STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155661  NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CC A. BUILDING B. WING STREET A	(X3) DATE SURVEY COMPLETED 12/16/2024	
OWEN V	ALLEY REHABILITATION AND HEALTHCARE CENT		HIGHWAY 46 ER, IN 47460	
(X4) ID PREFIX TAG E 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg E 0041 SS=F	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 12/16/24  Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560  At this Emergency Preparedness survey, Owen Valley Rehabilitation And Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 113 certified beds, with a current census of 76.  Quality Review completed on 12/23/24  The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:  482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power	E 0000	This plan of correction is submitted as required under Federal and State regulation a statues applicable to long term care providers. This plan of correction does not constitute admission of liability on the pathe facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's finding or conclusions are accurate, the findings constitute a deficiency, or that the scope of severity regarding any of the deficiencies cited are correctly applied.  The facility respectfully requested the findings consideration paper compliance for this plant correction.	an an art of e ot e ings hat r
Bldg	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2).  1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator	E 0041	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice:  No residents were identified as being affected by the alleged deficient practice.	nts y the

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

TITLE

(X6) DATE

Michael Meadows Executive Director 01/06/2025

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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: OH8Q21 Facility ID: 010892 If continuation sheet Page 1 of 26

PRINTED: 01/08/2025 PROVED 0938-039

EPARTMENT OF HEALTH AND HUMAN SERVICES								
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO.					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED					
	155661	B. WING	12/16/2024					

NAME OF PROVIDER OR SUPPLIER

920 W HIGHWAY 46

STREET ADDRESS, CITY, STATE, ZIP COD

OWEN	/ALLEY REHABILITATION AND HEALTHCARE CENTE	K SPEN	SPENCER, IN 47460				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	was provided with a properly operating alarm						
	annunciator in a location readily observed by		How other residents having the				
	operating personnel at a regular work station such		potential to be affected by the				
	as a nurses' stations. NFPA 99, 2012 Edition,		same deficient practice will be				
	Health Care Facilities Code, at 6.4.1.1.17 requires a		identified and what corrective				
	remote annunciator that is storage battery		action(s) will be taken:				
	powered shall be provided to operate outside of						
	the generating room in a location readily observed		All residents have the potential to				
	by operating personnel at a regular work station.		be affected.				
	The annunciator shall be hard-wired to indicate		(1) Evapar, an outside contractor				
	alarm conditions of the emergency or auxiliary		that installed the new generator				
	power source as follows:		was contacted to install an				
	(1) Individual visual signals shall indicate:		annunciator panel that meets the				
	a. When the emergency or auxiliary power source		requirement. Maintenance Director				
	is operating to supply power to load.		will routinely inspect annunciator				
	b. When the battery charger is malfunctioning.		panel for proper operation during				
	(2) Individual visual signals plus a common		scheduled generator test.				
	audible signal to warn of an engine-generator		(2) Maintenance Director will				
	alarm condition shall indicate:		complete a written record of				
	a. Low lubricating oil pressure.		monthly generator load testing as				
	b. Low water temperature.		required.				
	c. Excessive water temperature.		(3) Maintenance Director will				
	d. Low fuel when the main fuel storage tank		complete and document weekly				
	contains less than a 4-hour operating supply.		inspections and testing of the				
	e. Overcrank (failed to start).		emergency generator.				
	f. Overspeed.		(4) On December 17, 2024, the				
	Where a regular work station will be unattended		Maintenance Director verified that				
	periodically, an audible and visual derangement		there was a battery-operated light				
	signal, appropriately labeled, shall be established		inside the generator housing				
	at a continuously monitored location. This		located near the battery.				
	derangement signal shall activate when any of the						
	conditions in 6.4.1.1.17(1) and (2) occur but need						
	not display these conditions individually. This		What measures will be put into				
	deficient practice could affect all residents, as well		place and what systemic changes				
	as visitors and staff in the facility.		will be made to ensure that the				
			deficient practice does not recur.				
	Findings include:						
			(1) The Maintenance Director will				
	Based on observation on 12/16/24 between 2:30		routinely inspect annunciator				
	p.m. and 5:00 p.m. during a tour of the facility with		panel for proper operation during				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155661	B. W	ING		12/16/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CENT	ER		CER, IN 47460		
(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 APPROPR		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		etor, Regional Director of			scheduled generator test.		
		intenance Director from a			(2) Maintenance Director will		
	sister facility, there was a remote generator				complete and record the resul		
	annunciator panel located on the wall in the				monthly generator load testing	g as	
	sitting area across from the west Nurse's Station				required.		
	area. When tested by pushing all of the buttons,				(3) Maintenance Director will		
	the generator annunciator panel did not operate.				complete and record the resul		
	Based on interview at the time of observation, the		1		weekly inspections and testing	g of	
	Regional Director of Operations said the facility				the emergency generator.		
	had a new generator installed within the past two				(4) The Maintenance Director	Will	
	months and was told by the vendor that the				routinely verify that a		
	existing equipment, i.e., transfer switch and				battery-operated light is locate		
	annunciator panel, would be compatible with the				inside the generator housing r	near	
	new generator. The Regional Director of				the battery.		
	_	led the vendor and scheduled					
		correct the issue with the			l		
		tor panel not currently			How the corrective actions wil		
	operating.				monitored to ensure the defici	ent	
	This finding was no	viewed with the Evenutive			practice does not recur.		
	_	viewed with the Executive			(4) Maintanana Dinastanan		
	_	Director of Operations, and			(1) Maintenance Director or	-:-4	
		tor from the sister facility			designee will audit the annund		
	during the exit conf	erence.			panel for proper operation we X 4 weeks with any issues	екіу	
	2 Rased on record	review and interview, the	1		1	thon	
		iintain a complete written record			reported at morning meeting,	uieii	
	· ·	or load testing for 1 of 1			monthly X 5 months with any issues reported at the monthly	,	
		of the past 12 months. Chapter			QAPI meeting.	<i>y</i>	
	~ ~	12 NFPA 99 requires monthly			(2) Executive Director or design	nnee	
		ator serving the emergency			will audit documentation of the	-	
	1	be in accordance with NFPA			written record of monthly gene		
		or Emergency and Standby	1		load testing monthly for 6 mor		
	1	hapter 8. Chapter 6.4.4.2 of			Results will be reviewed at the		
	I -	a written record of inspection,	1		monthly QAPI meeting.	-	
	_	ising period, and repairs for the			(3) Executive Director will aud	lit	
	1 <b>^</b>	alarly maintained and available			weekly inspections and testing		
	for inspection by the authority having jurisdiction. This deficient practice could affect all				the emergency generator wee	_	
					4 weeks and then monthly X 5	-	
	residents, staff and	-			months. Results will be review		
	, , , , , , , , , , , , , , , , , , , ,				at the monthly QAPI meeting.		
	1		1		1		

