PRINTED: 10/20/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B			ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIEF	L CARE AND REHABILITATION		2100 M	ADDRESS, CITY, STATE, ZIP COD IIDWAY ST MBUS, IN 47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000	conducted by the Irr accordance with 42 Survey Date: 09/29 Facility Number: 0 Provider Number: 100 At this Emergency Columbus Transition was found not in conformation of the preparedness Requirements Requirements (CFR 483.73). The facility has 212 the survey, the cension of the conformation of the co	20/22 200058 200058 200058 200058 200058 200058 200058 200059 20	E 00	00	Submission of this plan of correction does not constitute admissions or agreement by t provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirer under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Pleafind enclosed this plan of correction for this survey. Due low scope and severity of the survey finding, please find the sufficient documentation provievidence of compliance with the plan of correction. The documentation serves to confithe facility's allegation of compliance. Thus, the facility respectfully requests the gran of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contain me.	on The and ment se to ding he irm	
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a	416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a))(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2)					

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

486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)

Plan Based on All Hazards Risk Assessment

(1)-(2)

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155133		B. WING		09/29/2022	
		100100	D. W.			03/23/	2022
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD IDWAY ST		
COLUME	BUS TRANSITIONA	L CARE AND REHABILITATION			IBUS, IN 47201		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
), §416.54(a)(1)-(2),					
), §441.184(a)(1)-(2),					
		§482.15(a)(1)-(2),					
		§483.475(a)(1)-(2),					
	- ' ' ' ' '), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),					
	- ' ' ' ' '), §486.360(a)(1)-(2),					
	- ' ' ' ' '	§494.62(a)(1)-(2)					
	3 = (.) (-) ,	3 10 110=(4)(1) (=)					
	[(a) Emergency P	lan. The [facility] must					
	develop and main	tain an emergency					
	preparedness plan that must be reviewed, and updated at least every 2 years. The plan						
	must do the follow	ving:]					
	(1) Be based on a	and include a documented,					
	facility-based and	community-based risk					
		ing an all-hazards					
	approach.*						
	(2) Include strateg	gies for addressing					
	emergency events	s identified by the risk					
	assessment.						
	* [For Hospices at	t §418.113(a):] Emergency					
		e must develop and					
		gency preparedness plan					
	that must be revie	wed, and updated at least					
		e plan must do the					
	following:						
	` '	ind include a documented,					
	_	community-based risk					
	assessment, utiliz approach.	ing an all-hazards					
		gies for addressing					
		s identified by the risk					
		iding the management of					
		s of power failures, natural					
	-	er emergencies that would					
		's ability to provide care.					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING				(3) DATE SURVEY COMPLETED	
111.15 1 2111.	, or conduction	155133	B. WIN			09/29/	
	PROVIDER OR SUPPLIER	L CARE AND REHABILITATION	<u> </u>	2100 M	ADDRESS, CITY, STATE, ZIP COD IDWAY ST IBUS, IN 47201	<u> </u>	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	*[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include stratege emergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency prebe reviewed, and years. The plan medicility-based and assessment, utiliz approach, includir (2) Include stratege emergency events assessment. Based on record revialled to maintain an plan that was (1) ba documented, facility risk assessment, utiliz including missing restrategies for addressidentified by the risk with 42 CFR 483.73. In the Survey & Ce 19-06-ALL dated 0.	The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ag missing residents. ites for addressing identified by the risk at 483.475(a):] Emergency must develop and maintain aparedness plan that must updated at least every 2 ust do the following: Ind include a documented, community-based risk ing an all-hazards	E 00	TAG	1. No residents, staff, or visito were affected. 2. All residents, staff, and visit have the potential to be affect thus the following corrective actions have been taken; 3. The Administrator updated Hazard Vulnerability Analysis include the Emerging Infection Diseases hazard (Attachment Policy was reviewed, no chan made.	ors ed, the to us A).	10/14/2022

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Event ID:

