STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED			
		155572	B. WING		12/12/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5) COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
E 0004 SS=C Bldg	State Licensure Sur Indiana Department 42 CFR 483.73. Survey Date: 12/12 Facility Number: 0 Provider Number: 100 At this Emergency I Care - Demotte was compliance with En Requirements for M Participating Provid Subpart 483.73. The facility is certif At the time of the su Quality Review con 403.748(a), 416.5441.184(a), 482.1484.102(a), 485.6485.727(a), 485.9491.12(a), 494.62	00471 155572 290390 Preparedness survey, Aperion s found in substantial mergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR Sied for 93 dual certified beds. survey, the census was 80. mpleted on 12/14/22 4(a), 418.113(a), 5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),	E 0000				
	Annually §403.748(a), §416 §441.184(a), §460 §483.73(a), §483. §485.68(a), §485.	6.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 6.360(a), §491.12(a),					
LABORATOR	RY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE		
Kelly DeYo	oung		HFA		12/28/2022		

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.

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE COMPI 12/12		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	Federal, State and preparedness required must develop estate comprehensive errorgram that mee section. The emer program must include the following eleminary	uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, ents: an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable d local emergency uirements. The [hospital or inp and maintain a mergency preparedness ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated]	E 0004	E 004		12/25/2022	
	Dascu on record fev	new and interview, the facility	E 0004	E 004		12/25/2022	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	ì	UILDING	ONSTRUCTION	(X3) DATE COMPL 12/12/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(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)	ATE	(X5) COMPLETION DATE
	preparedness plan t at least annually in 483.73(a). This def occupants.	nd maintain an emergency hat was reviewed and updated accordance with 42 CFR icient practice could affect all			The facility requests desk revi for this citation. This Plan of Correction is the center's credible allegation of		
	Preparedness Plan of to 10:02 a.m. with the present, documental preparedness prograwithin the most reconstruction available for relavailable had not be twelve-months with review having not be Based on interview the Maintenance Distriction on the plan. During facility Administration Director at 2:05 p.m.	The facility's Emergency on 12/12/22 between 9:30 a.m. the Maintenance Director tion for an updated emergency am reviewed by the facility ent twelve-month period was view. The emergency plan een reviewed within the past in the last documented date of been documented in the plan. The time of record review, irrector stated that he was airrement for an annual update of the exit conference with the tor and the Maintenance in., no additional information or provided contrary to this			Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR	ot ment the et	
					483.73(a). 2) How the facility identified other residents: All residents may be affected by this deficient practice. 3) Measures put into place/System changes:	d	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/12/2022
	PROVIDER OR SUPPLIE		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				The HFA/Executive Director will ensure that the Emergence Preparedness Plan is updated annually.	-
				4) How the corrective actions will be monitored: The HFA/Executive Director will ensure that the Emergence Preparedness Plan is reviewed and updated annually. An audill be performed yearly to ensure compliance.	cy ed
				The results of these audits with be reviewed in Quality Assurance Meeting monthly of months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicate so that the second of t	k6 f s
E 0013 SS=C Bldg	484.102(b), 485.6	5(b), 483.475(b), 483.73(b),			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	§403.748(b), §416 §441.184(b), §460 §483.73(b), §483. §485.68(b), §485.	(b) P Policies and Procedures 6.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b),					
	develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The policy	ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. To develop and imples preparedness policion the emergency (a) of this section, paragraph (a)(1) communication plasection. The policion	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.					