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

PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155661		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		<del></del>	(X3) DATE SURVEY COMPLETED 12/16/2024	
	PROVIDER OR SUPPLIE ALLEY REHABILIT	R FATION AND HEALTHCARE CENT	ER	920 W H	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 ER, IN 47460		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	Findings include:  Based on record re a.m. and 2:30 p.m. Regional Director of Director from a sis following was note a. There was no m documentation ava August of 2024 for Based on interview the Executive Diremonthly load test of August and Septen interview at the tim Regional Director had a temporary getime frame and the generator was suppload tests/inspection Operations was untests/inspections of vendor or in house b. The monthly loavailable for review 03/22/24, 04/30/24 12/10/24, all had p 36%. None of those calculations including reached the 30% or generator load test calculations, and the 42%. This was condirector of Operative ventor of Operative ventor of Operative ventor of Regional	conthly generator load test ilable for May, June, July, and the emergency generator.  The at the time of record review, ctor confirmed there was no locumentation available for other of 2024. Based on the of record review, the of Operations said the facility enerator during most of that wendor of the temporary bosed to perform the monthly ons. The Regional Director of the generator either from the maintenance logs.  The date of 1/03/24, 02/21/24, 10/14/24, 11/12/24, and the ercentage of load as 30% or see monthly reports had the ed as to how the facility of 36% mark. Only one monthly report was provided with the mat report was dated 09/10/24 at an offirmed by the Regional tons at the time of record eviewed with the Executive Director of Operations, and tor from the sister facility		TAG	(4) Maintenance Director or designee will verify and documentate that a battery-operated light is stored within the generator were X 4 weeks and then monthly X months. Any discrepancy will be corrected immediately and reported at the morning meeting. Results will be discussed at the monthly QAPI meeting.	nent rekly ( 5 pe	DATE

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

Event ID:

OH8Q21

Facility ID: 010892

If continuation sheet

Page 4 of 26

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

PRINTED: 01/08/2025 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	ı	JILDING	<del></del>	COMPL	
		155661	B. WI	NG		12/16/	2024
NAME OF P	ROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CENT	EK	SPENC	ER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC II		DATE
	3 Based on record	review and interview, the					
		sure a written record of weekly					
	_	1 generator was maintained					
		Chapter 6-4.4.1.3 of 2012					
	NFPA 99 requires batteries for on-site generators						
	_	in accordance with NFPA 110,					
	2010 Edition, Stand	lard for Emergency and					
	Standby Power Sys	tems. 8.3.7 requires storage					
	batteries, including	electrolyte levels or battery					
	voltage, used in cor	nnection with systems shall be					
	inspected weekly and maintained in full						
	compliance with manufacturer's specifications.						
		tive batteries shall be repaired					
	_	ately upon discovery of					
	_	5.4.2 of NFPA 99 requires a					
		spection, performance,					
		nd repairs shall be regularly					
		ilable for inspection by the					
		risdiction. This deficient					
	-	et all residents, staff and					
	visitors.						
	Findings include:						
	Based on review of	the generator inspection and					
		2/16/24 between 10:00 a.m. and					
	2:30 p.m. with the I	Executive Director, Regional					
	Director of Operation	ons, and Maintenance Director					
	from a sister facility	y present, there was no					
		lable to show the emergency					
	generator was inspe	ected/tested weekly between					
		4. Based on interview at the					
		ew, the Regional Director of					
	_	facility had a temporary					
	-	ost of that time frame and the					
	_	orary generator was supposed					
	_	kly inspections. The Regional					
	_	ons was unable to produce					
	weekly inspections	of the generator either from					

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 5 of 26

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

PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155661  AND PLAN OF CORRECTION  A. BUILDING  B. WING		UILDING	(X3) DATE SURVEY  COMPLETED  12/16/2024		ETED		
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CEN	TER	920 W H	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 ER, IN 47460		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	This finding was reduced Director, Regional I Maintenance Direct during the exit confiduring the exit confidure was provided with a 110, 2010 Edition at Level 1 or Level 2 I be provided with balighting. This requiled to a confidure walk-in according requires functional monthly, with a min maximum of 5 weet than 30 seconds, (3) conducted annually if the emergency light powered and (5) White inspections and test for inspections and test for inspection by the jurisdiction. This desidents in the facion observation in the facion of the faci	ation and interview, the sure 1 of 1 emergency generator a battery backup light. NFPA at section 7.3.1 requires the EPS equipment location(s) shall attery-powered emergency irement shall not apply to units enclosures that do not ess. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less of Functional testing shall be for a minimum of 1 1/2 hours ghting system is battery ritten records of visual s shall be kept by the owner e authority having efficient practice could affect all					

