ICF/IID's response to and						
	maintain documentation of all drills, tabletop						
		nergency events, and revise					
		rgency plan, as needed.					

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

Event ID:

NVXJ21

Facility ID: 000491

191 If continuation sheet

Page 35 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155495	A. BUILDING  B. WING			COMPLETED 08/29/2022		
NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS				STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PRI	O EFIX AG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	exercises to test to least annually. The following:  (i) Participate in a community-based (A) When a consist is not accessible, individual, facility-every 2 years; or.  (B) If the HH natural or man-man activation of the exempt from engate full-scale community-based functional exercise of this section is consisted include, but is not (A) A second community-based facility-based functional exercise facility-relevant set of problem start messages, or preto challenge an entition in the facility and problem start messages, or preto challenge an entition in the facility and problem start messages, and entitle exercises, and entitle exercises, and entitle exercises in the following in the following exercises, and entitle exercises in the following exercises, and entitle exercises in the following exercises, and entitle exercises in the following exercises in the followin	e HHA must conduct he emergency plan at e HHA must do the  full-scale exercise that is ; or ommunity-based exercise conduct an annual based functional exercise  A experiences an actual ade emergency that requires mergency plan, the HHA is aging in its next required nity-based or individual, stional exercise following the gency event. ditional exercise every 2 the year the full-scale or the under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is for an individual, stional exercise; or isaster drill; or the exercise or workshop that for and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed						

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 36 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155495	A. BU B. W	JILDING	<del></del>	COMPL 08/29/	
		155495	D. W.			00/29/	2022
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
PADDOC	CK SPRINGS				HELDON STREET AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	*[For OPOs at §48	-					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	<u> </u>					
	1 ''	er-based, tabletop exercise					
	-	ast annually. A tabletop					
	exercise is led by a facilitator and includes a group discussion, using a narrated, clinically						
		cy scenario, and a set of					
	1	its, directed messages, or					
	I '	is designed to challenge an					
		f the OPO experiences an					
	actual natural or man-made emergency that						
		of the emergency plan, the					
		om engaging in its next					
	· ·	xercise following the onset					
	of the emergency	event.					
	(ii) Analyze the Of	PO's response to and					
	maintain documer	ntation of all tabletop					
	exercises, and em	nergency events, and revise					
	the [RNHCI's and	OPO's] emergency plan, as					
	needed.						
	*[ RNCHIs at §403	3.7481:					
		e RNHCI must conduct					
	. , , ,	he emergency plan. The					
	RNHCI must do th						
		er-based, tabletop exercise					
	1 ''	A tabletop exercise is a					
	group discussion	led by a facilitator, using a					
	narrated, clinically	r-relevant emergency					
	scenario, and a se	et of problem statements,					
	directed message	s, or prepared questions					
	designed to challe	enge an emergency plan.					
	1 ' '	NHCI's response to and					
	maintain documer	ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 00	039	E-039 -Testing Requirements	3	10/05/2022
	failed to conduct ex	ercises to test the emergency	1		Compliance Date – 10/5/22		I

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 37 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIF A. BUILDII B. WING	LE CONSTRUCTION  NG	COM	TE SURVEY MPLETED 29/2022
	PROVIDER OR SUPPLIER		26	REET ADDRESS, CITY, ST 95 SHELDON STRE ARSAW, IN 46582		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF TA	IX (EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
	plan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a commun accessible, conduct facility-based funct b. If the LTC facilit or man-made emerg of the emergency plant from engaging its not man the onset of the acturation of the conset of the acturation of	drills using the emergency C facility must do the  annual full-scale exercise that d; or ity-based exercise is not an annual individual, ional exercise. y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a re individual, facility-based dexercise for 1 year following tal event. itional exercise that may simited to the following: tale exercise that is re an individual, facility-based drill; or se or workshop that is led by a des a group discussion, using ty-relevant emergency scenario, an statements, directed fied questions designed to the designed to the gency plan. TC facility's response to and faction of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This could affect all occupants.  Triew with the Administrator, the Support, and Maintenance		completed the tabletop exercise to be 10/5/22.  The Executive educated by Management Testing Requirements to table to the plan at least to including unausing the emergence testing requirements of this presented by the QAPI complete the Qual determines so compliance in This deficient	e Director has e facilities-based cise and has community-based e completed by  e Director was Facilities Support on E039 irrements 483.73(d) ust conduct test the emergency twice per year, nnounced staff drill ergency procedures. e Director will audit cy preparedness ements 1 X per Months. s audit will be Executive Director to nmittee for further tions and continue ity Assurance Team	
l	Director on 08/29/2	∠ at 10:49 a.m., no				

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPI A. BUILDIN B. WING	E CONSTRUCT G <u></u>	TION	(X3) DATE : COMPL 08/29/	ETED
	PROVIDER OR SUPPLIE	R	269	EET ADDRESS, 5 SHELDON RSAW, IN 4			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFI	X (EACI CROSS	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	documentation of a exercise, nor documentation annual exercise of available for review time of records rev Maintenance Direct participate in a full community-based within the last 12 m		TAG				DATE
		eviewed with the Administrator, ce Support, and Maintenance e exit conference.					
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital mus standby power sy emergency plan s this section and in	d LTC Emergency Power tition for Participation: and standby power systems. It implement emergency and estems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1)					
	The [LTC facility a implement emerg systems based or	.625(e) and standby power systems. and the CAH] must ency and standby power and the emergency plan set and (a) of this section.					
	Emergency gene generator must be the location requi Care Facilities Co Interim Amendme	83.73(e)(1), §485.625(e)(1) rator location. The e located in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety					

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 39 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155495	B. W	ING		08/29/	/2022
NAME OF I	PROVIDER OR SUPPLIER	)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		X.			HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(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	ATE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	,	and Tentative Interim					
		12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new					
		r when an existing					
	structure or building	•					
	Ţ.						
	, , , , _	3.73(e)(2), §485.625(e)(2)					
		rator inspection and testing.					
	The [hospital, CAH and LTC facility] must						
		ergency power system					
		g, and [maintenance]					
	requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.						
	l coust						
	482.15(e)(3), §48	3.73(e)(3), §485.625(e)(3)					
	Emergency gener	ator fuel. [Hospitals, CAHs					
	_	that maintain an onsite fuel					
		emergency generators must					
		ow it will keep emergency					
		perational during the					
	emergency, unles	s it evacuates.					
	*[For hospitals at	§482.15(h), LTC at					
	l	CAHs §485.625(g):]					
		corporated by reference in					
	this section are ap	pproved for incorporation by					
		Director of the Office of the					
		n accordance with 5 U.S.C.					
		R part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	, ,	mation on the availability of					
	go to:	ARA, call 202-741-6030, or					
	1 90 to.		1				1
	http://www.archive	es.gov/federal register/code					

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 40 of 80

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022
NAME OF PROVIDER OR SUPPL	ER	2695 S	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET AW, IN 46582	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
incorporated by document in the announce the co (1) National Fire Batterymarch P Quincy, MA 02: 1.617.770.3000 (i) NFPA 99, He 2012 edition, is (ii) Technical in NFPA 99, issue (iii) TIA 12-3 to 2012. (iv) TIA 12-4 to 2013. (v) TIA 12-5 to 2013. (vi) TIA 12-6 to 2014. (vii) NFPA 101, edition, issued (viii) TIA 12-1 to 11, 2011. (ix) TIA 12-2 to 30, 2012. (x) TIA 12-3 to 22, 2013. (xi) TIA 12-4 to 22, 2013. (xiii) NFPA 110 Standby Power including TIAs to 2009.	e Protection Association, 1 ark, 69, www.nfpa.org,	E 0041	E-041– LTC Emergency Pov	wer 09/23/2022
requirements fou Code, NFPA 110 accordance with	ent the emergency power system and in the Health Care Facilities and Life Safety Code in 42 CFR 483.73(e)(2). This could affect all occupants.		Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operatic conducted a monthly load for	

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	l í	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OI COMMECTION	155495	B. WING	<del>-</del>	08/29	
	PROVIDER OR SUPPLIE	R	2695	ET ADDRESS, CITY, STATE, ZIP 5 SHELDON STREET RSAW, IN 46582	COD	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETION DATE
	and Maintenance I a.m., the generator required by LSC ar interview at the tin Maintenance Direc missing some of th This finding was re	eviewed with the Administrator, ce Support, and Maintenance		generator The Executive Direct Director of Plant Ope educated by the Faci Management Suppor LTC Emergency Pow Facility must impleme emergency power sy inspection, testing, al requirements found in 110. The Executive Direct the Emergency prepa emergency power 1.2 12 Months. Results of this audit w presented by Executi the QAPI committee recommendations an until the Quality Assu determines substanti compliance has beer This deficient practice potential to affect all	erations was clities t on E041 ver. The LTC ent the stem and the NFPA or will audit aredness LTC X per month X will be five Director to for further and continue urance Team al the archieved. te had the	
K 0000					·	
Bldg. 02	Indiana Departmer 42 CFR 483.90(a). Survey Date: 08/2 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety	9/22 00491 155495	K 0000	Preparation or execuplan of correction does constitute admission of provider of the trut alleged or conclusion the Statement of Defi Plan of Correction is executed solely becarequired it is required position of Federal and The Plan of Correction submitted in order to	es not or agreement h of the facts as set forth on iciencies. The prepared and ause it is I by the and State Law. on is	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 42 of 80