	*Additional Requir ESRD Facilities:	rements for PACE and					
	procedures. The develop and imple preparedness poli on the emergency	60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at					

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	OF CORRECTION	IDENTIFICATION NUMBER 155572	ľ í	JILDING	INSTRUCTION	COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	communication plasection. The policiand address managen nonmedical emerginited to: Fire; eq failure; care-related disasters likely to safety of the partic. The policies and previewed and upd. *[For ESRD Faciliand procedures. develop and imple preparedness policibe reviewed and upd.) (a) of this section, paragraph (a)(1) communication plasection. The policibe reviewed and updessection. The policibe reviewed and updessection in the reviewed and updessection of the policies and procedupdated at least annual preparedness policibe and prepared	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 rgencies include, but are equipment or power ed emergencies, water and natural disasters are facility's geographic riew and interview, the facility implement emergency es and procedures. The ures must be reviewed and ually in accordance with 42 s deficient practice could affect	E 00	013	E 0013 The facility requests desk revie for this citation. This Plan of Correction is the center's credible allegation of compliance.	ew	12/25/2022
		the facility's Emergency on 12/12/22 between 9:30 a.m.			Preparation and/or execution of this plan of correction does no constitute admission or agreer	t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIEI		1	0352 N	DDRESS, CITY, STATE, ZIP COD I 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	present, documenta and procedures rev most recent twelve- available for review had not been review with the last docum- not been document interview at the tim Maintenance Direct of the requirement plan. During the ex Administrator and to 2:05 p.m., no additi	the Maintenance Director tion for an updated policies iewed by the facility within the month period was not v. The emergency plan available wed within the past 12 months mented date of review having ed in the plan. Based on the of record review, the tor stated that he was unaware for an annual update on the tit conference with the facility the Maintenance Director at tional information or evidence contrary to this deficient			by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a). 2) How the facility identified other residents: All residents may be affected by this deficient practice. 3) Measures put into place/ System changes: The HFA/Executive Director will ensure that the Emergen Preparedness Plan is update annually.	er r ss
					4) How the corrective actions will be monitored:	3

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	OF CORRECTION	IDENTIFICATION NUMBER 155572	A. BUILDING B. WING	SNSTRUCTION 	COM	TE SURVEY MPLETED 12/2022
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP CO N 600 E COUNTY LINE F TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
				The HFA/Executive Direction will ensure that the Em Preparedness Plan is reand updated annually. will be performed yearl ensure compliance.	ergency eviewed An audit	
				The results of these au be reviewed in Quality Assurance Meeting mo months or until an aver 100% compliance or grachieved x3 consecutive months. The QA Commonths. The QA commonths and make recommendations to replan of correction as in	enthly x6 rage of reater is ve nittee or	
E 0029 SS=C Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §483.73(c), §483.9: §485.68(c), §485.9: §494.62(c).	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) ommunication Plan 5.54(c), §418.113(c), 0.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 6.360(c), §491.12(c),		5) Date of compliance: 12-25-22		
		ust develop and maintain				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	A (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(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)	ATE	(X5) COMPLETION DATE
140	plan that complies local laws and mu at least every 2 ye facilities]. Based on record revisited to develop an preparedness comm with Federal, State, with 42 CFR 483.7 could affect all occurs in the facility of the revisited for revisited to 10:02 a.m. with the present, documentate communication plan within the most reconstruction plan within the most reconstruction available for revisitable had not be months with the last having not been does on interview at the Maintenance Direct of the requirement of	s with Federal, State and lest be reviewed and updated lears [annually for LTC] wiew and interview, the facility and maintain an emergency munication plan that complies and local laws in accordance (3(c)). This deficient practice lapants. The facility's Emergency on 12/12/22 between 9:30 a.m. the Maintenance Director	E 0	029	E 0029 The facility requests desk revifor this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: The Emergency Preparedness in the Emergency Prepared in the Em	iew of ot ement the eet	12/25/2022

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	OF CORRECTION	IDENTIFICATION NUMBER 155572	A. BUILDING B. WING	JNSTRUCTION 	COMPLETED 12/12/2022
	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				3) Measures put into place/ System changes: The HFA/Executive Director will ensure that the Emerger Preparedness Plan is update annually.	<u> </u>
				4) How the corrective action will be monitored: The HFA/Executive Director will ensure that the Emerger Preparedness Plan is review and updated annually. An au will be performed yearly to ensure compliance.	ncy ved
				The results of these audits was reviewed in Quality Assurance Meeting monthly months or until an average of 100% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 12-25-22	x6 of is

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	-	SURVEY LETED 1/2022