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 6 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING			3) DATE SURVEY COMPLETED	
		155661	B. W	ING		12/16/2024	
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CEN	TER	STREET ADDRESS, CITY, STATE, ZIP COD 920 W HIGHWAY 46 FER SPENCER, IN 47460			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0000	sister facility ackno back up light set in generator.  This finding was re Director, Regional I	wledged there was no battery or around the emergency viewed with the Executive Director of Operations, and or from the sister facility					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 12/16 Facility Number: 0 Provider Number: 4IM Number: 2002 At this Life Safety of Rehabilitation And not in compliance w Participation in Med Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.  This one story facility Type V (111) const sprinklered. The faction with hard wired sme spaces open to the constepping rooms. The	10892 155661	K	0000	This plan of correction is submitted as required under Federal and State regulation a statues applicable to long term care providers. This plan of correction does not constitute admission of liability on the pathe facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findion or conclusions are accurate, the findings constitute a deficiency, or that the scope of severity regarding any of the deficiencies cited are correctly applied. The facility respectfully request desk review and consideration paper compliance for this plant correction.	an an art of e ot e ings hat	

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 7 of 26

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER  155661		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 12/16/2024				ETED	
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP COD 920 W HIGHWAY 46 TER SPENCER, IN 47460				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0321 SS=E Bldg. 01	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.  Quality Review completed on 12/23/24  NFPA 101  Hazardous Areas - Enclosure		K 0		What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice:  No residents were identified as being affected by the alleged deficient practice.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	nts y the s	01/06/2025	
					All residents have the potential be affected. On December 23, 2024, the Maintenance Director installed a self closing hinge of the door to the identified storal room.  What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recome.	or n ge o ges		

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 8 of 26

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

PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

	N OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COM		COMPL 12/16/	ETED			
	ROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	STREET ADDRESS, CITY, STATE, ZIP COD 920 W HIGHWAY 46 NTER SPENCER, IN 47460				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					designee will ensure that all storage areas have a self closi door during weekly safety rour Any discrepancies will be corrected immediately and reported at the morning meeting	nds.	
					How the corrective actions will monitored to ensure the deficient practice does not recur.		
					The Maintenance Director or designee will inspect storage spaces for a self closing door weekly X 4 weeks and then monthly X 5 months with any issues reported at the monthly QAPI meeting.		
K 0345 SS=F Bldg. 01	failed to maintain 1 accordance with NF Sections 19.3.4.5.1 at 14.3.1 states that un 14.3.2, visual inspectace of the more often if require	iew and interview, the facility of 1 fire alarm system in PA 72, as required by LSC 101 and 9.6. NFPA 72, Section less otherwise permitted by ctions shall be performed in schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following	K 0	345	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice:  No residents were identified as being affected by the alleged deficient practice.	nts y the	01/27/2025
	<ul><li>a. Control unit troub</li><li>b. Remote annuncia</li><li>c. Initiating devices</li></ul>	tors (e.g. duct detectors, manual at detectors, smoke detectors,			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:  All residents have the potentia		

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 9 of 26

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  IND PLAN OF CORRECTION IDENTIFICATION NUMBER  155661		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024	
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CEN	TER	920 W I	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 CER, IN 47460		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
TAG	This deficient pract in the facility.  Findings include:  Based on record revalue.  Regional Director of Director from a sist documentation provalurm system inspection listed 11: and 8 duct smoke ditested/inspected vis Furthermore, there is Inspections Fire System of the factor of record review, the semi-annual visual match the annual in hard wired smoke didetectors.  This finding was redicted.  This finding was redicted.	riew on 12/16/24 between 10:00 with the Executive Director, of Operations, and Maintenance er facility present, there was rided regarding an annual fire ction dated 12/26/23 by the inspection vendor. This 2 hard wired smoke detector etectors as having been ually and functionally. was a "Semi-Annual Visual stems" report dated 06/10/24 cility's Maintenance Director. ed 73 hard wired smoke at smoke detectors as being Based on interview at the time ee Executive Director agreed inspection report did not spection report's number of etectors and duct smoke		TAG	be affected. The Maintenance Director has created a list of a hard wired smoke and duct detectors that includes their location.  What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not recommended. The Maintenance Director has created and will maintain a list all hard wired smoke and duct detectors that includes their location. This list will be updated as needed and used for any required testing.  How the corrective actions with monitored to ensure the deficient practice does not recur.  The Maintenance Director will audit the hard wired smoke and duct detector list monthly X 6 months to verify that it is accurant and no changes are needed. discrepancies will be corrected immediately. Results will be reviewed at the monthly QAP	o onges e cur. st of t ted I be ent	DATE
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation on and interview, the facility	V	0251	meeting.  What corrective action(s) will		01/27/2025
		y one type of sprinkler head,	K	)351	accomplished for those reside		01/27/2025