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155133		r í	JILDING	NSTRUCTION	(X3) DATE COMPL 09/29 /	ETED	
	PROVIDER OR SUPPLIER	L CARE AND REHABILITATION		2100 M	ADDRESS, CITY, STATE, ZIP COD IDWAY ST IBUS, IN 47201		
(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
	Appendix Z of the streflect changes to a diseases to the definand stated "Plannin approach should als disease (EID) threat Influenza, Ebola, Z deficient practice of Findings include: Based on review of Program" document Administrator, the Administrator in Treview from 9:10 a documented facility risk assessment addisease (EID) threat EID was not include Vulnerability Analy Based on interview conference at 1:30 Administrator produce generated as part of Emergency Prepared 08/12/21 which incessoring for all risks Based on interview conference, the Administrator produce and the preparedness program address emerging in part of the facility-trisk assessment as a & Certification mer.	State Operations Manual to dd emerging infectious nition of all-hazards approach g for using an all-hazards so include emerging infectious its. Examples of EIDs include ika Virus and others". This bould affect all occupants. S"Emergency Preparedness tation dated 02/08/22 with the Maintenance Director and the raining (AIT) during record im. to 11:45 a.m. on 09/29/22, a pressed and community-based dressing emerging infectious its was not available for review ed in the current "Hazard ysis (HVA)" for the facility, at the time of the exit p.m. on 09/29/22, the uced a written HVA that was if the Plan of Correction for the endness survey conducted on luded EID as a hazard but the including EID, was not listed, at the time of the exit ministrator agreed emergency am documentation did not infectious diseases (EID) as based and community-based mandated by the CMS Survey mo QSO: 19-06-ALL. Viewed with the Administrator, irector and the AIT during the			4. Administrator and Maintena Director or designee will ensur the Hazard Vulnerability is completed annually per policy. 5. Corrective action will be completed on or before Octob 14, 2022.	nce re	
	exit conference.	needs and the ATT during the					

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Event ID: OW0221 Facility ID: 000058

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02.12.210.20	WILDICARD & MEDIC	TID SERVICES			OHID 110. 0700 007	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED 09/29/2022	
		155133	B. WING	<u>• . </u>		
		100100	_		00/20/2022	_
NAME OF	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD		
				MIDWAY ST		
COLUM	BUS TRANSITIONA	AL CARE AND REHABILITATION	COLUN	MBUS, IN 47201		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
K 0000						
Bldg. 01						
-	A Life Safety Code	Recertification and State	K 0000	Submission of this plan of		
	1	vas conducted by the Indiana		correction does not constitute		
	1	lth in accordance with 42 CFR		admissions or agreement by the		
	483.90(a).			provider of the truth of facts		
	()			alleged or correction set forth	on	
	Survey Date: 09/29	9/22		the statement of deficiencies.		
		·· ·		plan of correction is prepared		
	Facility Number: 0	000058		submitted because of requirer	I	
	Provider Number:			under state and federal law.	Hone	
	AIM Number: 100			Please accept this plan of		
	7 HIVI I VAINIOCI. 100	2033 10		correction as our credible		
	At this Life Safety	Code survey, Columbus		allegation of compliance. Plea	200	
	-	nd Rehabilitation was found		find enclosed this plan of	136	
		with Requirements for		correction for this survey. Due	, to	
	_	dicare/Medicaid, 42 CFR		low scope and severity of the	; 10	
	_	Life Safety from Fire and the				
		National Fire Protection		survey finding, please find the		
		(A) 101, Life Safety Code (LSC),		sufficient documentation provi	_	
		· · · · · · · · · · · · · · · · · · ·		evidence of compliance with the	ne	
	_	g Health Care Occupancies and		plan of correction. The		
	410 IAC 16.2.			documentation serves to confi	ırm	
	This f:1			the facility's allegation of		
		lity with a partial basement was		compliance. Thus, the facility	l	
		Type V (000) construction and		respectfully requests the grant	ting	
		The facility has a fire alarm		of paper compliance. Should		
	'	detection in the corridors and		additional information be		
	^	the corridor. The facility has		necessary to confirm said		
		noke detectors installed in all		compliance, feel free to contact	ct	
		ooms. The facility has a		me.		
		I had a census of 59 at the time				
	of this survey.					
	All areas where eas	idents have customary access				
	services were sprin	All areas providing facility				
	services were sprin	KICICU.				
	Quality Review con	mpleted on 10/03/22				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ì í				(3) DATE SURVEY	
AND PLAN	OF CORRECTION	155133	B. WING			COMPLETED 09/29/2022	
		155155	D. WI			09/29/	2022
	ROVIDER OR SUPPLIER BUS TRANSITIONA	L CARE AND REHABILITATION		2100 M	ADDRESS, CITY, STATE, ZIP COD IDWAY ST IBUS, IN 47201		
(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
K 0300	NFPA 101						
SS=E	Protection - Other						
Bldg. 01	Protection - Other						
	List in the REMAR	RKS section any LSC					
	Section 18.3 and	19.3 Protection					
	requirements that	are not addressed by the					
	provided K-tags, b	out are deficient. This					
	information, along	with the applicable Life					
	Safety Code or NF	FPA standard citation,					
	should be included	d on Form CMS-2567.					
	1. Based on observa	ntion and interview, the facility	K 0.	300	1. No residents, staff, or visito	rs	10/14/2022
	failed to replace 3 o	f over 50 battery operated			were affected.		
	smoke alarms instal	led in resident sleeping rooms			2. All residents, staff, and visit	ors	
	in accordance with	NFPA 72. NFPA 72, 2010			have the potential to be affecte	ed,	
	Edition, Section 14.	4.8.1 states unless otherwise			thus the following corrective		
	recommended by th	e manufacturer's published			actions have been taken;		
	instructions, single-	and multiple-station smoke			3. The Maintenance Director		
	alarms shall be repla	aced when they fail to respond			replaced the smoke alarms in		
	to operability tests b	out shall not remain in service			Room 7 (Attachment B-1), Ro	om	
	longer than 10 years	s from the date of manufacture.			431 (Attachment B-2), and Ro	om	
	This deficient practi	ice could affect over 20			518 (Attachment B-3) with nev	V	
	residents, staff and	visitors.			smoke alarms. The Maintenar	ice	
	Findings include:				Director moved the smoke ala to be within 12 inches of the		
	Rased on observation	ons with the Maintenance			ceiling in Room 429 (Attachme B-4). The Maintenance Directo		
		our of the facility from 11:45			inspected all battery operated	וכ	
	_	n 09/29/22, manufacturer's			smoke detectors in the facility	to	
	-	xed to the First Alert Model			ensure they are in compliance		
		ated smoke alarm installed on			(Attachment B-5).		
		nt sleeping Room 7 and in			4. The Maintenance Director a	nd	
	_	ch unit was manufactured in			Administrator or designees wil		
		n installation date of July 2012			ensure all battery operated sm		
	was written on the b	_			detectors are in compliance	IOVE	
		umentation affixed to the First			monthly. The audit will be revi	awad	
		battery operated smoke alarm			monthly during the facility's	CWEU	
		ing in resident sleeping Room			morning meeting. The plan of		
		was manufactured June 12,			correction will be reviewed		
		on date of July 2012 was written			quarterly and adjusted		
		evice. Based on interview at			accordingly.		
	on the back of the u	C. ICC. Daboa on mitor view at	1		accordingly.		I