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP CO N 600 E COUNTY LINE I FTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	484.102(d), 485.6: 485.727(d), 485.9: 491.12(d), 494.62: EP Training and T §403.748(d), §416: §441.184(d), §466: §483.73(d), §485.6: §485.920(d), §486: §485.920(d), §486: §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625: 485.727, CMHCs: §486.360, and RH Training and testindevelop and maintiperparedness trainthat is based on the in paragraph (a) of assessment at paragraph (b) of this section, plan at paragraph training and testing reviewed and update in the emergency plan at the emergency plan of this section, risk (a)(1) of this section, risk (a)(1) of this section, risk (a)(1) of this section.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) resting 5.54(d), §418.113(d), 2.54(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 2.360(d), §491.12(d), 2.360(d), §491.12(d), 3.360(d), 3.360				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETEI B. WING 12/12/202			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(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*	ΓE	(X5) COMPLETION
TAG	communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facili Training, testing, at dialysis facility must be reviewed and patient orients on the emergency prepared patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at paragraph.	an at paragraph (c) of this ing and testing program and updated at least [483.475(d):] Training and D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every IID must meet the evacuation drills and training and orientation. The lest develop and maintain an redness training, testing ation program that is based or plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c)		TAG	DEFICIENCY)		DATE
	orientation progra updated at every	ne training, testing and m must be evaluated and 2 years. view and interview, the facility	E 00	036	E 0036		12/25/2022
	failed to develop an preparedness training was reviewed and u	d maintain an emergency ng and testing program that updated at least annually in CFR 483.73(d). This deficient			The facility requests desk review for this citation.	ew	
	practice could affect				This Plan of Correction is the center's credible allegation of		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		A. BUILDING B. WING		COMPLETED 12/12/2022	
	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(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) compliance.	(X5) COMPLETION DATE
	Preparedness Plan of to 10:02 a.m. with the present, documentate and testing program within the most recent available for reveavailable had not be months with the last having not been documented on interview at the the Maintenance Director of the requirement o	the facility's Emergency in 12/12/22 between 9:30 a.m. he Maintenance Director ion for an updated training reviewed by the facility ent twelve-month period was riew. The emergency plan en reviewed within the past 12 documented date of review rumented in the plan. Based ime of record review, the or stated that he was unaware for an annual update on the training to the Maintenance Director at conal information or evidence contrary to this deficient		Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: The Emergency Preparedness Plan was reviewed and updated immediately in accordance with 42 CFR 483.73(a). 2) How the facility identified other residents: All residents may be affected by this deficient practice. 3) Measures put into place/ System changes: The HFA/Executive Director will ensure that the Emerger Preparedness Plan is update annually.	ot ment the et
			ı		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 12/12/2022			ETED		
	PROVIDER OR SUPPLIE			10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD ITE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	DDEELY (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					4) How the corrective action will be monitored: The HFA/Executive Director will ensure that the Emerger Preparedness Plan is review and updated annually. An activity be performed yearly to ensure compliance.	ncy red	
					The results of these audits was be reviewed in Quality Assurance Meeting monthly months or until an average of 100% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 12-25-22	x6 of is	
K 0000							
Bldg. 01	Licensure Survey v	e Recertification and State was conducted by the Indiana lith in accordance with 42 CFR	K 00	000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155572	B. W	ING		12/12/	/2022
E 0E B				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		10352 N 600 E COUNTY LINE RD				
APERION	N CARE DEMOTTE			DEMOT	TE, IN 46310		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	Facility Number: 0 Provider Number:						
	AIM Number: 100290390						
	Anvi Number. 1002	270370					
	At this Life Safety (Code survey, Aperion Care -					
	-	not in compliance with					
	Requirements for Pa	articipation in					
	Medicare/Medicaid	, 42 CFR Subpart 483.70(a),					
	•	re, and the 2012 edition of the					
		ction Association (NFPA) 101,					
	,	SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one-story facility was determined to be of						
	•	ruction and was fully					
		cility has a fire alarm system					
	_	on in the corridors, spaces					
		rs and hard-wired detectors in					
	_	grooms. The facility has a					
		nad a census of 80 at the time					
	of this survey.						
	All areas where the	residents have customary					
		ered. All areas providing					
	_	re sprinklered except for one					
	•	storage and one detached					
		ch provided facility storage					
	and were not sprink						
	•						
	Quality Review con	npleted on 12/14/22					
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas	- Enclosure					
	Hazardous areas	are protected by a fire					
	barrier having 1-h	our fire resistance rating					
	(with 3/4 hour fire	rated doors) or an					
		nguishing system in					
		3.7.1 or 19.3.5.9. When the					
	approved automat	tic fire extinguishing system					
	approved automat	tic fire extinguishing system					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPL	ETED
		155572	B. WING 12/12/202			/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			N 600 E COUNTY LINE RD		
APERIO	N CARE DEMOTTE	=		DEMOTTE, IN 46310			
74 21401	· · · · · · · · · · · · · · · · · · ·	-	_	DE.WIO	112, 11 10010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 '	e areas shall be separated					
	· ·	s by smoke resisting					
	l ·	ors in accordance with 8.4.					