09/22/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 08/29/2022 155495 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2695 SHELDON STREET PADDOCK SPRINGS WARSAW, IN 46582 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE for Participation in Medicare/Medicaid, 42 CFR the allegation of noncompliance Subpart 483.90(a), Life Safety from Fire and the cited during the survey visit with 2012 edition of the National Fire Protection exit on August 29, 2022. Association (NFPA) 101, Life Safety Code (LSC), E-004 – Develop EP Plan, Chapter 18, New Health Care Occupancies and 410 **Review and Update Annually** IAC 16.2. Compliance Date - 9/23/22 This one story facility constructed in 2018 was determined to be of Type V (111) construction and Immediate Intervention was fully sprinklered. The facility has a fire alarm The Executive Director has system with hard wire smoke detection in the updated the Emergency corridors, areas open to the corridors and in all Operations Plan for both locations resident rooms. The facility is fully protected by a - Nurse station and maintenance Type II ESS 150 kW Natural Gas generator. The office. Healthcare Facility is connected to an Assisted The Executive Director was Living Facility (Residential Board and Care educated by Facilities Occupancy) from which it is separated by a Fire Management Support on E004 Wall with a 2-hour Fire Resistance Rating. All Develop EP plan, review, and areas where the residents will have customary update annually. The facility must access were sprinklered. The facility has a develop and maintain an capacity of 60 and had a census of 54 at the time emergency preparedness plan that of this survey. must be reviewed and updated at least annually. Quality Review completed on 09/08/22 The Executive Director will audit the Emergency preparedness communication 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants. E-013 - Development of EP policies and procedures Compliance Date – 9/23/22

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 43 of 80

	T OF HEALTH AND HU				FORM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	•			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED
		155495	B. WING	_	08/29/2022
NAME OF F	PROVIDER OR SUPPLIE	R	STREET.	ADDRESS, CITY, STATE, ZIP COD	
		-		SHELDON STREET	
PADDOC	CK SPRINGS		WARS	AW, IN 46582	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				Immediate Intervention	
				The Executive Director has	
				updated the Policies and	
				Procedures to include emerge	ncy
				services in the Emergency	
				Operations Plan for both locati	ons
				<ul> <li>Nurse station and maintenar</li> </ul>	nce
				office.	
				The Executive Director was	
				educated by Facilities	
				Management Support on E013	3
				Development of EP Policies ar	nd
				Procedures. The LTC facility m	
				develop and implement emerg	-
				preparedness and polices and	
				procedures, based on the	
				emergency plan set forth in	
				paragraph (a) of this section, ri	
				assessment at paragraph (a)(1	I) of
				this section, and the	
				communication plan at paragra	
				(c) of this section. The policies	
				and procedures must be review	wed
				and updated at least annually.	
				The Executive Director will aud	dit
				the Emergency preparedness	
				communication 1 X per month	X
				12 Months.	
				Results of this audit will be	
				presented by Executive Director	
			1	the QAPI committee for further	-

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

recommendations and continue until the Quality Assurance Team

compliance has been achieved. This deficient practice had the potential to affect all occupants.

determines substantial

E-029 - Development of **Communication Plan** 

Page 44 of 80

	OF HEALTH AND HUN MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	ľ	JILDING	ONSTRUCTION 02	(X3) DATE COMPL 08/29/	SURVEY ETED
	ROVIDER OR SUPPLIER			2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582		
(X4) ID PREFIX TAG	SUMMARY (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 APPROPRIAT DEFICIENCY)  Compliance Date — 9/23/22  Immediate Intervention The Executive Director has removed out date policies and updated the Emergency Operations Plan located at the Nurse station. The Executive Director was educated by Facilities Management Support on E029 Develop EP plan, review, and update annually. The facility meter develop and maintain an emergency preparedness plan must be reviewed and updated least annually. The Executive Director will aud the Emergency preparedness communication 1 X per month 12 Months. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continual until the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice had the potential to affect all occupants  E-031 — Emergency Officials contact Information Compliance Date — 9/23/22	oust that dat dit X or to e am	(X5) COMPLETION DATE
					1		

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

Event ID:

NVXJ21

Facility ID: 000491

**Immediate Intervention** The Executive Director has updated the Emergency

Operations Plan to include contact information for ombudsman

If continuation sheet

Page 45 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	02	COMPL	ETED
		155495	B. WIN	G		08/29/	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		2695 S	HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					located at all locations.		
					The Executive Director was		
					educated by Facilities		
					Management Support E031, Emergency Officials Contact		
					Information to include Federal		
					State, Tribal, Regional, and lo		
					emergency preparedness staf		
					The State Licensing and		
					Certification Agency. The Office	ce of	
					the State Long-Term Care		
					Ombudsman, Other sources of	f	
					assistance.		
					The Executive Director will au		
					the Emergency preparedness		
					officials contact information 1	X	
					per month X 12 Months.		
					Results of this audit will be presented by Executive Direct	or to	
					the QAPI committee for furthe		
					recommendations and continu		
					until the Quality Assurance Te		
					determines substantial		
					compliance has been achieve	d.	
					This deficient practice had the		
					potential to affect all occupant	s.	
					E 026 Training and Tarting		
					E-036 – Training and Testing		
					Compliance Date – 9/23/22		
					Immediate Intervention		
					The Executive Director has		
					updated the Training and Test	ing	
					plan for the Emergency		
					Operations Plan located at the	)	
					Nurse station.		
					The Executive Director was		
					educated by Facilities	2	
					Management Support on E036  Develop EP plan, review, and		
	ī				T DEVELOU DE DIAN TEVIEW AND		•

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 46 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 08/29/2022
	ROVIDER OR SUPPLIER K SPRINGS	?	2695 S	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET AW, IN 46582	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE
				update annually to include and Testing (483.73(d). The must develop and maintain emergency preparedness produced and update least annually. The Executive Director will the Emergency preparednest training and testing 1 X per X 12 Months.  Results of this audit will be presented by Executive Director further QAPI committee for further ecommendations and confuntil the Quality Assurance determines substantial compliance has been achied. This deficient practice had potential to affect all occupate. E-039 -Testing Requireme Compliance Date — 10/5/22 Immediate Intervention  The Executive Director has completed the facilities-base tabletop exercise and has scheduled a community-base exercise to be completed be 10/5/22. The Executive Director was educated by Facilities Management Support on E Testing Requirements 483. The facility must conduct exercises to test the emerginal plan at least twice per year including unannounced statusing the emergency proced the Executive Director will	e facility an plan that ated at audit audit ass month  ector to ther tinue Team  eved. the ants.  ents 2  6  6  6  7  7  7  8  8  8  9  7  8  8  8  8  8  8  8  8  8  8  8  8

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

Event ID:

NVXJ21

Facility ID: 000491

1 If continuation sheet

Page 47 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS  STREET ADDRESS, CITY, STATE, 2IP COD 28:95 SHELDON STREET WARSAW, IN 46:582  WASAW, IN 46:582  URSAW, IN 46:582  ID PREFIX TAG  REGULATORY OR I SCUDINTIFYING INFORMATION  IT AG  REGULATORY OR I SCUDINTIFYING INFORMATION  IT AG  REGULATORY OR I SCUDINTIFYING INFORMATION  IT AG  IF Emergency preparedness Results of this audit will be presented by Executive Director to the QAP Locamittee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.  E-041-LTC Emergency Power Compliance Date - 9/23/22  Immediate Intervention  The Director of Plant Operations conducted a monthly load for the generator  The Executive Director and Director of Plant Operations was educated by the Facilities  Management Support on E041  LTC Emergency Power. The LTC Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110.  The Executive Director will audit the Emergency power system inspection, testing, and requirements found in the NFPA 110.  The Executive Director will audit the Emergency preparedness LTC emergency power 1X per month X 12 Months.  Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER  PADDOCK SPRINGS   (X4) ID  PREFIX  (RACH DEFICIENCY MUST BE PRECEDED BY PULL  TAG  REGULATORY OR I SC IDENTIFYING INFORMATION  TAG  REGULATORY OR I SC IDENTIFYING INFORMATION  TAG  REGULATORY OR I SC IDENTIFYING INFORMATION  TAG  TO THE COMPLETION  PROVIDERS TAN OF CORRECTION  PROVIDERS TO A CORPETANCY OF CREATION  TAG  TAG  PROVIDERS TO A CORPETANCY OF CREATION  TAG  PROVIDERS TO A	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1		02		
NAME OF PROVIDER OF SETPILER PADDOCK SPRINGS  (X4) ID PREFIX TAG    D PREFIX   GEARD DEFICIENCY MUST BE PRECEDED BY FULL TAG			155495	B. WI	NG		08/29/	/2022
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  THE EMERGENCY PROPERTIES AND A PROPERTIES COMMERCED TO THE PROPERTIES AND A PROPERTIES TO THE PROPERTIES TO T			R		2695 S	HELDON STREET		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  THE EMERGENCY PROPERTIES AND A PROPERTIES COMMERCED TO THE PROPERTIES AND A PROPERTIES TO THE PROPERTIES TO T	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
the Emergency preparachess testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.  E-041-LTC Emergency Power Compliance Date - 9/23/22  Immediate Intervention The Director of Plant Operations conducted a monthly load for the generator The Executive Director and Director of Plant Operations was educated by the Facilities Management Support on E041 LTC Emergency Power. The LTC Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110. The Executive Director will audit the Emergency power 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team				PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice had the potential to affect all occupants.  E-041-LTC Emergency Power Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operations conducted a monthly load for the generator The Executive Director and Director of Plant Operations was educated by the Facilities Management Support on E041 LTC Emergency Power. The LTC Facility must implement the emergency power system inspection, testing, and requirements found in the NFPA 110. The Executive Director will audit the Emergency preparedness LTC emergency power 1 X per month X 12 Months. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team	TAG				TAG	DEFICIENCY)	IE	DATE
determines substantial	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	the Emergency preparedness testing requirements 1 X per month X 12 Months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved. This deficient practice had the potential to affect all occupant.  E-041- LTC Emergency Power Compliance Date - 9/23/22  Immediate Intervention The Director of Plant Operation conducted a monthly load for the generator. The Executive Director and Director of Plant Operations were ducated by the Facilities. Management Support on E04-LTC Emergency Power. The Lacility must implement the emergency power system inspection, testing, and requirements found in the NFF 110. The Executive Director will audite Emergency power 1 X per mon 12 Months. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Testing in the presented by Executive Director the Incommendations and continuuntil the Quality Assurance Testing in the Incommendation in the Incommendat	r ile ream d. f. s. er ins the dit LTC onth X for to r ile	DATE