i ´		ľ í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 155133	A. BUILD	ING	01	COMPLETED 09/29/2022	
		133133		_		03/23/	2022
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD IDWAY ST		
COLUMB	BUS TRANSITIONA	L CARE AND REHABILITATION			1BUS, IN 47201		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		rvations, the Maintenance three smoke alarms were each			Corrective action will be completed on or before Octob	or	
	more than ten years				14, 2022.	CI	
	,				,		
	_	viewed with the Administrator,					
		rector and the Administrator					
	in Training during t	he exit conference.					
	3.1-19(b)						
	2. Based on observe	ation and interview, the facility					
		ery operated smoke detectors					
		er 50 resident sleeping rooms					
	were installed in ac	cordance with NFPA 72,					
		n and Signaling Code, 2010					
		Section 29.8.3.3 states smoke					
		tectors mounted on walls shall					
		er than 12 inches (300 mm)					
		ceiling surface. This deficient					
	visitors in the vicini	t over 15 residents, staff and					
		ny 01 (100)11 42).					
	Findings include:						
	Based on observation	ons with the Maintenance					
	Director during a to	our of the facility from 11:45					
	•	n 09/29/22, the wall mounted					
		oke detector installed in					
		oom 429 was installed 16					
		iling. Based on interview at					
		eview, the Maintenance					
		wall mounted smoke detector					
	installed in Room 4 inches from the ceil	29 was installed more than 12					
	menes nom me cen	ing.					
	This finding was re	viewed with the Administrator,					
		rector and the Administrator					
	in Training during t	he exit conference.					
	3.1-19(b)						
ı	1 .5.1-19(D)		1				I

