STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. BUILDING -- B. WING	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MONROE	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/21/24 Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620 At this Emergency Preparedness survey, Aperion Care Monroe was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 38 certified beds and had a census of 36 at the time of this visit. Quality Review completed on 11/22/24	E 0000	1 E000 By submitting the enclosed material, we are not admitting to the truth or accuracy of any specific binding or allegations. We reserve the right to contest the finding or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance effective December 2nd, 2024 for the Annual Life Safety Recertification and State Licensure Emergency Preparedness Survey.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within	E 0004	E004 The facility develops and implements emergency preparedness plans and they are evaluated and updated at least annually. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder.	12/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faith Arvin	HFA	12/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155532	A. BUILDING -- B. WING	11/21/2024

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	the last year. Based on an interview during records review, the Administrator stated the EEP was reviewed recently but during the survey no documentation was provided indicating the EPP was updated within the last year. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.		All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. All facility staff received in servicing education on 11/26/2024 on the EOP binder, requirements, location and purpose. The administrator and/or designee will monitor the emergency preparedness plans including but not limited to the disaster plan monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP's	E 0013	E013 The facility develops and implements emergency preparedness policies and procedures. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan	12/02/2024

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	Policies and Procedures were reviewed recently but during the survey no documentation was provided indicating the EPP Policies and Procedures were updated within the last year. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.		to be kept current and reviewed at a minimum annually. This includes policies and procedures. The administrator and/or designee will monitor the emergency preparedness monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(Procedures for Tracking of Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., a policy and procedure that includes a system to track the location of sheltered residents in the LTC facility's care during and after an emergency was provided, but the policy did not provide a system to track the location for on-duty staff. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.	E 0018	E018 The facility develops and implements polices and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. This includes policies and procedures. The administrator and/or designee will monitor the emergency preparedness policies and	12/02/2024

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			procedures (tracking) monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(Policies/Procedures-Volunteers and Staffing Based on record review and interview, the facility failed to ensure emergency preparedness plan (EPP) included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the plan provided did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Administrator stated the facility did not usually use volunteers but was unaware of a written policy stating no volunteers were used or if volunteers were used, what guidelines would be in place and did not address the use or non-use of volunteers in an emergency. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.	E 0024	E024 The facility develops and implements policies and procedures that include the use of volunteers in an emergency or other emergency staffing strategies. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. This includes policies and procedures. The maintenance director received in servicing education on the volunteer policy. The administrator and/or designee will monitor the emergency preparedness policies and procedures (volunteers) monthly x three months. The findings of the monitoring will be reported to	12/02/2024

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			QAPI committee monthly by the maintenance director or his designee.	
E 0026 SS=F Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(Roles Under a Waiver Declared by Secretary Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.	E 0026	E026 The facility develops and implements policies and procedures that include the role of the LTC facility under a waiver declared by the secretary, in accordance with section 1135 of the act. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder. 1135 waiver placed in EOP binder. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. This includes policies and procedures. The maintenance director received in servicing education on the 1135 waiver. The administrator and/or designee will monitor the emergency preparedness policies and procedures (volunteers) monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the	12/02/2024

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			maintenance director or his designee.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP Communication Plan was reviewed recently but during the survey no documentation was provided indicating the Communications Plan was updated within the last year. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.	E 0029	E029 The facility develops and implements emergency preparedness communication plans that complies with the federal, state, and local laws. Disaster plan has been reviewed and updated on 11/25/2024 with the date of review documented. Cover page with updated and reviewed date added to EOP binder. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. All facility staff received in servicing education on 11/26/2024 on the EOP binder, requirements, location and purpose. The administrator and/or designee will monitor the emergency preparedness plans including but not limited to the disaster plan monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	12/02/2024