	Doors shall be sel						
	_	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	•					
	· •	-Fired Heater Rooms					
		er than 100 square feet)					
	, -	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons)	(
	e. Trash Collectio	n Rooms					
	(exceeding 64 gal						
		orage Rooms/Spaces					
	(over 50 square fe	-					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	2)					
	Based on observation	on and interview, the facility	K 0	321	K- 321		12/25/2022
	failed to ensure 1 or	f 5 hazardous areas, such as a					
		o-hazard room or a storage			The facility requests desk revi	ew	
	room of combustibl	le supplies over 50 square feet			for this citation.		
	in size, was provide	ed with a self-closing door or					
	device which would				This Plan of Correction is the		
		and latch into the door frame.			center's credible allegation of		
	_	ice could affect as many as 20			compliance.		
	residents, 4 staff, ar	nd 2 visitors in the facility.					
					Preparation and/or execution		
	Findings include:				this plan of correction does no		
					constitute admission or agreei		
		ons made during a tour of the			by the provider of the truth of t		
	facility with the Ma	nintenance Director on 12/12/22			facts alleged or conclusions se	et .	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/12/2022
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RI TTE, IN 46310	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
140	the following was ra a) At 1:05 p.m. the a room that measure by 24 feet long and packed full of well and miscellaneous la supplies creating a b) At 1:09 p.m. the Lobby, an area that feet long by 25 feet was packed full of cardboard and misc remodeling supplies. It was noted that be doors and therefore separated to protect path of egress. Base the observations, the there was nowhere these items, but he the Administrator. I the facility Adminis Director at 2:05 p.m.	oted: area identified as the "Cubby", ed approximately 20 feet wide open to the corridor was over 100 boxes of cardboard building and remodeling		forth in the statement of deficiencies. The plan of correction is prepared an executed solely because required by the provisions federal and state law. 1)Immediate actions take those residents identified. All cardboard boxes and miscellaneous building remodeling supplies we removed on 12-13-22 and placed in an enclosed at 2) How the facility identification of the residents: All residents may be affected by this deficient practice. 3) Measures put into plate system changes: Maintenance Director In-Serviced regarding prestorage procedures. Contractors notified of fistorage guidelines.	en for ed: d and re d rea. ified ected e.
				4) How the corrective ac will be monitored: HFA/Maintenance Direct	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/12/2022
	PROVIDER OR SUPPLIEI		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE DATE
				perform daily audits to er all remodel materials are stored properly in enclos areas. HFA/Maintenance Director also ensure all other materials properly stored in enclos areas. Audits will be performed 6 months. The results of these audit be reviewed in Quality Assurance Meeting montomonths or until an average 100% compliance or great achieved x3 consecutive months. The QA Commit will identify any trends or patterns and make recommendations to reviplan of correction as indicated in the store of the store	or to erial osed times ts will hly x6 ge of tter is ttee
K 0351 SS=E Bldg. 01	by construction ty throughout by an sprinkler system i 13, Standard for t Systems. In Type I and II co protection measu	Installation nd hospitals where required			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and the closet footprinklers. Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 19.3.5.5, 19.4.2, 19.3.5.6, 19.4.2, 19.3.5.6 and the conservation of the Installation of 2010 edition, Section escutcheons, or othe annular space around or shall be listed for deficient practice of the installation of 2010 edition, Section escutcheons, or othe annular space around or shall be listed for deficient practice of the installation of the installati	19.3.5.3, 19.3.5.4, 9.3.5.10, 9.7, 9.7.1.1(1) on and interview, the facility the ceiling construction in 1 of 5 nnce with NFPA 13, Standard of Sprinkler Systems. NFPA 13, on 6.2.7.1 states plates, or devices used to cover the d a sprinkler shall be metallic the use around a sprinkler. This could affect as many as 20 d 2 visitors within the smoke on with the Maintenance 2 at 12:52 p.m., the corridor the West Nurses station had a d Based on interview at the the Maintenance Director missing escutcheon and ld have his vendor replace the time they were in the building ther system. During the exit facility Administrator and the or at 2:05 p.m., no additional ence could be provided	K 0351	K- 351 The facility requests desk rev for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: Notified Valley Fire Protection Systems immediately. Missi Escutcheon will be replaced 12-28-22.	of ot ment the et

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 12/12/2022
	PROVIDER OR SUPPLIE		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(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 APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
				2) How the facility identified other residents:	
				All residents may be affected by this deficient practice	
				3) Measures put into place/ System changes:	
				Maintenance Director /Assista was In-Serviced regarding observation of missing Escutcheon.	ant
				4) How the corrective actions will be monitored:	
				Maintenance Director/Designa will perform weekly audits to assure all Escutcheons are properly installed at all times for 6 months.	ee e