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155133		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIER	L CARE AND REHABILITATION	•	2100 M	ADDRESS, CITY, STATE, ZIP COD IDWAY ST IBUS, IN 47201	•	
(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 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller landware. Roller landware. Roller landware. Roller landware. Roller landware of complying to auxiliary standard the door complying with the door closed with a control of the door closed with a polied. There is closing of the door release when the permitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lad other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restricts resistance of glass assemblies.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 09/29/2022				
	PROVIDER OR SUPPLIEF BUS TRANSITIONA	L CARE AND REHABILITATION	2100 M	ADDRESS, CITY, STATE, ZIP COD IIDWAY ST MBUS, IN 47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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
K 0511	fire protection ration devices, etc. Based on observation failed to ensure 1 or impediment to closs frame and would residents, staff and mail room by the mail room by the mail room by the mail room by the mail room that the latching protrude into the lat when tested to closs interview at the time Maintenance Direct door handle was not mechanism was tap the room and agree room would not late ensure the door worsmoke. This finding was re	As details of doors such as angs, automatics closing on and interview, the facility of over 50 corridor doors had no ing and latching into the door sist the passage of smoke. ice could affect over 20 visitors in the vicinity of the anin entrance door set. Ons with the Maintenance our of the facility from 11:45 to 109/29/22, the latching corridor door to the mail room are door set was taped down and mechanism would not to the observations, the cor stated the keypad on the to operable so the latching ed down to allow entry into do the corridor door to the mail the corridor door the corridor door to the corridor door the corridor	K 0363	1. No residents, staff, or visito were affected. 2. All residents, staff, and visit have the potential to be affect thus the following corrective actions have been taken; 3. The Maintenance Director removed the tape from the late mechanism on the door to the mail room and replaced the keypad to ensure door and latching mechanism work properties (Attachment C-1). 4. Administrator or Maintenant Director or designees will ensure monthly inspection of mail roo door and latching mechanism (Attachment C-2). The plan of correction will be reviewed quarterly and adjusted accordingly. 5. Corrective action will be completed on or before Octob 14, 2022.	ching cerly ce ure m	10/14/2022
SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and					

Equipment using gas or related gas piping

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/29/2022 155133 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2100 MIDWAY ST COLUMBUS TRANSITIONAL CARE AND REHABILITATION COLUMBUS, IN 47201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 1. No residents, staff, or visitors 10/14/2022 failed to ensure electrical receptacles in 1 of 1 were affected. Main Dining Rooms were properly wired and 2. All residents, staff, and visitors grounded in accordance with NFPA 70. LSC 19.5.1 have the potential to be affected, requires utilities to comply with Section 9.1. LSC thus the following corrective 9.1.2 requires electrical wiring and equipment to actions have been taken; comply with NFPA 70, National Electrical Code. 3. The Maintenance Director took NFPA 70, 2011 Edition at 406.4 General Installation the plug out, put the wires inside Requirements states receptacle outlets shall be of the box, and put a blank over located in branch circuits in accordance with Part the outlet so it cannot be used by III of Article 210. General installation anyone and no longer be an active requirements shall be in accordance with 406.4(A) or accessible electrical receptacle through (F). (Attachment D). (A) Grounding Type. Receptacles installed on 15-4. The Maintenance Director or and 20-ampere branch circuits shall be of the Administrator or designees will grounding type. inspect electrical receptacles Grounding-type receptacles shall be installed only annually per policy and life safety on circuits of the voltage class and current for code. Policy reviewed, no changes which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). 5. Corrective action will be Exception: Nongrounding-type receptacles completed on or before October installed in accordance with 406.4(D). 14, 2022. (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment

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grounding conductor contacts of receptacles and cord connectors shall be grounded by connection

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

PRINTED: 10/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155133		(X2) MULTIPLE CONSTRUCTION X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 09/29/2022			ETED		
	PROVIDER OR SUPPLIER	L CARE AND REHABILITATION		2100 MI	ADDRESS, CITY, STATE, ZIP COD IDWAY ST IBUS, IN 47201	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE
IAU	to the equipment greircuit supplying the The branch-circuit of provide an equipment which the equipment contacts of the recession contacts of the re	ounding conductor of the e receptacle or cord connector. wiring method shall include or ent grounding conductor to nt grounding conductor ptacle or cord connector are No. 1: See 250.118 for ng means. No. 2: For extensions of uits, see 250.130. ice could affect over 20 visitors in the Main Dining ons with the Maintenance ur of the facility from 11:45 n 09/29/22, four of four electrical all mounted outlet box in the near the entrance door to the found to have an "open d with an Ideal Industries UL resting device. Based on e of the observations, the for agreed the testing device entioned electrical receptacles wiewed with the Administrator, rector and the Administrator		IAU			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OW0221 Facility ID: 000058 If continuation sheet Page 11 of 11