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and Maintenance Director (MD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the EEP lacked a cover page, and no date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP Training and Testing Plan was reviewed recently but during the survey no documentation was provided. This finding was acknowledged by the Administrator and MD at the time of records review and again at the exit conference.	E 0036	E036 The facility develops and maintains an emergency preparedness training and testing program that is based on the emergency plan at least annually. The training and testing program has been reviewed, dated, and updated if necessary on 11/25/2024. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on requirements for the disaster plan to be kept current and reviewed at a minimum annually. All facility staff received in servicing education on 11/26/2024 on the EOP binder, requirements, location and purpose. The administrator and/or designee will monitor that the training and testing program has been reviewed, dated, and updated at least annually, monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	12/02/2024
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system	E 0041	E041 The facility ensures the	12/23/2024

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	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). This deficient practice could affect all occupants. Findings include: Based on records review and observation with the Maintenance Director (MD) and Administrator on 11/21/24 between 8:30 a.m. and 1:00 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour load test. This was confirmed by the MD, who stated he was new to the facility and was unaware of the requirement. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference.		emergency power system inspection, testing, and maintenance requirements are completed. All residents have the potential to be affected by this finding. 4 HR/36 month generator run will be completed on 12/23/2024. Work from Evapar approved from preventative maint work on machine. Generator log documentation will be filed with generator logs and attached. The maintenance director received in servicing education on emergency power system inspections, testing, and maintenance requirements and the required 4 HR/36 month generator run. The administrator and/or designee will monitor the emergency power system logs monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/21/24	K 0000	1 E000 By submitting the enclosed material, we are not admitting to the truth or accuracy of any specific binding or allegations. We reserve the right to contest the finding or allegations as part of	

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	Facility Number: 000460 Provider Number: 155532 AIM Number: 100290620 At this Life Safety Code survey, Aperion Care Monroe was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 38 and had a census of 36 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage. Quality Review completed on 11/22/24		any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance effective December 2nd, 2024 for the Annual Life Safety Recertification and State Licensure Emergency Preparedness Survey.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 4 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the facility.	K 0211	K211 The facility ensures aisles, passageways, corridors, exit discharges, exit locations, and accesses are all free of obstructions to full use in case of emergency. All affected obstructed areas were	12/02/2024

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	Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the exit corridor across from the nurses' station leading to the side exit contained 15 large boxes. This condition was observed at 8:15 a.m. when the surveyor entered the facility. The condition was present throughout the survey and at the exit. The MD stated that the delivery material had not been sorted and put away. The Administrator stated that the facility struggles with a lack of storage space. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		immediately resolved. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on 11/21/2024 on corridor obstructions. All facility staff received in servicing education on 11/21/2024 in regard to corridor obstructions, and boxes and items being left at the doors. The maintenance director and/or designee will monitor the corridors daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the Main Entrance exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include:	K 0222	K222 The facility ensures the means of egress through the main entrance/exit was readily accessible. All residents have the potential to be affected by this finding. All main entrance/exit's immediately made readily accessible with codes posted by MD on 11/21/2024. The maintenance director received in servicing education on 11/21/2024 on door codes, at a legible font and size and updating monthly or as needed and/or	12/02/2024

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	Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the (1) Main Entrance exit door, (2)side exit door, and (3) rear exit door - each marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		changed. The maintenance director and/or designee will monitor the entrance/exit's daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review and observation with the Maintenance Director (MD) and Administrator on 11/21/24 between 8:30 a.m. and 1:00 p.m., no	K 0300	K300 The facility ensures documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms is complete. All residents have the potential to be affected by this finding. All battery-operated smoke alarms were tested on 11/22/2024. All documentation attached and findings included. The maintenance director received in servicing education on 11/22/2024 on battery operated smoke alarms and documentation. Not limited to cleaning logs, install dates, and testing logs. The maintenance director and/or designee will monitor the battery-operated smoke alarms weekly x4 weeks and monthly x2 months. The findings of the	12/02/2024