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		155661	B. W	ING		12/16/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CENT	ER_		ER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		or standard sprinklers were			found to have been affected b	y the	
	installed in 1 of 8 smoke compartments. NFPA 13,				deficient practice:		
	2010 Edition, Installation of Sprinkler Systems,						
		es where quick-response			No residents were identified a	S	
	-	led, all sprinklers within a			being affected by the alleged		
	-	be quick-response unless			deficient practice.		
	otherwise permitted in Section 8.3.3.3 Section						
	8.3.3.4 states when existing light hazard systems						
	are converted to use quick response or residential				How other residents having th		
	sprinklers, all sprinklers in a compartmented space				potential to be affected by the		
	_	This deficient practice could			same deficient practice will be	!	
	affect at least 10 residents, staff, and visitors.				identified and what corrective		
					action(s) will be taken:		
	Findings include:						
					All residents have the potentia		
		ons on 12/16/24 between 2:30			be affected. All deficient sprinl		
		during a tour of the facility with			heads that were identified duri	-	
		Regional Director of			the inspection will be replaced	l by	
	-	intenance Director from the			a qualified contractor.		
	_	corridor near the east exit door					
		ndry room door there was one					
		prinkler head mixed with all			What measures will be put into		
		e sprinkler heads. Based on			place and what systemic chan	~	
		e of observation, this was	will be made to ensure that the				
		ne Executive Director who			deficient practice does not rec	ur.	
	_	mixture of different type			l		
	sprinkler heads in the	nis compartmented spaces.			All sprinkler heads will be		
	TEL : C' 1:				inspected routinely by the		
	-	viewed with the Executive			Maintenance Director or desig		
	-	Director of Operations, and			to ensure all sprinkler heads a	ire	
		for from the sister facility			the same response type.		
	during the exit conf	erence.					
	2 1 10/4)				Llow the competitive actions of	l bo	
	3.1-19(b)				How the corrective actions will		
					monitored to ensure the defici-	ent	
					practice does not recur.		
					The Maintenance Director or		
					designee is to complete	ata d	
			1		inspection and auditing of affe	ciea	

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 11 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155661	B. WI	NG		12/16/	12/16/2024	
				CTREET	A DDDEGG GITY GTATE ZID GOD			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  920 W HIGHWAY 46					
OMENIA		ATION AND LIEALTHOADE CENT						
OWENV	ALLET KENADILIT	ATION AND HEALTHCARE CENT	EK	SPEINC	CER, IN 47460			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
					sprinkler heads weekly X 4 we	eks		
					and then monthly X 5 months	to		
					ensure sprinkler heads are of	the		
					same response type. These			
					results will be reviewed and			
					discussed at the monthly QAP	I		
					meeting.			
K 0353	NFPA 101							
SS=F	Sprinkler System -	- Maintenance and Testing						
Bldg. 01								
		review, observation, and	K 03	353	What corrective action(s) will b		01/27/2025	
		ty failed to document sprinkler			accomplished for those reside			
		n accordance with NFPA 25			found to have been affected by	y the		
		tler system during 38 of the			deficient practice:			
	-	e sprinkler system's pressure						
		8 of the past 12 months for the			No residents were identified as	3		
		ontrol valves. NFPA 25,			being affected by the alleged			
		pection, Testing, and			deficient practice.			
		ter-Based Fire Protection						
		on, Section 5.2.4.2 states						
		sprinkler systems shall be			How other residents having the	Э		
		ensure that normal air and			potential to be affected by the			
	-	being maintained. Section			same deficient practice will be identified and what corrective			
	5.1.2 states valves a	e inspected, tested, and						
		dance with Chapter 13.			action(s) will be taken:			
		tes Table 13.1.1.2 shall be			All regidents have the notantic	l to		
		on, testing and maintenance of			All residents have the potentia be affected.	110		
	-	onents and trim. Section 4.3.1			1a. The Maintenance Director	or		
	_	be made for all inspections,			designee will inspect the dry	Oi		
		nce of the system and its			sprinkler system gauges week	lv		
		all be made available to the			1b. The Maintenance Director	-		
	-	isdiction upon request. This			designee will inspect the sprin			
		ould affect all residents, staff,			system control valves monthly			
	and visitors in the fa				All deficient sprinkler heads			
		,			that were identified during the	•		
	Findings include:				inspection will be replaced by	а		
					qualified contractor.	-		
	a. Based on record	review on 12/16/24 between			Backup sprinkler heads that			
	a. Dabea on record	10.10.1. OH 12/10/2 / Octwooli	l		o. Daokup sprilikiei lieaus tilat			

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 12 of 26

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155661		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024	
	F PROVIDER OR SUPPLIE	R TATION AND HEALTHCARE CENT	ER	920 W I	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 EER, IN 47460		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	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)	ΓE	(X5) COMPLETION DATE
TAG	10:00 a.m. and 2:30 Director, Regional Maintenance Director, Regional Maintenance Director present, there was a show the facility's of were inspected were week period. The inspections availabto 109/10/24 to 12/09/24 time of record revior Operations confirm documentation avas prinkler gauges has weekly during 38 to observations on 12 5:00 p.m. during a Executive Director Operations, and Maister facility, the figures at the spring b. Based on record 10:00 a.m. and 2:30 Director, Regional Maintenance Director present, there was a control valves inspethe past 12 months	Director of Operations, and tor from a sister facility no documentation available to dry sprinkler system gauges skly during 38 of the past 52 only weekly sprinkler gauge le for review were from 24. Based on interview at the ew, the Regional Director of med there was no ilable to show that the facility's and been inspected at least of the past 52 weeks. Based on 1/16/24 between 2:30 p.m. and tour of the facility with the past 52 weeks do not not prector of med the past 52 weeks. Based on 1/16/24 between 2:30 p.m. and tour of the facility with the past 52 weeks. Based on 1/16/24 between 2:30 p.m. and tour of the facility with the past 52 weeks. Based on 1/16/24 between 2:30 p.m. and tour of the facility with the past 52 weeks. Based on 1/16/24 between 2:30 p.m. and 1/16/24 bet		TAG	were not needed in the spare sprinkler box were removed ar sprinkler heads of the same ty and temperature as the facility were added to meet the requirement.  What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not reconsignee will complete and reconsignee will sprinkler heads will be inspected routinely by the Maintenance Director or designee will routinely inspect	pe or cord or cord nkler n.	DATE
	Based on interview the Regional Direc	r, and December of 2024. That the time of record review, tor of Operations confirmed the estem inspections on the control past 12 months.			spare sprinkler head box to en that it has the correct spare sprinkler heads that match the type and temperature of those the facility.		
	Director, Regional	eviewed with the Executive Director of Operations, and tor from the sister facility ference.			How the corrective actions will monitored to ensure the deficient practice does not recur.		