				The results of these audits wi be reviewed in Quality Assurance Meeting monthly x months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	se e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE C A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Automatic sprinkler are inspected, test accordance with Nater-based Fire Records of system inspection and test secure location are a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkler successed on record revidence the sprink been inspected and	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, etting are maintained in a find readily available. system last checked system test supply source RKS information on non-required or partial er system.	K 0353		12/25/2022
	required for compli- maintained in accor requirements. Sprin maintained in accor for the Inspection, 7 Water-Based Fire P 4.3.1 requires recor- inspections, tests, and	dance with this Code be dance with applicable NFPA nkler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreem by the provider of the truth of the facts alleged or conclusions set	ent e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED
		155572	B. WI	NG		12/12/2022
				CTDFFT A	DDDEGG OFFI GTATE ZID COD	
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	
ADEDION	U OADE DEMOTTE				N 600 E COUNTY LINE RD	
APERIO	N CARE DEMOTTE	:		DEMOT	TE, IN 46310	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	authority having jur	risdiction upon request. 4.3.2			forth in the statement of	
	requires that record	s shall indicate the procedure			deficiencies. The plan of	
	_	pection, test, or maintenance),			correction is prepared and/or	
		at performed the work, the			executed solely because it is	
	_	e. NFPA 25, 5.2.5 requires that			required by the provisions of	
		vices shall be inspected			federal and state law.	
		hey are free of physical				
		5.3.3.1 requires the mechanical			1)Immediate actions taken fo	or
	_	vices including, but not limited			those residents identified:	···
		gs, shall be tested quarterly.				
	_	e-type and pressure			Safe care contacted to obtain	n
		ow alarm devices shall be			missing documentation for t	
		This deficient practice could			first quarter. Documents wer	
		staff, and visitors in the			not able to be obtained for th	
	facility.	starr, and visitors in the			first quarter due to prior	ie
	lacinty.				Director error. Contacted	
	Findings include:				Valley Fire to ensure	
	rindings include.				inspections are scheduled for	\ <u></u>
	Rosed on record res	view of the quarterly sprinkler			the next year.	"
		ecords on 1212/22 at 9:52 a.m.			the next year.	
		ce Director present, there was				
		er system inspection report				
		st quarter (January, February,			2) How the facility identified	
		2. During an interview at the			other residents:	
		ew, the Maintenance Director			other residents:	
					All regidents receive after the	.
		nd was told that the previous			All residents may be affected	¹
		for called them on January 1st			by this deficient practice	
		em they would no longer be				
		system inspections for the				
		exit conference with the facility				
		he Maintenance Director at			3) Measures put into place/	
	_	onal information or evidence			System changes:	
	_	contrary to this deficient				
	finding.				Maintenance Director	
					In-Serviced regarding	
	3.1-19(b)				Automatic Sprinkler Standpi	=
					Systems are inspected, teste	
					and maintained in accordance	
					NFPA 25. Sprinkler Inspection	
					confirmed with Valley Fire fo	or

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		A. BUILDING B. WING	01	COMPLETED 12/12/2022	
	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0511 SS=C Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using goomplies with NFF	Electric	TAG	following year . 4) How the corrective action will be monitored: HFA will perform quarterly audits to ensure Sprinkler System components have be inspected per NFPA 25 standards. The results of these audits to be reviewed in Quality Assurance Meeting monthly months or until an average 100 % compliance or greate achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 12-25-22	een will xx6 of r is
	complies with NFF	PA 70, National Electric tallations can continue in o hazard to life.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING		COMPL	X3) DATE SURVEY COMPLETED 12/12/2022	
NAME OF PROVIDER APERION CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
,	ACH 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
failed a relial require 19.5.1.	to ensure that ble source of ments of NF 1, 9.1, 9.1.3. SC section 9.	on and interview the facility the emergency generator had fuel in accordance with the PA 101 - 2012 edition, Section 1 and NFPA 110, 2010 Edition, 1.3.1 states emergency	K 0	511	K 511 The facility requests desk revie for this citation.	ew	12/25/2022
mainta Standa Systen follow	ined in accord rd for Emergns, 2010 Editing energy so	installed, tested, and dance with NFPA 110, ency and Standby Power ion. Section 5.1.1 states the burces shall be permitted to be			This Plan of Correction is the center's credible allegation of compliance.	,	
(1) Lic pressu (2) Lic withdr	uid petroleur e uefied petrol awal)	ency power supply (EPS): n products at atmospheric eum gas (liquid or vapor			Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of t facts alleged or conclusions se	t ment the	
Except where fuel su alterna output	the probabili pplies is high te energy sou of the EPSS	el 1 installations in locations ty of interruption of off-site n, on-site storage of an urce sufficient to allow full to be delivered for the class			forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		
automa to the	ntic transfer f alternate ener	equired, with the provision for from the primary energy source gy source. ples of probability of			1)Immediate actions taken fo those residents identified:	r	
interru earthqi utility potenti	ption could i ıake, flood d unreliability.	nclude the following: amage, or a demonstrated This deficient practice had the Il residents, visitors, and staff			The HFA contacted NIPSCO (The facilities natural gas supplier) immediately requesting a letter stating the facilities natural gas was provided from a reliable		
	gs include:				source.		