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 48 of 80

09/22/2022 PRINTED:

	Γ OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII TIDI E	E CONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPI	
AND PLAN	OF CORRECTION	155495	B. WING	02	08/29	
		155495	B. WING		06/29	12022
NAME OF I	PROVIDER OR SUPPLIE	D.	STRE	ET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	X.	2695	5 SHELDON STREET		
PADDO	CK SPRINGS		WAF	RSAW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		ΔΤΕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	/ ( L	DATE
				compliance has been achieve	ed.	
				This deficient practice had the	е	
				potential to affect all occupar		
				'		
				K-131 – Multiple Occupanci	es	
				Compliance Date – 9/23/22		
				0,20,22		
				Immediate Intervention		
				The Director of Plant Operation	ons	
				has acquired the appropriate	0110	
				documentation showing the		
				window in the 90 – minute fire	2	
				rated door was provided with		
				rated door was provided with	a III C	
				The Director of Plant operation	nnc.	
				was educated by the Executi		
				Director on K131 Multiple	VC	
				Occupancies, LSC 8.3.3 Sec	tion	
				<b>■</b>		
				8.3.3.12 states new fire prote		
				- rated glazing shall be mark		
				accordance with Table 8.3.3.	12	
				and Table 8.3.4.2, and such	,	
				marking shall be permanently	′	
				affixed.	ono	
				The Director of Plant Operation		
				will audit the deficient windov		
				located in the 90-minute rate	J	
				door for appropriate glazing	-1	
				material 1 X per week X 6 we	eks.	
				Results of this audit will be		
				presented by Executive Direct		
				the QAPI committee for further		
				recommendations and contin		
				until the Quality Assurance T	eam	
				determines substantial		
				compliance has been achieve	ed.	1

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

Event ID:

NVXJ21

Facility ID: 000491

This deficient practice had the potential to affect 20 residents in one smoke compartment.

> If continuation sheet Page 49 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022		
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
PADDOC	K SPRINGS		2695 SHELDON STREET WARSAW, IN 46582					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	L LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
					K-211 – Means of Egress Compliance Date – 9/19/22			
					Immediate Intervention The Director of Plant Operation removed food serving equipmed two soiled linen carts, boxes, furniture stored in the Service corridor. The Director of Plant Operation was educated by the Executive Director on K211 – Means of Egress – General. Aisles, passageways, corridor's, exitted discharges, exitted locations, and access are in accordance with Chapter 7 The Director of Plant Operation will audit the Service Hall corrifor obstructions impeding the of egress 1 X per week X 6 we Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice would a staff using the Service Hall executive Director of Plant has instantial compliance Date – 9/19/22  Immediate Intervention The Director of Plant has instantial componed in 15 seconds by pusitive discounts of the process of the	ent, and Hall  hall  ons d  ons idor path eeks.  tor to er ue eam d. affect it.		
					on the doors	-		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 50 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2022		
	ROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(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		
	ALGOLIATORI OF			The Director of Plant Operatio was educated by the Executiv Director on K22, Means of Egi LSC 7.2.1.6.1 (3)(4) states a readily visible, durable sign in letters not less than 1 in. high not less than 1/8 in stroke wid on a contrasting background t reads as follows shall be locat on the door leaf adjacent to th release device in the direction egress. "PUSH UNTIL ALARMSOUNDS. DOOR CAN OPENED IN 15 SECONDS" The Director of Plant Operatio will audit the deficient door on 300 hall for appropreait signag X per week X 6 weeks X 2 more Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice could as 15 residents in the 300 -hall K-324 – Cooking Facilities Compliance Date – 9/19/22  Immediate Intervention The Director of Plant Operation and Kitchen staff have clean the kitchen hood removing the oily sludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood quarterly cleanings of the hood	eress, and th hat eed ee of N BE ons the ge 1 onths. or to r lie eam d. ffect		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

The Director of Plant Operations

Page 51 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED		
		155495	B. W	NG		08/29/	2022	
			CTREET ADDRESS CITY STATE ZIR COD					
NAME OF P	PROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP COD					
DADDOG	NY OBBINIOS		2695 SHELDON STREET					
PADDOC	CK SPRINGS			WARSA	AW, IN 46582			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWIDEDIS DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IE	DATE		
					was educated by the Executiv			
					Director on K324, Cooking	•		
					equipment is protected in			
					accordance with NFPA 96,			
					Standard for Ventilation Control	ol		
					and Fire Protection of Comme			
					cooking Operations.	Join		
					The Director of Plant Operation	ne		
					will audit the kitchen hood for	113		
					cleanliness 1 X per day X 4we	ake		
					X 1 months.	CNO		
					Results of this audit will be			
					presented by Executive Direct	or to		
					the QAPI committee for furthe			
					recommendations and continu			
					until the Quality Assurance Te	am		
					determines substantial	.1		
					compliance has been achieved			
					This deficient practice could at			
					at least 30 residents in the din	ing		
					room and kitchen staff.			
					K 244 Fine Alemas Occateres			
					K-341 – Fire Alarm System –			
					Installation			
					Compliance Date – 9/23/22			
					Immediate Intervention			
					The Director of Plant Operatio			
					contacted contractor to move	ше		
					smoke detector located in the			
					breakroom with a minimum of			
					36in. from the air supply.			
					The Director of Plant Operatio			
					was educated by the Executiv	е		
					Director on K341, Fire Alarm			
					System – installation. A fire ala			
					system is installed with systen			
					and components approved for			
					purpose in accordance with N	FPA		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

70, National Electrical Code, and

Page 52 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2022			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
	K SPRINGS		2695 SHELDON STREET WARSAW, IN 46582				
(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			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				NFPA 72, National Fire Alarm Code.			
				The Director of Plant Operation will audit the smoke detector			
				the breakroom for location 1.2			
				week X 4weeks X 1 months.			
				Results of this audit will be			
				presented by Executive Direct			
				the QAPI committee for further			
				recommendations and continu			
				until the Quality Assurance To determines substantial	eam		
				compliance has been achieve	ed.		
				This deficient practice could a			
				staff in the breakroom.			
				K-351 – Sprinkler System -			
				Installation.  Compliance Date – 9/23/22			
				Immediate Intervention			
				The Director of Plant Operation has contacted Contractor to h			
				the sprinkler head moved and			
				extended.			
				The Director of Plant Operation	ons		
				was educated by the Executiv	/e		
				Director on K351, Sprinkler			
				System – Installation. Building			
				are to be protected throughout an approved automatic sprink	- I		
				system in accordance with NI			
				13, Standard for the installation			
				sprinkler systems.			
				The Director of Plant Operation			
				will audit the deficient sprinkle			
				head located in dining room for			
				proper installation 1 X per we 4weeks X 1 months.	ек х		
				Results of this audit will be			