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 13 of 26

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155661	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 12/16/2024
	ROVIDER OR SUPPLIEF	ATION AND HEALTHCARE CENT	920 W	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 CER, IN 47460	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	facility failed to eas smoke compartmen replaced. NFPA 25 sprinklers shall not be free of corrosion physical damage; at correct orientation (sidewall). Furthern that shows signs of replaced: (1) Leaks Damage (4) Loss of responsive element unless painted by the This deficient pract staff, plus residents smoke compartment. Findings include:  Based on observation p.m. and 5:00 p.m. the Executive Direct Operations, and Masister facility, there washer area within corrosion. Based of observation, the Executive Direct of Sprinkler head was should be replaced.  This finding was red Director, Regional in the Executive Director, Regional in the Execution of the Execution	ons on 12/16/24 between 2:30 during a tour of the facility with etor, Regional Director of intenance Director from a was one sprinkler head in the the laundry room covered with in interview at the time of ecutive Director agreed the covered with corrosion and viewed with the Executive Director of Operations, and for from the sister facility		1a. The Executive Director wi audit the results of the weekly sprinkler system gauges inspection weekly X 4 weeks then monthly X 5 months.  1b. The Executive Director wi audit the monthly sprinkler system to control valve inspection month 6 months.  2. The Maintenance Director of designee is to complete inspection and auditing of affes sprinkler heads weekly X 4 wo and then monthly X 5 months. These results will be reviewed discussed at the monthly QAF meeting.  3. The Maintenance Director wandit the spare sprinkler heads that match the same type and temperature a facility weekly X 4 weeks and monthly X 5 months.	and  II stem hly X  or ected eeks . d and ell  will box es s the

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155661			JILDING	nstruction <u>01</u>	(X3) DATE : COMPL 12/16/	ETED	
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	ER	920 W F	NDDRESS, CITY, STATE, ZIP COD HIGHWAY 46 ER, IN 47460		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility failed to enswere provided with sprinklers in a spare premises for the typ the sprinklers on the Standard for the Ins Maintenance of Wa Systems, 2011 Editional Edition	ons on 12/16/24 between 2:30 during a tour of the facility with tor, Regional Director of intenance Director from a ent type Quick Response e installed throughout the he attic. There were no Response spare sprinkler are sprinkler cabinet at the er or on the premises. Based time of the observations, the agreed the spare sprinkler ain any pendent type Quick					

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 15 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155661	B. WI	NG		12/16/	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			HIGHWAY 46		
OWENIV	ALLEV DELIADILIT	ATION AND HEALTHCARE CENT	ED				
OVVEIN V	ALLET KEHADILIT	ATION AND HEALTHCARE CENT	EK	SPENC	CER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This finding was re-	viewed with the Executive					
		Director of Operations, and					
	Maintenance Direct	tor from the sister facility					
	during the exit conf	Perence.					
	3.1-19(b)						
K 0711	NFPA 101						
SS=F	Evacuation and R	elocation Plan					
Bldg. 01							
		view and interview, the facility	K 0	711	What corrective action(s) will be		01/27/2025
	•	complete facility specific			accomplished for those reside		
		lan for the protection of all			found to have been affected b	y the	
		ely address all life safety			deficient practice:		
		em addressing all items					
		101, 2012 edition, Section			No residents were identified a	S	
		.2.2 requires a written health care			being affected by the alleged		
		ty plan that shall provide for			deficient practice.		
	the following:						
	(1) Use of alarms				l., ., .,		
		f alarm to fire department			How other residents having th		
		ne call to fire department			potential to be affected by the		
	<ul><li>(4) Response to alar</li><li>(5) Isolation of fire</li></ul>				same deficient practice will be		
	· /				identified and what corrective		
	(6) Evacuation of in				action(s) will be taken:		
	(7) Evacuation of sr	loors and building for			All regidents have the netentia	N 40	
	evacuation	loors and building for			All residents have the potentia	וו נט	
	(9) Extinguishment	of fire			be affected.  a. The facility emergency		
		states any required aisle or			procedure plan has been char	agod	
		e less than 48 inches in clear			1 · · · · · · · · · · · · · · · · · · ·	_	
		g as means of egress from			to identify smoke barrier locati and evacuation procedure in o		
		oms. Projections into the			b. The facility emergency	iciaii.	
		l be permitted for wheeled			procedure plan has been char	naed	
	_	I the relocation of wheeled			to clarify when the K type	.gcu	
		fire or similar emergency is			extinguisher would be used in		
		itten fire safety plan and			relationship to the overhead		
		r the facility. The wheeled			extinguishing system.		
	equipment is limited				oxangaioning system.		
	i. Equipment in use						
	Equipment in use		1		1		1