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	completed itemized list for preventative maintenance of resident room battery operated smoke alarms was available for review. Furthermore, the documentation reflecting testing and cleaning of the appliances was available for review. No documentation indicating the manufacture and install dates of the battery-operated smoke detectors was available for review. The documentation provided was a template only providing an itemized list of the battery-operated smoke detectors in the facility, but the data was blank. Based on interviews at the time of review, the Maintenance Director stated no other documentation was available. During the tour battery operated smoke detectors were observed in the resident sleeping rooms. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to 2 of over 4 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 4 staff. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area:	K 0321	K321 The facility ensures corridor doors have a self-closing device that would cause the door to automatically close and latch into the door frame. All residents have the potential to be affected by this finding. All affected doors were immediately fixed to be self-closing as necessary. (Kitchen and Nursing Supply.) Trash Receptacles immediately removed, and oxygen cylinders were placed in the proper storage.	12/02/2024

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	155532	A. BUILDING 01 B. WING	11/21/2024

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	a) the kitchen door leading to the corridor did not self-close and latch. The kitchen contained large trash receptacles. b) The Nurses Supply room did not self-close and latch. The aforementioned location contained over 20 oxygen cylinders which were being stored. Based on interview at the time of observation, the Maintenance Director agreed the rooms were hazardous storage areas, and the doors to the rooms did not self-close and latch into the frame. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		The maintenance director received in servicing education on 11/21/2024 on doors closing and latching. The maintenance director and/or designee will monitor the corridor doors weekly x4 weeks and monthly x2 months to ensure there are no findings and are self-closing and functioning correctly. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator on 11/21/24 between 8:15 a.m. and 1:00 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on	K 0346	K346 The facility ensures to provide a complete written policy indicating procedures to be followed in the event the fire alarm system must be placed out of service. Fire Alarm System policy has been reviewed and updated. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on the fire and sprinkler policies. The administrator and/or designee will monitor the emergency preparedness policies and procedures (fire alarm system) monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance	12/02/2024

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	interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		director or his designee.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator on	K 0354	K354 The facility ensures to provide a complete written policy indicating procedures to be followed in the event the sprinkler system must be placed out of service. Sprinkler alarm system policy has been reviewed and updated All residents have the potential to be affected by this finding. The maintenance director received in servicing education on the fire and sprinkler policies. The administrator and/or designee will monitor the emergency preparedness policies and procedures (sprinkler system) monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	12/02/2024

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	11/21/24 between 8:15 a.m. and 1:00 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of over 8 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect 5 staff in 1 smoke compartment. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., one ABC portable fire extinguisher located in the laundry area was blocked by a popcorn machine and a laundry cart. The MD agreed that the popcorn machine was wedged up against the fire extinguisher and obstructed access to the extinguisher and would	K 0355	K355 The facility ensures portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10 standards. Effected portable fire extinguisher immediately unblocked by the obstructed item on 11/21/2024. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on 11/21/2024 on fire extinguisher obstructions, and double checking these accesses. All facility staff received in servicing education on 11/21/2024 in regard to keeping the fire extinguisher's clear in all areas of	12/02/2024

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	impede its release from the wall. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		the facility and being sure they are not obstructed. The maintenance director and/or designee will monitor the fire extinguishers daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the following corridor doors failed to latch positively into their respective door frames: a) Pantry Door near the Kitchen b) Double door set near resident room #4 failed to completely close, this door was also obstructed from closing with a utility cart. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)	K 0363	K363 The facility ensures all corridor doors have no impediment to closing and latching into the door frame to resist the passage of smoke. All residents have the potential to be affected by this finding. All affected doors were immediately fixed to be self-closing and latching as necessary. The maintenance director received in servicing education on 11/21/2024 on doors closing and latching Utility cart moved from obstructed door. All facility staff received in servicing education on 11/21/2024 in regard to corridor obstructions, and boxes and items being left at the doors. The maintenance director and/or designee will monitor the corridor doors weekly x4 weeks and monthly x2 months to ensure	12/02/2024