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 53 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED		
		155495	B. WING			08/29/2022		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	ER			HELDON STREET			
PADDOC	CK SPRINGS				AW, IN 46582			
(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			
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
					presented by Executive Direct			
					the QAPI committee for furthe			
					recommendations and continu			
					until the Quality Assurance Te determines substantial	am		
					compliance has been achieve	d		
					This deficient practice could a			
					all residents.			
					K-353 – Sprinkler System –			
					Maintenance and Testing			
					Compliance Date – 9/23/22			
					Immediate Intervention			
					The Director of Plant Operation	ns		
					has contacted contractor to			
					replace the deficient gauge or	ı the		
					sprinkler system.			
					The Director of Plant Operation			
					was educated by the Executiv	е		
					Director on K353, Sprinkler			
					System – Maintenance and			
					Testing Automatic sprinkler ar			
					standpipe systems are inspected tested and maintained in	ieu		
					accordance with NFPA 25.			
					The Director of Plant Operation	ons		
					will audit the sprinkler gauge f			
					proper inspection and date 1.2			
					week X 4weeks X 1 months.			
					Results of this audit will be			
					presented by Executive Direct	or to		
					the QAPI committee for furthe			
					recommendations and continu			
					until the Quality Assurance Te	am		
					determines substantial			
					compliance has been achieve			
					This deficient practice could a			
					all residents, staff, and visitors	; III		

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 54 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 08/29/2022	
	ROVIDER OR SUPPLIE	R	2695 S	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET AW, IN 46582	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				K-363 – Corridor – Doors Compliance Date – 9/19/22	
				Immediate Intervention The Director of Plant Operation removed the door wedge proper the Therapy door open. The Director of Plant Operation was educated by the Executive Director on K363, 18.3.6.3 The is no impediment to the closing the doors. The Director of Plant Operation will audit Therapy for wedges the could prop door open 1 X per vox X 4weeks X 1 months. Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuountil the Quality Assurance Tead determines substantial compliance has been achieved This deficient practice could afform the form of the Compliance of the C	pring  ns element g of ns hat veek  or to element am  I. fect
				Immediate Intervention The Director of Plant Operation has made repairs to the two penetrations located 100 hall smoke barriers. The Director of Plant Operation was educated by the Executive Director on K363, NFPA 101,	าร

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 55 of 80

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 08/29/2022			
NAME OF	PROVIDER OR SUPPLIEI	<b>R</b>		ADDRESS, CITY, STATE, ZIP COD SHELDON STREET	•			
PADDO	CK SPRINGS			SAW, IN 46582				
(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		
IAU	REGULATORY OF	A LSC IDENTIFYING INFORMATION	IAG	2012 edition Smoke barriers are constructed to provide at least 1-hour fire resistance rating constructed in accordance with 8.5  The Director of Plant Operation will audit smoke barrier located 100 for penetrations 1 X per vice X 4weeks X 1 months.  Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuatil the Quality Assurance To determines substantial compliance has been achieved This deficient practice could a 20 residents in two smoke compartments.  K-379 – Smoke Barrier Door Glazing  Compliance Date – 9/23/22  Immediate Intervention  The Director of Plant Operation has acquired the appropriate documentation showing the window in 5 of 5 smoke barried doors with windows was proving with a fire rated – glazing mat The Director of Plant Operation was educated by the Executive Director on K379, Smoke Barrier doors shall be installed.	east I and Ith Insert one Ith	DATE		

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

Event ID:

NVXJ21

Facility ID: 000491

each cross-corridor swing or horizonal-sliding door protected by fire – rated glazing or by wired glass panels in approved frames.

If continuation sheet

Page 56 of 80

DEPARTMENT		FORM APPROVED				
	MEDICARE & MEDIC		<b>I</b>			B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPL	
		155495	B. WING		08/29/	2022
NAME OF P	ROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP COD		
PADDOC	K SPRINGS			SAW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	AIE	DATE
				18.3.7.9		
				The Director of Plant Operation	ons	
				will audit the 5 of 5 smoke ba	rrier	
				doors for fire rated glazing 1	X per	
				week X 4weeks X 1 months.		
				Results of this audit will be		
				presented by Executive Direc	tor to	
				the QAPI committee for further	er	
				recommendations and continue		
				until the Quality Assurance Te	eam	
				determines substantial		
				compliance has been achieved.		
				This deficient practice could a	affect	
				all residents.		
				K-712 – Fire Drills		
				Compliance Date – 9/23/22		
				Immediate Intervention		
				The Director of Plant Operation	ons	
				has conducted a fire drill for e	each	
				shift		
				The Director of Plant Operation		
				was educated by the Executiv	/e	
				Director on K712, Fire drills,		
				NFPA 101, Fire Drills are held		
				expected and unexpected tim		
				under varying conditions, at le	east	
				quarterly on each shift.		
				The Executive Director will		
			1	audit/review each fire drill with	n the I	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Director of Plant Operations 1 X

presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team

compliance has been achieved.

Results of this audit will be

determines substantial

Month X 3 Months

Page 57 of 80

DEPARTMENT	FORM APPROVED OMB NO. 0938-039					
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER 155495	A. BUILDING B. WING	02	COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIE	R	2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
IAU	REGULATORY	R ESC IDENTIFITING INFORMATION	IAU	This deficient practice could af all staff and residents.  K-754 – Soiled Linen and Trast Containers  Compliance Date – 9/23/22  Immediate Intervention  The Director of Plant Operation has removed the two 30-gallor soiled linen carts that are side side in the service hall corridor The Director of Plant Operation was educated by the Executive Director on K754, Soiled Linen and Trash Containers, soiled li or trash collection receptacles shall not exceed 32 gallons in capacity.  The Director of Plant Operation will audit the service hall for the storage of soiled linen carts assuring this does not exceed more than 32 gallons within 64 feet 1 X per day X 4weeks X 1 months.  Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuents.	fect sh  ns ns by : ns e inen ns e	
				recommendations and continue until the Quality Assurance Tea determines substantial		

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

Event ID: NVXJ21

Facility ID: 000491

If continuation sheet

compliance has been achieved. This deficient practice could affect

K-918 - Electrical Systems -**Essential Electrical System** Maintenance and Testing. Compliance Date – 9/22/22

all staff in service hall.

Page 58 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

EE: TENDIOI	THE CONTENTS	IID SERVICES			0.11	2::0:0:0	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED		
		155495	B. WING		08/29/		
					20,20,		
NAME OF I	PROVIDER OR SUPPLIEF	1		ADDRESS, CITY, STATE, ZIP COD HELDON STREET			
PADDOC	CK SPRINGS			AW, IN 46582			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PD 0417877810		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
				Immediate Intervention The Director of Plant Operation has exercised the generator is for a minimum of 30 minutes a documented. The Director of Plant Operation was educated by the Executive Director on K918, NFPA 101 Electrical System Essential Electrical System Maintenance and Testing. Generator sets a inspected weekly, exercised using load 30 minutes 12 times per in 20–40-day intervals, and exercised once every 36 monte for 4 continuous hours. The Executive Director will audit/review the monthly geneset exercise with Director of Poperations 1 X per Months X Months Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve This deficient practice could a all staff in service hall.	et and and ans e e re re nder year ths arator lant 6 cor to r ue am d.		
K 0131 SS=E Bldg. 02	Care Facilities Sections of health other occupancies	cies cies - Sections of Health care facilities classified as meet all of the following:					

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

more inpatients for purposes of housing,

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 59 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	î î			DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u> COMPI			LETED
		155495	B. W	B. WING 08/29/202			/2022
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
	OK CDDINGS		2695 SHELDON STREET WARSAW, IN 46582				
PADDOC	CK SPRINGS			WARSA	4VV, IIV 40302		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	treatment, or customary access.						
	o They are separated from areas of health						
	care occupancies	by					
	construction ha	aving a minimum two hour					
	fire resistance rati	ng in					
	accordance wi	th Chapter 8.					
	o The entire build	ding is protected throughout					
	by an approved, s	upervised					
	automatic sprir	nkler system in accordance					
	with Section 9.7.						
		it surgical departments are					
	•	ssified as an Ambulatory					
	Health Care Occu	pancy regardless of the					
	number of patients						
		482.41, 42 CFR 485.623					
		on and interview, the facility	K C	131	K-131 – Multiple Occupancies		09/23/2022
		f 1 90-minute fire rated			Compliance Date – 9/23/22		
	-	oors with a window met the					
		s for window glazing in			Immediate Intervention		
		SC 8.3.3. Section 8.3.3.12 states			The Director of Plant Operation	ns	
	_	rated glazing shall be marked			has acquired the appropriate		
		Table 8.3.3.12 and Table			documentation showing the		
		arking shall be permanently			window in the 90 – minute fire		
		zing in fire window assemblies,			rated door was provided with	a tire	
		ng fire window installations of			rated – glazing material.		
	_	er fire-rated glazing material,			The Director of Plant operatio		
		that has been tested to meet			was educated by the Executiv	e	
		ceptance of NFPA 257or			Director on K131 Multiple		
	_	rotection-rated glazing in fire			Occupancies, LSC 8.3.3 Sect		
		her than in existing fire-rated all be of a design that has			8.3.3.12 states new fire protect		
	•	9			<ul> <li>rated glazing shall be marked accordance with Table 8.3.3.1</li> </ul>		
		the conditions of acceptance				12	
	of NFPA252, ANSI/UL 10B, or 10C. This deficient practice could affect 20 residents in one smoke				and Table 8.3.4.2, and such		
	-	20 residents in one smoke			marking shall be permanently		
	compartment.				affixed.	no	
	Findings include:				The Director of Plant Operation will audit the deficient window		
	r manigs include:				located in the 90-minute rated		
	Dagad on abasement	on with the English				I	
	Based on observation	on with the racility			door for appropriate glazing		