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 16 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155661		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024		
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	ER	920 W I	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 CER, IN 47460		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
	ii. Medical emerger iii. Patient lift and to This deficient pract in the event of an er  Findings include:  Based on a review of Procedure-Fire plant a.m. and 3:00 p.m. Regional Director of Director from a sist not address the follo a. The plan did add compartment, howe where the smoke ba facility and evacuat b. The use of the K kitchen in relationsl overhead extinguish plan did say "Note: Type K." Based on interview the Executive Direct Emergency Procedu the previously ment  This finding was re Director, Regional I	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  rey equipment not in use ransport equipment fice could affect all occupants mergency.  of the facility's Emergency on 12/10/24 between 10:00 with the Executive Director, f Operations, and Maintenance er facility present, the plan did owing: ress evacuation of the smoke ever, the plan did not identify rriers were located in the ion in detailclass fire extinguisher in the nip with the use of the kitchen hing system. However, the Kitchen fire extinguishers are  at the time of record review, tor acknowledged the hire-Fire plan did not include hined items.  wiewed with the Executive Director of Operations, and or from the sister facility			What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not recommon and the evacuation procedure plan is more detailed. The facility emergency procedure plan is more detailed help identify smoke barrier locations and the evacuation procedure in more detailed. The facility emergency procedure plan provides more detail as to when the K type extinguisher would be used in relationship to the overhead extinguishing system.  How the corrective actions will monitored to ensure the deficit practice does not recur.  a. The Executive Director or designee will audit the emerging procedure plan to ensure that identifies smoke barrier location and the evacuation procedure more detail monthly X 6 mont The result will be reviewed in monthly QAPI meeting. b. The Executive Director or designee will audit the emerging procedure plan to ensure that	o onges e cur.  ed to  li be ency it ons e in hs. the ency it ons the ency it on ency it o	1 1
					provides clarification as to wh the K type extinguisher would used in relationship to the overhead extinguishing systel monthly X 6 months. The res will be reviewed in the monthl QAPI meeting.	be m ult	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155661		l í	UILDING	onstruction <u>01</u>	COMP	E SURVEY PLETED 6/2024	
	PROVIDER OR SUPPLIE	R FATION AND HEALTHCARE CE	NTER	920 W	ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46 CER, IN 47460		
(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)	ATE	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	failed to ensure fire for 1 of 3 employer. This deficient pract the facility.  Findings include:  Based on review of on 12/16/24 betwee the Executive Dire Operations, and M sister facility prese (evening) fire drills p.m. and 7:30 p.m. of record review, the acknowledged the were performed an varied enough.  This finding was re Director, Regional	view and interview, the facility e drills were held at varied times e shifts during 3 of 4 quarters. tice could affect all residents in fine the facility's fire drill reports en 10:00 a.m. and 2:30 p.m. with ctor, Regional Director of aintenance Director from a nt, 3 of 4 second shift is were performed between 6:16. Based on interview at the time the Executive Director times the second shift fire drills diagreed the times were not eviewed with the Executive Director of Operations, and stor from the sister facility ference.	K	0712	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice:  No residents were identified as being affected by the alleged deficient practice.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:  All residents have the potential be affected. The Maintenance Director will schedule fire drills be held on unexpected days a unexpected times under varying conditions.  What measures will be put interplace and what systemic charm will be made to ensure that the deficient practice does not recomply the process of the designee will monitor the fire of the schedule to ensure that fire drare held on unexpected days unexpected times under varying conditions.	ents by the as as al to as sto at ang anges e cur. drill rills at	01/27/2025

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 18 of 26

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155661		A. BUILDING 01 COMPLETED B. WING 12/16/2024					
	ROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	STREET ADDRESS, CITY, STATE, ZIP COD 920 W HIGHWAY 46 FER SPENCER, IN 47460				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems  Based on observation failed to ensure 1 of provided with a propannunciator in a local operating personnel as a nurses' stations. Health Care Facilities remote annunciator powered shall be properating persons. The annunciator shall alarm conditions of power source as foll (1) Individual visuals. When the emerge is operating to supplies. When the battery (2) Individual visuals.	- Essential Electric Syste  In and interview, the facility I emergency generator was beerly operating alarm ation readily observed by at a regular work station such NFPA 99, 2012 Edition, es Code, at 6.4.1.1.17 requires a that is storage battery by ovided to operate outside of in a location readily observed hel at a regular work station. Il be hard-wired to indicate the emergency or auxiliary ows: I signals shall indicate: ency or auxiliary power source y power to load. I charger is malfunctioning. I signals plus a common orn of an engine-generator I indicate: bil pressure. erature.	K 09		How the corrective actions will monitored to ensure the deficient practice does not recur.  The Executive Director or designee will audit fire drills monthly X 6 months to ensure drills are held on unexpected of at unexpected times and undervarying conditions with any issure ported at the monthly QAPI meeting.  What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice:  No residents were identified as being affected by the alleged deficient practice.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:  All residents have the potential be affected. Evapar, an outside contractor that installed the negenerator was contacted to instant annunciator panel that meet the requirement. Maintenance Director will routinely inspect annunciator panel for proper	fire days rues eents y the	01/27/2025