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			there are no findings and are self-closing and functioning correctly. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0364 SS=E Bldg. 01	NFPA 101 Corridor - Openings Based on observation, the facility failed to ensure 1 of over 25 corridor openings were free of transfer grilles as required by the LSC. Section 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors. This deficiency could affect 14 residents plus staff and visitors near the Director of Nursing office and Nurses Station. Findings Include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the wall between the Director of Nursing office and the Nurses Station had a louvered vent which also had several wires running through it. This opening would allow smoke originating in the Director of Nursing's office to penetrate into the nurse's station (which is open to the corridor.) This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)	K 0364	K364 The facility ensures corridor openings are free of transfer grilles as required by the LSC. Transfer grilles in Nurses Station was immediately removed and fixed on 11/25/2024. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on 11/21/2024 on transfer grills and fire hazards when it comes to smoke. The maintenance director and/or designee will monitor the transfer grilles weekly x4 weeks and monthly x2 months to ensure there are no findings. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	12/02/2024

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation, the facility failed to ensure 1 of 1 electrical light on 1 of over 10 resident rooms were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 2 residents. Findings include: Based on observations and interviews with the Maintenance Director (MD) and Administrator during a tour of the facility on 11/21/24 between 10:15 a.m. and 11:30 a.m., the ceiling light fixture in resident room # 12 had exposed wire on the ballast and the cover was missing. The MD stated he was unaware the cover to the ceiling light was missing. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)	K 0511	K511 The facility ensures electrical lights are maintained in a safe operating condition. RM 12 light fixture immediately fixed and placed in proper working condition All residents have the potential to be affected by this finding. The maintenance director received in servicing education on the safety issue of the exposed wire, as well as room rounding. The maintenance director and/or designee will monitor the light fixtures daily x 4 weeks, and weekly x2 months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	12/02/2024
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance	K 0712	K712 The facility ensures fire drills are conducted at unexpected times on each shift at least quarterly Drills were gone through and	12/02/2024

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	engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review and observation with the Maintenance Director (MD) and Administrator (AD) on 11/21/24 between 8:30 a.m. and 1:00 p.m., the following shifts were missing documentation of a completed fire drill: a) A second shift fire drill in the second and fourth quarters of 2024 and 2023 (4th). b) A first shift fire drill in the second quarter of 2024. c) A third shift fire drill in the first, second and fourth quarters of 2024 and 2023 (4th). 6 of the required 12 drills were missing complete documentation. Based on interview at the time of record review, the MD and AD stated the drills were likely completed but could not find completed documentation to show the aforementioned drills were conducted. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b) 3.1-51(c)		organized, missing drills found were added to the binder. Some signature sheets needed. All residents have the potential to be affected by this finding. The maintenance director received in servicing education on the importance of quarterly fire drills being conducted on each shift. The maintenance director and/or designee will monitor the fire drills monthly x3 months to ensure there are no findings and drills are competed timely and accurately. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1.	K 0918	K918 The facility ensures the emergency power system inspection, testing, and maintenance requirements are completed.	12/23/2024

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	NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. This deficient practice could affect all building occupants. Findings include: Based on records review and observation with the Maintenance Director (MD) and Administrator on 11/21/24 between 8:30 a.m. and 1:00 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour load test. This was confirmed by the MD, who stated he was new to the facility and was unaware of the requirement. This finding was reviewed with the MD and Administrator at the time of discovery and again at the exit conference. 3.1-19(b)		All residents have the potential to be affected by this finding. 4 HR/36 month generator run will be completed on 12/23/2024. Work from Evapar approved from preventative maint work on machine. Generator log documentation will be filed with generator logs and attached. The maintenance director received in servicing education on emergency power system inspections, testing, and maintenance requirements and the required 4 HR/36 month generator run. The administrator and/or designee will monitor the emergency power system logs monthly x three months. The findings of the monitoring will be reported to QAPI committee monthly by the maintenance director or his designee.	