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 60 of 80

					PRIN	TED:	09/22/2022	
OF HEALTH AND HU	MAN SERVICES				FORM APPROVED			
R MEDICARE & MEDIC	AID SERVICES				OM	OMB NO. 0938-039		
IT 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		
155495		B. W	ING		08/29/	2022		
NAME OF PROVIDER OR SUPPLIER  PADDOCK SPRINGS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				HELDON STREET				
SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION				(X5)	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMI	PLETION	
REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D.	ATE	
Maintenance Suppo	ort, and Maintenance Director			material 1 X per week X 6 wee	eks.			
on 08/29/22 at 12:4	0 p.m., the separation fire door			Results of this audit will be				
was a 90-minute ra	ted fire door with a window.			presented by Executive Director to				
The window lacked	l an identifier or marking, and it			the QAPI committee for further	r			
was unknown if the	window was provided with a			recommendations and continu	e			
	-			until the Quality Assurance Te	am			
				determines substantial				
	•							
				· •				
				· ·				
	EMEDICARE & MEDIC IT OF DEFICIENCIES OF CORRECTION  PROVIDER OR SUPPLIED OF SUMMARY (EACH DEFICIEN REGULATORY OF Maintenance Support on 08/29/22 at 12:4 was a 90-minute rather window lacked was unknown if the fire-rated glazing in the time of observa Support agreed the fire-rated glazing in	OF CORRECTION IDENTIFICATION NUMBER 155495 PROVIDER OR SUPPLIER	R MEDICARE & MEDICAID SERVICES  IT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X2) M OF CORRECTION IDENTIFICATION NUMBER A. BU 155495 B. W  ROVIDER OR SUPPLIER  CK SPRINGS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Maintenance Support, and Maintenance Director on 08/29/22 at 12:40 p.m., the separation fire door was a 90-minute rated fire door with a window. The window lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the window was not marked with a fire-rated glazing identifier and stated it was	RMEDICARE & MEDICAID SERVICES  IT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO. A. BUILDING B. WING  ROVIDER OR SUPPLIER  STREET A. 2695 S. WARSA  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Maintenance Support, and Maintenance Director on 08/29/22 at 12:40 p.m., the separation fire door was a 90-minute rated fire door with a window.  The window lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the window was not marked with a fire-rated glazing identifier and stated it was	MEDICARE & MEDICAID SERVICES  IT OF DEFICIENCIES OF CORRECTION  IDENTIFICATION NUMBER 155495  ROVIDER OR SUPPLIER  CK SPRINGS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Maintenance Support, and Maintenance Director on 08/29/22 at 12:40 p.m., the separation fire door was a 90-minute rated fire door with a window.  The window lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the window was not marked with a fire-rated glazing identifier and stated it was  X1) PROVIDERS PLAN OF CORRECTION (A. BUILDING D2  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  material 1 X per week X 6 wee Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continu until the Quality Assurance Tedetermines substantial compliance has been achieved. This deficient practice had the	TOF HEALTH AND HUMAN SERVICES  EMEDICARE & MEDICAID SERVICES  TO FORRECTION  TO SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  TO FORRECTION  TO FORME  TO FORME	TOF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155495  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Support, and Maintenance Director on 08/29/22 at 12:40 p.m., the separation fire door was a 90-minute rated fire door with a window. The window lacked an identifier or marking, and it was unknown if the window was provided with a fire-rated glazing material. Based on interview at the time of observation, the Facility Maintenance Support agreed the window was not marked with a fire-rated glazing identifier and stated it was  X2) MULTIPLE CONSTRUCTION X2) MULTIPLE CONSTRUCTION X2) MULTIPLE CONSTRUCTION X2) MULTIPLE CONSTRUCTION X3) DATE SURVE COMPLETED 09/22 MULTIPLE CONSTRUCTION X3) DATE SURVE COMPLETED 08/29/2022  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582  ID PROVIDERS PLANOF CORRECTION FACT CORRECTION FROWIDERS PLANOF CORRECTION COMPLETED 08/29/2022  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582   ID PROVIDERS PLANOF CORRECTION FACT CORRECTION FROWIDERS PLANOF CORRECTION COMPLETED 08/29/2022  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582  ID PROVIDERS PLANOF CORRECTION FROVIDERS PLANOF CORRECTION COMPLETED 08/29/2022  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582  ID PROVIDER OR SUPPLIER  FROVIDERS PLANOF CORRECTION FROVIDER OR SUPPLIER COMPLETED 08/29/2022  STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582   ID PROVIDER OR SUPPLIER  FROVIDER OR SUPPLIER  FROVIDER OR SUPPLIER  FROVIDER OR STREET ADRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582   TO SUPPLIED 155495  TO SUPPLIED 154	

This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.

3.1-19(b)

fire-rated glazing material.

K 0211 SS=E Bldg. 02 **NFPA 101** 

Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1

Based on observation and interview, the facility failed to ensure the means of egress in 1 of 6 corridors were continuously maintained free of obstructions. This deficient practice would affect staff using the Service Hall exit.

Findings include:

Based on observation with the Facility Maintenance Support and Maintenance Director on 08/29/22 at 12:42 p.m., the Service Hall was not

potential to affect 20 residents in one smoke compartment.

K 0211 K-211 – Means of Egress Compliance Date – 9/19/22

**Immediate Intervention** 

The Director of Plant Operations removed food serving equipment, two soiled linen carts, boxes, and furniture stored in the Service Hall corridor.

The Director of Plant Operations was educated by the Executive

> Page 61 of 80 If continuation sheet

09/19/2022

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 08/29/2022
	PROVIDER OR SUPPLIER CK SPRINGS		2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) BE COMPLETION PRIATE DATE
	to food serving equ boxes, and furniture on interview at the Facility Maintenand Director stated the removed from the h	viewed with the Administrator, ce Support, and Maintenance		Director on K211 – Means Egress – General. Aisles, passageways, corridor's, exdischarges, exit locations, a access are in accordance with Chapter 7  The Director of Plant Opera will audit the Service Hall of for obstructions impeding the fegress 1 X per week X 6 Results of this audit will be presented by Executive Dir the QAPI committee for further QAPI committee for fu	xit and vith ations orridor ne path weeks. ector to ther inue Team eved. d affect
K 0222 SS=E Bldg. 02	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special lockinical security not used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times.	d means of egress shall not a latch or a lock that if a tool or key from the susing one of the following rangements:  SOR SECURITY THREAT  king arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ited by staff at all times; or emeans available to the			

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES  AN OF CORRECTION	IDENTIFICATION NUMBER  155495		UILDING	02	COMPL 08/29/	ETED
NAME	OF PROVIDER OR SUPPLIE	₹	STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET				
PADI	OCK SPRINGS			WARSA	W, IN 46582		
(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
IAG	19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the Clinical or Sec are being met. In electrical locks the release upon loss building is protected detection system at an attended loc space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servir contents in buildir an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTE LOCKING ARRAI Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOB LOCKING ARRAI Elevator lobby ex accordance with 18.2.2.2.1	S LOCKING S cking arrangements for the se patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to so fo power to the device; the ed by a supervised er system and the locked drop by a complete smoke (or is constantly monitored cation within the locked the sprinkler and detection aged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING S delayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system.  2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall  2.4 BY EXIT ACCESS		IAU			DATE

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 63 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG <u>02</u>	(X3) DATE SURVEY  COMPLETED  08/29/2022	COMPLETED	
PADDOC	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION SI  CROSS-REFERENCED TO THE A	HOULD BE COMPLETION	J
TAG	throughout by an a automatic fire dete approved, supervisystem.  18.2.2.2.4, 19.2.2. Based on observation failed to ensure the 7 delayed egress locall residents, staff, a (4) states a readily ynot less than 1 in. (2 1/8 in. (3.2mm) in sbackground that read on the door leaf adjute direction of egres SOUNDS. DOOR (SECONDS".  This deficient pract the 300-hall.  Findings include:  Based on observation Maintenance Support on 08/29/22 at 1:17 provided with a delay the proper signage in opened in 15 second Based on interview with the Facility Maintenance Direct sign must have fell.  This finding was residued:	approved, supervised action system and an sed automatic sprinkler  2.4  an and interview, the facility means of egress through 1 of eks was readily accessible for and visitors. LSC 7.2.1.6.1.(3) visible, durable sign in letters 25mm) high and not less than stroke width on a contrasting ds as follows shall be located acent to the release device in ess: "PUSH UNTIL ALARM CAN BE OPENED IN 15  ice could affect 15 residents in  ons with the Facility art and Maintenance Director p.m., the 300-hall exit door was ayed egress lock but lacked andicating the door could be dis by pushing on the door, at the time of observation, aintenance Support and or stated the delayed egress off the door.  viewed with the Administrator, we Support, and Maintenance	K 0222	K-222 – Egress Doors Compliance Date – 9/2  Immediate Intervention The Director of Plant has ignage indicating that door located on 300 has opened in 15 seconds on the doors. The Director of Plant Cowas educated by the Educated by Eventual LSC 7.2.1.6.1 (3)(4) streadily visible, durable letters not less than 1/8 in strong a contrasting backgreads as follows shall on the door leaf adjaced release device in the degress. "PUSH UNTIL ALARMSOUNDS. DOODENED IN 15 SECOTHE Director of Plant Cowill audit the deficient of 300 hall for appropreasing X per week X 6 weeks Results of this audit with presented by Executive the QAPI committee for recommendations and until the Quality Assurated by Executive the Qapital Compliance has been a This deficient practice.	on  as installed the exit all could be by pushing  Operations executive as of Egress, ates a sign in in. high and oke width pround that be located ent to the lirection of  OR CAN BE INDS" Operations door on the it signage 1	2