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 19 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155661	B. W	ING		12/16/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R			HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CEN	TER		CER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
		he main fuel storage tank			operation during scheduled		
		4-hour operating supply.			generator test.		
	e. Overcrank (faile						
	f. Overspeed.						
	Where a regular wo	ork station will be unattended			What measures will be put into	0	
	periodically, an aud	lible and visual derangement			place and what systemic char		
	signal, appropriatel	y labeled, shall be established			will be made to ensure that the	-	
	at a continuously m	onitored location. This			deficient practice does not rec		
	derangement signal	shall activate when any of the					
	conditions in 6.4.1.	1.17(1) and (2) occur but need			The Maintenance Director wil	I	
	not display these co	onditions individually. This			routinely inspect annunciator		
	deficient practice co	ould affect all residents, as well			panel for proper operation dur	ing	
	as visitors and staff	in the facility.			scheduled generator test.		
	Findings include:						
					How the corrective actions wil	l be	
		on on 12/16/24 between 2:30			monitored to ensure the defici	ent	
	1	during a tour of the facility with			practice does not recur.		
		etor, Regional Director of					
		intenance Director from a			Maintenance Director or design		
	1	was a remote generator			will audit the annunciator pane		
		ocated on the wall in the			proper operation weekly X 4 v	/eeks	
	_	rom the west Nurse's Station			with any issues reported at		
		by pushing all of the buttons,			morning meeting, then monthl	•	
		nciator panel did not operate.			5 months with any issues repo	orted	
		at the time of observation, the			at the monthly QAPI meeting.		
	_	of Operations said the facility					
	1	r installed within the past two					
		d by the vendor that the					
		, i.e., transfer switch and					
	_	would be compatible with the					
		e Regional Director of					
	_	led the vendor and scheduled					
		correct the issue with the					
		tor panel not currently					
	operating.						
	This finding was re	viewed with the Executive					
	_	Director of Operations, and					
	_	tor from the sister facility					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155661	B. WI			12/16/	
					_		-
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD		
OMEN !	A. I. E. V. DELLA DIL IT	ATION AND LIEALTHOADE OFNIT			W HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CENT	EK	SPE	NCER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	during the exit conf	erence.					
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01							
		review and interview, the	K 09	918	What corrective action(s) will be		01/27/2025
	-	intain a complete written record			accomplished for those reside		
		or load testing for 1 of 1			found to have been affected by	y the	
		of the past 12 months. Chapter			deficient practice:		
		12 NFPA 99 requires monthly					
		ator serving the emergency			No residents were identified as	5	
	-	be in accordance with NFPA			being affected by the alleged		
		or Emergency and Standby			deficient practice.		
		napter 8. Chapter 6.4.4.2 of					
	-	written record of inspection,					
		sing period, and repairs for the			How other residents having the	е	
		llarly maintained and available			potential to be affected by the		
	for inspection by the				same deficient practice will be		
	-	eficient practice could affect all			identified and what corrective		
	residents, staff and	visitors.			action(s) will be taken:		
	E' 1' ' 1 1						
	Findings include:				All residents have the potentia	I to	
	D111	: 12/16/24 h 10:00			be affected.		
		riew on 12/16/24 between 10:00			(1) Maintenance Director will		
		with the Executive Director, f Operations, and Maintenance			complete a written record of		
	-	er facility present, the			monthly generator load testing	as	
	following was noted				required.		
		onthly generator load test			(2) Maintenance Director will complete and document week	lv.	
		lable for May, June, July, and			inspections and testing of the	ıy	
		the emergency generator.			emergency generator.		
	-	at the time of record review,			(3) On December 17, 2024, th	e	
		tor confirmed there was no			Maintenance Director verified		
		ocumentation available for			there was a battery-operated I		
		ber of 2024. Based on			inside the generator housing	.9.11	
		e of record review, the			located near the battery.		
		f Operations said the facility			located floar the battery.		
		nerator during most of that					
	in in Polary Ser		l				

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 21 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155661	B. W	ING		12/16/	2024
				CENTER	ADDRESS STEW STATE STR COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
O)4/511/	ALLEY DELIABILIT	ATION AND LIEALTHOADE OFNIT			HIGHWAY 46		
OWEN V	ALLEY REHABILII	ATION AND HEALTHCARE CENT	EK	SPENC	ER, IN 47460		
(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
	time frame and the	vendor of the temporary			What measures will be put into	0	
	generator was supp	osed to perform the monthly			place and what systemic chan	iges	
	load tests/inspection	ns. The Regional Director of			will be made to ensure that the	e	
	Operations was unable to produce monthly load				deficient practice does not rec	ur.	
	tests/inspections of	the generator either from the					
	vendor or in house				(1) Maintenance Director will		
	b. The monthly loa	d testing reports that were			complete and record the resul	ts of	
		were dated 01/03/24, 02/21/24,			monthly generator load testing	g as	
		, 10/14/24, 11/12/24, and			required.		
		ercentage of load as 30% or			(2) Maintenance Director will		
		e monthly reports had the			complete and record the resul		
		ed as to how the facility			weekly inspections and testing	g of	
		36% mark. Only one monthly			the emergency generator.		
	-	report was provided with the			(3) The Maintenance Director	will	
		at report was dated 09/10/24 at			routinely verify that a		
		firmed by the Regional			battery-operated light is locate		
	_	ons at the time of record			inside the generator housing r	near	
	review.				the battery.		
	TELL: C'L'	. 1 M 4 E					
	_	viewed with the Executive			l		
	_	Director of Operations, and			How the corrective actions wil		
		tor from the sister facility			monitored to ensure the defici	ent	
	during the exit conf	erence.			practice does not recur.		
	2 1 10(b)				(1) Evoquitivo Director on decid	, no o	
	3.1-19(b)				(1) Executive Director or designable will audit documentation of the		
	2 Racad on racord	review and interview, the			written record of monthly gene		
		sure a written record of weekly			load testing monthly for 6 mor		
	•	1 generator was maintained			Results will be reviewed at the		
	-	Chapter 6-4.4.1.3 of 2012			monthly QAPI meeting.	-	
		patteries for on-site generators			(2) Executive Director will aud	it	
	•	in accordance with NFPA 110,			weekly inspections and testing		
					the emergency generator wee		
	2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage				4 weeks and then monthly X 5	-	
	batteries, including electrolyte levels or battery				months. Results will be review		
	voltage, used in connection with systems shall be				at the monthly QAPI meeting.	, 54	
	inspected weekly and maintained in full				(3) Maintenance Director or		
	compliance with manufacturer's specifications.				designee will verify and docun	nent	
	-	tive batteries shall be repaired			that a battery-operated light is		
		ately upon discovery of			stored within the generator we		
	or replaced minicul	area, apon ansocrety of	1		I stated within the generator we	-CINI y	