Director for the natural	or at 11:48 a. emergency g gas. Additio	on made with the Maintenance m. on 12/12/22, the fuel source generator was verified as to be onally, based on interview, the e a letter from their natural gas			2) How the facility identified other residents:	·#	
-		the natural gas was from a			All residents, visitors and sta may be affected by this	411	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIE		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE	
TAG	reliable source. The the fuel source for from a reliable sou Maintenance Director observation. During facility Administra Director at 2:05 p.1	e lack of this letter stating that the emergency generator was ree was acknowledged by the stor at the time of the g the exit conference with the tor and the Maintenance m., no additional information or provided contrary to this	TAG	deficient practice 3) Measures put into place/System changes: The HFA will ensure that the letter from NIPSCO stating facility has a reliable gas source complying with NFP 54, National Fuel Gas code always available in the emergency preparedness manual. 4) How the corrective action will be monitored: The HFA /Executive Directo will ensure that Emergency Preparedness Plan is review and updated annually to ensure compliance. An aud will be performed yearly to ensure compliance. The results of these audits be reviewed in Quality Assurance Meeting monthly months or until an average 90% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indica	e the PA is wed dit will y x6 of is e
				pian of correction as mulca	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155572	A. BUILDING B. WING	G <u>01</u>	COMPLETED 12/12/2022		
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-tern do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Based on observatio failed to ensure 1 of	d electrical equipment les that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE out 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was set the conditions of 10.2.4. D), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 on and interview, the facility C2 lounge areas where flexible	K 0920	5) Date of compliance: 12/25/22 K-920	12/25/2022		
	wiring. LSC 9.1.2 re equipment shall be i National Electrical (Article 400.8 require	as a substitute for fixed equires electrical wiring and in accordance with NFPA 70, Code. NFPA 70, 2011 Edition, es that, unless specifically cords and cables shall not be		The facility requests desk revision for this citation. This Plan of Correction is the center's credible allegation of compliance.			

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/12/2022	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE		STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR used as a substitute This deficient practi residents, 4 staff and compartment. Findings include: Based on observation Director on 12/12/2 was found to be in u area and had a micro refrigerator plugged power strip, the Man the power strip from microwave oven and into a wall socket re Although this deficile	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION for fixed wiring of a structure. ice could affect as many as 20 id 2 visitors within the smoke on with the Maintenance 2 at 12:59 p.m., a power strip use in the Room #106 Lounge owave oven and a small into it. Upon seeing the intenance Director removed in use and plugged both the id the small refrigerator directly emoving the deficiency. ency was removed prior to my y, it still was reviewed with the exist conference on 12/22/22 at	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE TO THE APPROPRIADE PROPERIES OF THE APPROPRIATION OF	of ot ment the et UL lt ver	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		01	COMPLETED	
		155572	B. WING			12/12/2022	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
711 E11101	TO/ITE DEMOTTE	•	DEMOTTE, IN 40310				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PR	EFIX	CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	TAG DEFICIENCY)			DATE
					An All-Staff In-Service was		
					performed on 12-14-22		
					regarding proper power strip)	
					usage.		
					4) How the corrective actions will be monitored:	5	
					Maintenance / Designee will		
					perform weekly audits to		
					assure proper power strips a	ire	
					being used in facility in		
				accordance with NFPA . times			
					6 months .		
					The results of these audits w	/ill	
					be reviewed in Quality		
					Assurance Meeting monthly	x6	
					months or until an average o	of	
					100% compliance or greater	is	
					achieved x3 consecutive		
					months. The QA Committee		
					will identify any trends or		
					patterns and make		
					recommendations to revise t	:he	
					plan of correction as indicate	ed.	
					5) Date of compliance:		
					12-25-22		

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