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 64 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155495	B. W	ING		08/29/	2022
	PROVIDER OR SUPPLIER		•	2695 SI	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
					15 residents in the 300 -hall		
K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipmer accordance with N Ventilation Contro Commercial Cook *residential cook appliances such a toasters) are used cooking in accorda 19.3.2.5.2. *cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2. *cooking facilities with 30 or fewer portions under 1 Cooking facilities 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 interview, the facility kitchen exhaust systems inspected in accorda 11.4 states the entire inspected for grease	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: king equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, I so open to the corridor in ents with 30 or fewer ith the conditions under 1.5.3, or is in smoke compartments attents comply with 18.3.2.5.4, 19.3.2.5.4. For the conditions under 1.5.3 are not required to be reduced according to 3 are not required to be reduced according to 3 are not required to be reduced and 18.3.2.5.4, 19.3.2.5.1 and 19.3.2.5.1	K 0	324	K-324 – Cooking Facilities Compliance Date – 9/19/22  Immediate Intervention The Director of Plant Operatio and Kitchen staff have clean the		09/19/2022
	acceptable to the au and in accordance v systems serving hig such as 24-hour coc cooking requires qu	nd certified person(s) thority having jurisdiction with Table 11.4 which states h-volume cooking operations, oking, charbroiling, or wok arterly inspections. Section inspection, if the exhaust			kitchen hood removing the oily sludge. The Hood Cleaning Contractor was scheduled for quarterly cleanings of the hood system.  The Director of Plant Operatio was educated by the Executive	d ns	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 65 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155495	A. BUILDING B. WING	<u>02</u>	COMPLETED 08/29/2022
	PROVIDER OR SUPPLIER		2695	T ADDRESS, CITY, STATE, ZIP COD SHELDON STREET SAW, IN 46582	
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5)  ILE  RIATE  COMPLETION  DATE
	from grease laden v portions of the exha by a properly trained person(s) acceptable jurisdiction. Hoods ducts, and other app to remove combusti surfaces becoming by grease or oily sludge could affect at least room and kitchen st.  Based on observation Maintenance Suppo on 08/29/22 at 12:40 system there was a cabove the grill were oily sludge. Based on the hood system is it grease build up sem Based on interview Facility Maintenance uses the charbroil gi and hot dogs and the grease. The Maintenhood is only inspect twice a year.  This finding was reversely Facility Maintenance Director during the state of the hood system is and hot dogs and the grease. The Maintenhood is only inspect twice a year.	on with the Facility ort and Maintenance Director 0 p.m., under the kitchen hood charbroil grill and the vents completely covered with an on records review at 10:00 a.m., nspected and cleaned for ciannually instead of quarterly. at the time of observation, the see Support stated the facility ill daily to cook hamburgers ere was heavy build up with nance Director agreed the sted for grease and cleaned wiewed with the Administrator, see Support, and Maintenance		Director on K324, Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Corand Fire Protection of Commooking Operations.  The Director of Plant Opera will audit the kitchen hood for cleanliness 1 X per day X 4 X 1 months.  Results of this audit will be presented by Executive Director the QAPI committee for furth recommendations and continuntil the Quality Assurance determines substantial compliance has been achied. This deficient practice could at least 30 residents in the corom and kitchen staff.	nercial tions or weeks ector to ner nue Team ved. affect
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System Fire Alarm System				

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 66 of 80

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection is also in appliance circuit p supervising station Fire alarm system transmission path integrity.  18.3.4.1, 19.3.4.1 Based on observation failed to ensure 1 or installed in accordance requires a fire alarm and maintained in a National Electrical Fire Alarm Code. It is spaces served by air shall not be located operation of the detector on 08/29/22 at 1:14 there was a smoke of where air flow wouthe detector. The deform the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deform the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deform the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deform the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deform the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deformed the vent. Based observation, the Farand Maintenance Deformed the control of the detector. The deformed the vent. Based observation, the Farand Maintenance Deformed the control of the	9.6, 9.6.1.8 on and interview, the facility for a fire alarm systems was nee with 18.3.4.1. LSC 9.6.1.3 on system to be installed, tested, eccordance with NFPA 70, Code and NFPA 72, National NFPA 72, 17.7.4.1 requires in thandling systems, detectors where air flow prevents ectors. This deficient practice the break room.  on with the Facility out and Maintenance Director p.m., in the staff break room detector next to an air supply lid prevent proper operation of tector was about 24 inches d on interview at the time of facility Maintenance Support irector agreed the smoke direct airflow from air supply	K 0341	K-341 – Fire Alarm System – Installation Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operation contacted contractor to move smoke detector located in the breakroom with a minimum of 36in. from the air supply. The Director of Plant Operation was educated by the Executive Director on K341, Fire Alarm System – installation. A fire all system is installed with system and components approved for purpose in accordance with N 70, National Electrical Code, NFPA 72, National Fire Alarm Code. The Director of Plant Operation will audit the smoke detector if the breakroom for location 1 2 week X 4weeks X 1 months. Results of this audit will be	ons the ons ee arm ons r the FPA and ons n	

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 67 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU		SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BI	JILDING	02	COMPL	ETED.
		155495	B. WI	NG		08/29/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	Ł.			HELDON STREET		
PADDOC	CK SPRINGS				AW, IN 46582		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	l	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	This finding was ro	id with the Administrator			presented by Executive Director		
		eviewed with the Administrator, ce Support, and Maintenance			the QAPI committee for further		
	Director during the				recommendations and continu- until the Quality Assurance Te		
	birector during the exit conference.				determines substantial	anı	
	3.1-19(b)				compliance has been achieved	4	
	3.1 17(0)				This deficient practice could af		
	1				staff in the breakroom.	ieci	
	1				Stair in the Steam com.		
K 0351	NFPA 101					1	·
SS=E	Sprinkler System -	- Installation				1	
Bldg. 02	Spinkler System -	Installation				1	
	2012 NEW					1	
	-	e protected throughout by				1	
		matic sprinkler system in				1	
		NFPA 13, Standard for the				1	
	Installation of Spri	_				ļ	
	• •	onstruction, alternative				1	
		res are permitted to be				1	
		rinkler protection in specific				1	
		e and local regulations				1	
	prohibit sprinklers.					1	
	l ' '	onse or listed residential				1	
		ed throughout smoke				1	
		th patient sleeping rooms.				1	
		klers are not required in patient sleeping rooms					
	l	the closet does not exceed				ļ	
		id sprinkler coverage covers				ļ	
		it as required by NFPA 13,				1	
		allation of Sprinkler				1	
	Systems.	nation of opinion.			1	1	
	I *	, 18.3.5.5, 18.3.5.6, 9.7,				1	
	9.7.1.1(1), 18.3.5.					1	
	` '	on and interview, the facility	K 0.	351	K-351 – Sprinkler System -	ļ	09/23/2022
		spray pattern for 1 of 20			Installation.	1	05,25,252
		he dining/community area were			Compliance Date – 9/23/22	1	
	_	ecordance with 18.3.5.1. NFPA				1	
	13, 2010 edition, Se	ection 8.5.5.1 states sprinklers			Immediate Intervention	1	
	shall be located so a	as to minimize obstructions to			The Director of Plant Operation	ns	

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 68 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY  COMPLETED  08/29/2022	
	PROVIDER OR SUPPLIER CK SPRINGS		2695 9	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET SAW, IN 46582	
(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
	discharge as defined additional sprinkler adequate coverage of and 8.5.5.3 do not pronocontinuous obstation 18 inches below the horizontal plane mosprinkler deflector the from fully developic could affect all resident of the findings include:  Based on observation Maintenance Support on 08/29/22 at 12:3 area by the parlor affrom a ceiling light, the spray pattern of interview at the time Maintenance Support of the sprinkler would measurement between This finding was refacility Maintenance Director during the 3.1-19(b)	It in 8.5.5.2 and 8.5.5.3 or shall be provided to ensure of the hazard. Sections 8.5.5.2 permit continuous or ructions less than or equal to a sprinkler deflector or in a per than 18 inches below the hat prevent the spray patterning. This deficient practice dents.  On with the Facility part, and Maintenance Director 1 p.m., in the dining/community sprinkler head was two inches. This condition would obstruct the sprinkler. Based on the of observation, the Facility part agreed the spray pattern of the obstructed and provide the ten the sprinkler and light.  Wiewed with the Administrator, the Support, and Maintenance		has contacted Contractor to he the sprinkler head moved and extended.  The Director of Plant Operation was educated by the Executive Director on K351, Sprinkler System – Installation. Building are to be protected throughout an approved automatic sprinkles system in accordance with NI 13, Standard for the installation sprinkler systems.  The Director of Plant Operation will audit the deficient sprinkle head located in dining room for proper installation 1 X per well 4weeks X 1 months.  Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuitil the Quality Assurance To determines substantial compliance has been achieved This deficient practice could a all residents.	nave d ons ve gs ut by kler FPA on of ons er or ek X  ctor to er ue eam
K 0353 SS=C Bldg. 02	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system	- Maintenance and Testing - Maintenance and Testing - Maintenance and Testing - And Standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, Iting are maintained in a			