OH8Q21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155661	B. W			12/16/	
					_		-
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					HIGHWAY 46		
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CENT	ER	SPENC	ER, IN 47460		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION	ection (X5)	
PREFIX	(EACH DEFICIEN	ICY 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
		5.4.2 of NFPA 99 requires a			X 4 weeks and then monthly X	(5	
	written record of in	spection, performance,			months. Any discrepancy will I		
		and repairs shall be regularly			corrected immediately and		
		ilable for inspection by the			reported at the morning meeti	ng.	
		risdiction. This deficient			Results will be discussed at th	-	
		et all residents, staff and			monthly QAPI meeting.		
	visitors.						
	Findings include:						
	_						
	Based on review of	the generator inspection and					
	testing reports on 1	2/16/24 between 10:00 a.m. and					
	2:30 p.m. with the l	Executive Director, Regional					
	Director of Operation	ons, and Maintenance Director					
	from a sister facility	y present, there was no					
	documentation avai	lable to show the emergency					
	generator was inspe	ected/tested weekly between					
	02/21/24 to 10/01/2	24. Based on interview at the					
	time of record revie	ew, the Regional Director of					
	Operations said the	facility had a temporary					
	generator during me	ost of that time frame and the					
	vendor of the tempo	orary generator was supposed					
	to perform the weel	kly inspections. The Regional					
	Director of Operation	ons was unable to produce					
	weekly inspections	of the generator either from					
	the vendor or in ho	use maintenance logs.					
	This finding was re	viewed with the Executive					
	Director, Regional	Director of Operations, and					
	Maintenance Direct	tor from the sister facility					
	during the exit conf	ference.					
	3.1-19(b)						
	3. Based on observation and interview, the						
	facility failed to ensure 1 of 1 emergency generator						
	was provided with a battery backup light. NFPA						
	110, 2010 Edition at section 7.3.1 requires the						
	Level 1 or Level 2	EPS equipment location(s) shall					
	be provided with ba	attery-powered emergency					

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 23 of 26

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  IND PLAN OF CORRECTION (IDENTIFICATION NUMBER)  155661		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/16/2024			
NAME OF PROVIDER OR SUPPLIER  OWEN VALLEY REHABILITATION AND HEALTHCARE CEN			NTER	STREET ADDRESS, CITY, STATE, ZIP COD  920 W HIGHWAY 46  SPENCER, IN 47460					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	located outdoors in include walk-in acc requires functional monthly, with a min maximum of 5 wee than 30 seconds, (3 conducted annually if the emergency lig powered and (5) W inspections and test for inspection by th jurisdiction. This diresidents in the faci.  Findings include:  Based on observation, and 5:00 p.m. the Executive Direct Operations, and Masister facility, the endicated at the rear of from the nearest particular back up light set progenerator. Based on observation, the Masister facility acknowledges of the progenerator.  This finding was red Director, Regional and the required of the progenerator.	eficient practice could affect all lity.  on on 12/16/24 between 2:30 during a tour of the facility with etor, Regional Director of contenance Director from a mergency generator was of the facility at least 100 feet ring lot. There was no battery ovided in or around the nan interview at the time of contenance Director from the weldged there was no battery or around the emergency							
K 0921 SS=F	NFPA 101 Electrical Equipme	ent - Testing and							

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet

Page 24 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155661		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024		
NAME OF I	PROVIDER OR SUPPLIEF	₹	-			ADDRESS, CITY, STATE, ZIP COD HIGHWAY 46	-	
OWEN V	ALLEY REHABILIT	ATION AND HEALTHCARE CEN	ITER			ER, IN 47460		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG					TAG	DEFICIENCY)		DATE
Bldg. 01	Maintenanc							
	Based on record review, observation, and			K 0921		What corrective action(s) will be		01/27/2025
	interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care					accomplished for those residents found to have been affected by the deficient practice:		
	Related Electrical Equipment (PCREE). NFPA 99							
	2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and					No residents were identified as		
						being affected by the alleged		
		for fixed and portable PCREE				deficient practice.		
		uired in 10.3. Testing intervals						
		policies and protocols. All				l		
	_	ient care rooms is tested in				How other residents having the		
		.3.5.4 or 10.3.6 before being put				potential to be affected by the		
		er any repair or modification.				same deficient practice will be		
		ing of several electrical				identified and what corrective		
		trates compliance with NFPA				action(s) will be taken:		
		stem. Service manuals,				<b>.</b>		
		ocedures provided by the				All residents have the potentia		
		de information as required by				be affected. The Maintenance		
		considered in the development				Director or designee will inspe		
		ectrical equipment maintenance.  nt instructions and maintenance				all Patient Care Related Elect	ricai	
						Equipment.		
	manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is							
						What measures will be put into		
						place and what systemic changes		
maintained for a period of time to demonstrate					will be made to ensure that the			
	_	rdance with the facility's				deficient practice does not red		
	_	responsible for the testing,				denoient practice does not rec	Jul.	
		se of electrical appliances				The Maintenance Director or		
		training. This deficient				designee will complete and re	cord	
	practice could affect					the results of all Patient Care	-001 <b>u</b>	
	ratative could affect					Related Electrical Equipment		
	Findings include:					inspections.		
	Based on record review on 12/16/24 between 10:00							
	_	with the Executive Director,				How the corrective actions will be		
		of Operations, and Maintenance				monitored to ensure the defic	ent	
	Director from a sister facility present, there was no					practice does not recur.		
	documentation for t	the testing of PCREE, such as						

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

Event ID:

OH8Q21 Facility ID: 010892

If continuation sheet Page 25 of 26

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

PRINTED: 01/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155661	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/16/2024			
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY REHABILITATION AND HEALTHCARE CENTE			STREET ADDRESS, CITY, STATE, ZIP COD 920 W HIGHWAY 46 SPENCER, IN 47460					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)  TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
	*				The Executive Director will au the results of all Patient Care Related Electrical Equipment inspections weekly X 4 weeks then monthly X 5 months with issues reported at the monthly QAPI meeting.	and any		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OH8Q21 Facility ID: 010892 If continuation sheet Page 26 of 26