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 69 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION	IDE	ENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLETED				
	15	55495	B. WI	NG		08/29/2022	
NAME OF PROVIDER OR SUP	PLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID SUMM	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDENCE NEARLOS CORRECTION		(X5)
PREFIX (EACH DEF	CIENCY N	MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG REGULATO	Y OR LSC	C IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		eadily available. stem last checked					
b) Who prov	ded sys	stem test					
c) Water sys	tem sup	oply source					
coverage for automatic spin 9.7.5, 9.7.7, 9 Based on obse failed to ensure were replaced tested every 5 calibrated gauge Inspection, Tell Water-Based Fedition, Section replaced every comparison with accurate to with the recalibrated could affect all facility.  Findings incluse Based on obse Maintenance Son 08/29/22 at systems with each than five years recalibration disprinkler systet time of the obsession of th	any non-nkler sy. 7.8, and vation and 1 of 8 species by the end of the protein of		K 02	353	K-353 – Sprinkler System – Maintenance and Testing Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operation has contacted contractor to replace the deficient gauge on sprinkler system. The Director of Plant Operation was educated by the Executive Director on K353, Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspect tested and maintained in accordance with NFPA 25. The Director of Plant Operation will audit the sprinkler gauge for proper inspection and date 1.2 week X 4weeks X 1 months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuantil the Quality Assurance Tedetermines substantial compliance has been achieved.	the  ns e  d ded  ns or (per  or to r e am	09/23/2022

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 70 of 80

ENTERSTOR	R MEDICARE & MEDIC	AID SERVICES			ONIB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED	
		155495	B. WING		08/29/2022	
	PROVIDER OR SUPPLIEF	2	2695 S	ADDRESS, CITY, STATE, ZIP COD HELDON STREET AW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	viewed with the Administrator, ce Support, and Maintenance exit conference.		all residents, staff, and visitors the facility.	in	
	3.1 15(0)					
K 0363	NFPA 101					
SS=E	Corridor - Doors					
Bldg. 02		corridor openings shall be				
Diag. 02		ist the passage of smoke.				
		d doors to rooms containing				
		bustible materials have				
		positive latching hardware.				
		prohibited by CMS				
		requirements do not apply				
	_	s that do not contain				
	flammable or com					
		en bottom of door and floor				
	-	ceeding 1 inch. Powered				
		with 7.2.1.9 are permissible				
	1 '	device capable of keeping				
		hen a force of 5 lbf is				
	applied.	liment to the closing of the				
	· ·	liment to the closing of the				
		devices that release when				
	· ·	d or pulled are permitted.				
	•	ve plates of unlimited height				
	are permitted. Dut	_				
	18.3.6.3.6 are per	millea.				
	10 2 6 2 42 055	Dorto 402 449 460 492				
		Parts 403, 418, 460, 482,				
	483, and 485	C dotails of doors such as				
		(S details of doors such as				
		ngs, automatic closing				
	devices, etc.		17.00.60	K 000   0 mid   5	00/10/2022	
		on and interview, the facility	K 0363	K-363 – Corridor – Doors	09/19/2022	
		f 2 therapy gym corridor doors		Compliance Date – 9/19/22		
	•	a means suitable for keeping		1		
		d no impediment to closing,		Immediate Intervention		
	latching and would	resist the passage of smoke.		The Director of Plant Operation	ıs	

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet

Page 71 of 80

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SUR'  COMPLETE  08/29/202	D
	PROVIDER OR SUPPLIE	R	2695 S	ADDRESS, CITY, STATE, ZIP COD SHELDON STREET AW, IN 46582		
(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 APPROPRIA DEFICIENCY)	ATE CO	(X5) DMPLETION DATE
	the therapy gym.  Findings include:  Based on observati Maintenance Suppon 08/29/22 at 1:28 therapy was propportion based on interview Maintenance Direct propped open and of this finding was re-	on with the Facility ort and Maintenance Director g p.m., the main corridor door ad open with a door wedge. The time of observation, the tor acknowledged the door was removed the door wedge. The viewed with the Administrator, acc Support, and Maintenance exit conference.		removed the door wedge properties. The Director of Plant Operation was educated by the Executive Director on K363, 18.3.6.3 The is no impediment to the closing the doors.  The Director of Plant Operation will audit Therapy for wedges could prop door open 1 X per X 4weeks X 1 months.  Results of this audit will be presented by Executive Director the QAPI committee for further recommendations and continuantial the Quality Assurance Tedetermines substantial compliance has been achieved This deficient practice could a 6 residents in Therapy gym.	ons ye here hg of ons that week tor to her	
K 0372 SS=E Bldg. 02	Barrie Subdivision of Bu Barrier Construct 2012 NEW Smoke barriers s provide at least a rating and construent 8.5. Smoke barrier terminate at an at are not required if ducted HVAC system 18.3.7.3, 18.3.7.4 Describe any means system in REMAR Based on observatif failed to ensure the	nall be constructed to one hour fire resistance ucted in accordance with ers shall be permitted to rium wall. Smoke dampers in duct penetrations of fully stems.  , 18.3.7.5, 8.3 chanical smoke control	K 0372	K-372 – Subdivision of Build Spaces – Smoke Barrier Construction	ling 09	9/19/2022

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 72 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	02	COMPLETED	
		155495	B. W	ING		08/29/	/2022
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
DADDOO	OK CDDINGS			1	HELDON STREET		
PADDOC	CK SPRINGS			WARSA	AW, IN 46582		
(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 APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		were protected to maintain the			Compliance Date – 9/19/22		
		each smoke barrier. LSC					
	Section 18.3.7.3 requires smoke barriers to be				Immediate Intervention		
		rdance with LSC Section 8.5			The Director of Plant Operation	ns	
		nimum 1-hour fire resistive			has made repairs to the two		
		nt practice could affect 20			penetrations located 100 hall		
	residents in two sm	oke compartments.			smoke barriers.		
					The Director of Plant Operation		
	Findings include:				was educated by the Executiv	е	
					Director on K363, NFPA 101,		
	Based on observation	<del>_</del>			2012 edition Smoke barriers s		
		ort and Maintenance Director			be constructed to provide at le		
		p.m., above the ceiling tile of			a 1-hour fire resistance rating		
		barrier there were two small,			constructed in accordance wit	h	
	-	ns around wiring. Based on			8.5		
		e of observation, the			The Director of Plant Operation		
		tor acknowledged the unsealed			will audit smoke barrier locate		
	holes in the 100 Ha	II smoke wall.			100 for penetrations 1 X per w	/eek	
					X 4weeks X 1 months.		
		viewed with the Administrator,			Results of this audit will be		
		ce Support, and Maintenance			presented by Executive Direct		
	Director during the	exit conference.			the QAPI committee for furthe		
	2.1.10(1)				recommendations and continu		
	3.1-19(b)				until the Quality Assurance Te	eam	
					determines substantial	ـا	
					compliance has been achieve		
					This deficient practice could a	nect	
					20 residents in two smoke		
					compartments		
K 0379	NFPA 101						
SS=F	Smoke Barrier Do	or Glazing					
Bldg. 02	Smoke Barrier Do	<del>-</del>					
g. v_	2012 NEW	o. Claring					
	-	e barrier doors shall be					
	Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated						
	_	d glass panels in approved					
	frames.	- 3 pa app. 0.00					

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

18.3.7.9

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 73 of 80

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155495			UILDING	onstruction 02	(X3) DATE COMPI 08/29	LETED			
NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS				STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582					
(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)	IATE	(X5) COMPLETION DATE		
IAU	Based on observation failed to ensure 5 or windows met the program of the provided in the state of the state	on and interview, the facility oper requirements for window ce with LSC 18.3.7.9 and 3.7.9 states vision panels ted glazing in approved frames each cross-corridor swinging oss-corridor horizontal-sliding rier. 18.3.7.10 states vision moke barriers, if provided, d glazing in approved frames. ice could affect all residents.  on with the Facility ort, and Maintenance Director in 12:00 p.m. and 2:00 p.m., the doors contained windows that and it was unknown if the a fire-rated glazing material. at the time of observation, the see Support agreed the windows th fire-rated glazing identifier known if the glass windows in ore provided with a fire-rated viewed with the Administrator, see Support, and Maintenance	K O	379	K-379 – Smoke Barrier Door Glazing Compliance Date – 9/23/22  Immediate Intervention The Director of Plant Operati has acquired the appropriate documentation showing the window in 5 of 5 smoke barridoors with windows was provisited a fire rated – glazing mather than the Director of Plant Operati was educated by the Executi Director on K379, Smoke Barrier doors shall be installed each cross-corridor swing or horizonal-sliding door protect fire – rated glazing or by wire glass panels in approved fram 18.3.7.9  The Director of Plant Operati will audit the 5 of 5 smoke bardoors for fire rated glazing 1 week X 4weeks X 1 months. Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuntil the Quality Assurance T determines substantial compliance has been achieved.	ons er vided terial. ons ve rrier noke d in ed by d mes. ons urrier X per ctor to er ue eam	09/23/2022		
K 0712 SS=E Bldg. 02	3.1-19(b)  NFPA 101  Fire Drills  Fire drills include in	the transmission of a fire			This deficient practice could all residents.	anect			
		ine transmission of a fire simulation of emergency fire							

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 74 of 80

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED	
155495		B. WING 08/29/2022				/2022	
NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS			STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
PADDOC (X4) ID PREFIX TAG	summary:  (EACH DEFICIEN  REGULATORY OR  conditions. Fire dr  and unexpected ti  conditions, at leas  The staff is familia  aware that drills ar  routine. Where dr  9:00 PM and 6:00  announcement ma  audible alarms.  18.7.1.4 through 1  Based on record rev  failed to conduct fir  orientation training  QSO-20-31 1135 te  03/20/20 and ending  physical fire drill, a  training program re  which considers cur  acceptable. The trai  including existing, to  on their current duti the fire protection de  This deficient pract  residents.  Findings include:  Based on record rev  Facility Maintenand  Director on 08/29/2  shifts were missing  fire drill or docume  a) Third shift drill in  b) Second shift drill in  b) Second shift drill  Based on interview	ay be used instead of	K 07	ID PREFIX TAG		ons ach ons e I at es east tor to er ue eam d.	(X5) COMPLETION DATE  09/23/2022
	missing fire drills and staff has not been trained in the fire safety procedures for the first and seconds quarters.				all staff and residents		

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

Event ID:

NVXJ21 Facility ID: 000491

If continuation sheet Page 75 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 02 COMPLETED  B. WING 08/29/2022						
NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS			STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582					
(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 0754 SS=E Bldg. 02	This finding was re Facility Maintenand Director during the 3.1-19(b) 3.1-51(c)  NFPA 101 Soiled Linen and Soiled linen or trashall not exceed 3 average density or room or space share gallons/square feed capacity of 32 gall within any 64 squal linen or trash collect capacities greater located in a room area when not attace to containers used as permitted to be extra requirements when than or equal to 90 and containers for and listed as meed 6921 or equivalent 18.7.5.7, 19.7.5.7 Based on observation failed to ensure soil corridors were main 18.7.5.7. This deficin the service hall.	Frash Containers Frash Containers Frash Containers Frash Containers Sh collection receptacles 2 gallons in capacity. The f container capacity in a fall not exceed 0.5 for A total container fons shall not be exceeded fare feet area. Mobile soiled for receptacles with fran 32 gallons shall be fortected as a hazardous for each container is less for gallons unless attended, from the above free each container is less for gallons unless attended, from bustibles are labeled from the facility for and interview, the facility for and interview, the facility for and interview, the facility for and interview with finent practice could affect staff	K 0754	K-754 – Soiled Linen and Tra Containers Compliance Date – 9/23/22 Immediate Intervention The Director of Plant Operation has removed the two 30-gallo soiled linen carts that are side	ash 09/23/2022			
	with the Facility Ma	ons during a tour of the facility aintenance Support and or on 08/29/22 at 1:01 p.m.		side in the service hall corrido The Director of Plant Operatio	ons			

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 76 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>02</u>			COMPLETED	
		155495	B. WI	NG		08/29/	2022
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					HELDON STREET		
PADDO	CK SPRINGS			WARSA	AW, IN 46582		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION gallon soiled linen carts side by		TAG		<u> </u>	DATE
		hall corridor. Based on			Director on K754, Soiled Line and Trash Containers, soiled		
		ne of observation, the			or trash collection receptacles		
		etor stated there were two			shall not exceed 32 gallons in		
		soiled linen totaling 60 gallons			capacity.		
	_	area in the service hall corridor.			The Director of Plant Operation	ns	
	1				will audit the service hall for the		
	This finding was re	eviewed with the Administrator,			storage of soiled linen carts		
		ice Support, and Maintenance			assuring this does not exceed	I	
	Director during the				more than 32 gallons within 6		
					feet 1 X per day X 4weeks X	1	
	3.1-19(b)				months.		
					Results of this audit will be		
					presented by Executive Direct	tor to	
					the QAPI committee for furthe		
					recommendations and continu		
					until the Quality Assurance Te	eam	
					determines substantial		
					compliance has been achieve		
					This deficient practice could a	ffect	
					all staff in service hall		
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 02		s - Essential Electric					
	System Maintena						
	1 -	other alternate power					
	source and assoc	ciated equipment is capable					
	of supplying servi	ice within 10 seconds. If the					
		on is not met during the					
		ocess shall be provided to					
	1	this capability for the life					
	•	l branches. Maintenance					
		generator and transfer					
		ormed in accordance with					
	NFPA 110.	re inspected weekly					
	I Generator sets at	re inspected weekly,					I
	evercised under l	and 30 minutes 12 times a					
		oad 30 minutes 12 times a rintervals, and exercised					

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

Event ID:

NVXJ21 Facility ID: 000491

Page 77 of 80 If continuation sheet

CENTERS FOI	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155495			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 08/29/2022	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD SHELDON STREET		
PADDO	CK SPRINGS		WARS	SAW, IN 46582		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a complete simula automatic or man loads, and are copersonnel. Mainte energy power sou accordance with Nicircuit breakers all program for period components is es manufacturer requivers of maintenance and readily availa and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.11 Based on record in facility failed to man of monthly generated to man of monthly the emergency election accordance with NI Emergency and States NFPA 110 8.4.2 service to be exerciminimum of 30 min 99 requires a writted performance, exercing generator to be regular for inspection by the	(NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, the sintain a complete written record for load testing for 7 of the last of 6.4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving trical system to be in FPA 110, the Standard for ndby Powers Systems, Chapter requires diesel generator sets in sed at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA in record of inspection, ising period, and repairs for the alarly maintained and available	K 0918	K-918 – Electrical Systems – Essential Electrical System Maintenance and Testing. Compliance Date – 9/22/22  Immediate Intervention The Director of Plant Operatio has exercised the generator so for a minimum of 30 minutes a documented. The Director of Plant Operatio was educated by the Executive Director on K918, NFPA 101 Electrical System Essential Electrical System Maintenance and Testing. Generator sets a	ns et and ns e	09/22/2022

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

residents in the facility.

Findings include:

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

inspected weekly, exercised under load 30 minutes 12 times per year

in 20-40-day intervals, and exercised once every 36 months

Page 78 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155495		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  O2		(X3) DATE SURVEY COMPLETED 08/29/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582					
(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			
	Facility Maintenance Director on 08/29/2 documentation was generator set in serv once monthly for a months of January t interview at the tim Maintenance Direct testes were not reco	available to show the vice was exercised at least minimum of 30 minutes, for the o July of 2022. Based on an e of record review, the or stated the monthly load		for 4 continuous hours. The Executive Director will audit/review the monthly gene set exercise with Director of P Operations 1 X per Months X Months Results of this audit will be presented by Executive Direct the QAPI committee for further recommendations and continuuntil the Quality Assurance Tedetermines substantial compliance has been achieve	lant 6 for to r r ue eam			
	facility failed to ensigenerator battery batte	sure 2 of 2 emergency task ackup lights were maintained. dition at section 7.3.1 requires 12 EPS equipment location(s) ith battery-powered. This requirement shall not ed outdoors in enclosures that the in access. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a less between tests, for not less 1) Functional testing shall be for a minimum of 1 1/2 hours extiting system is battery written records of visual as shall be kept by the owner the authority having efficient practice could affect all		This deficient practice could a all staff in service hall.				
	Facility Maintenance Director on 08/29/2 documentation was	eview with the Administrator, the Support, and Maintenance 2 at 11:11 a.m., no available to show the prowered lights at the generator						

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

Event ID:

NVXJ21

Facility ID: 000491

If continuation sheet

Page 79 of 80

PRINTED: 09/22/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155495	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022	
NAME OF PROVIDER OR SUPPLIER PADDOCK SPRINGS			STREET ADDRESS, CITY, STATE, ZIP COD 2695 SHELDON STREET WARSAW, IN 46582				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and transfer switch were tested monthly for a minimum of 30 seconds. Based on an interview at the time of record review, the Maintenance Director stated the monthly light tests for the lights at the generator were not tested in 2022.  This finding was reviewed with the Administrator, Facility Maintenance Support, and Maintenance Director during the exit conference.						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NVXJ21 Facility ID: 000491 If continuation sheet Page 80 of 80