STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2024		
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE	33,23,232
APERION	N CARE LINCOLN		EVAN	NSVILLE, IN 47714	
(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
E 0000					
Bldg E 0039 SS=F Bldg	conducted by the In accordance with 42 Survey Date: 03/26 Facility Number: 00 Provider Number: 1002 At this Emergency I Care Lincoln was for Emergency Prepared Medicare and Medicare and Medicare and Suppliers, 42 Company of 36. Quality Review conductive The requirement at 4 MET as evidenced by 403.748(d)(2), 416 441.184(d)(2), 482 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 495	24 00443 155820 289580 Preparedness survey, Aperion bund not in compliance with dness Requirements for caid Participating Providers FR 483.73 Pertified beds, with a current appleted on 04/03/24 42 CFR, Subpart 483.73 is NOT by: 0.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 102(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2)	E 0000	By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We rethe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farespectively requests the 256 plan of correction to be considured allegation of compliance effective April 20, 2024 to the State findings of the Annual's conducted on March 26, 2024 respectfully request a desk rein lieu of a post-survey review.	iffic serve gs or e cility 7 dered e survey 1. We eview
	§460.84(d)(2), §48 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2),	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)			
LABORATOR		/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Teri McNeely Administrator 04/18/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820		UILDING	NSTRUCTION	(X3) DATE COMPL 03/26/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(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	
TAG	OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [for exercises to test to annually. The [fact following:	cons" under §485.727, 200, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan fility] must do all of the full-scale exercise that is		TAG	DEFICIENCE		DATE	
	not accessible, co functional exercis (B) If the [fac	every 2 years; or munity-based exercise is anduct a facility-based e every 2 years; or ility] experiences an actual ade emergency that requires						
	activation of the e is exempt from en community-based functional exercise actual event.	mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the						
	every 2 years, oppor functional exercity (i) of this section include, but is not	ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) s conducted, that may limited to the following: scale exercise that is						
	community-based functional exercis (B) A mock disast (C) A tabletop exe	or individual, facility-based e; or er drill; or ercise or workshop that is						
	discussion using a clinically-relevant set of problem sta	emergency scenario, and a itements, directed pared questions designed						
	(iii) Analyze the [fa maintain docume	acility's] response to and ntation of all drills, tabletop nergency events, and revise						

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Event ID:

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Facility ID: 000443

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING COMPLETED B. WING 03/26/2024				ETED	
	PROVIDER OR SUPPLIER	2	-	1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX	SUMMARY	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		rgency plan, as needed.		TAG	DEFICIENCY)		DATE
	the patient's home conduct exercises plan at least annuithe following: (i) Participate in a community based (A) When a commaccessible, condubased functional of (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disass (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem sta	spices that provide care in a to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or annity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual etional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					
	care directly. The	spices that provide inpatient hospice must conduct he emergency plan twice					

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PRINTED: 04/22/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING				
		155820	B. W	ING		03/26	/2024	
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
					NCOLN AVE			
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE	
		spice must do the following:						
		nn annual full-scale exercise						
	that is community							
	' '	nunity-based exercise is not						
		ct an annual individual						
	facility-based fund							
	, ,	experiences a natural or						
	_	ency that requires activation plan, the hospice is						
		aging in its next required						
		nity based or facility-based						
		e following the onset of the						
	emergency event.	· ·						
		dditional annual exercise						
	' '	but is not limited to the						
	following:							
	_	scale exercise that is						
		or a facility based						
	functional exercise							
	(B) A mock disas							
	' '	ercise or workshop led by a						
		udes a group discussion						
	using a narrated,							
	_	rio, and a set of problem						
		ed messages, or prepared						
	questions designe	ed to challenge an						
	emergency plan.							
	(iii) Analyze the h	ospice's response to and						
	maintain documer	ntation of all drills, tabletop						
	exercises, and em	nergency events and revise						
	the hospice's eme	ergency plan, as needed.						
	4re	144 404/10 11 11 11 11						
	1 -	l41.184(d), Hospitals at						
	§482.15(d), CAHs	. , -						
	. ,	PRTF, Hospital, CAH] must						
		to test the emergency						
		ar. The [PRTF, Hospital,						
	CAH] must do the	•						
	(ɪ) Participate in a	an annual full-scale exercise					I	

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Event ID:

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Facility ID: 000443

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	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/26/2024			
	PROVIDER OR SUPPLIEI	R	1	236 LIN	DDRESS, CITY, STATE, ZIP COD ICOLN AVE /ILLE, IN 47714		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	l l	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ON SHOULD BE COMPLETE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	that is community						
	, ,	nunity-based exercise is not					
		ıct an annual individual,					
	-	ctional exercise; or					
		Hospital, CAH] experiences or man-made emergency					
		vation of the emergency					
	i '	is exempt from engaging in					
		ull-scale community based					
	· ·	ity-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	exercise or and th	nat may include, but is not					
	limited to the follo	wing:					
	(A) A second full-	-scale exercise that is					
	community-based	l or individual, a					
		ctional exercise; or					
	, ,	ock disaster drill; or					
		p exercise or workshop that					
		tor and includes a group					
	discussion, using						
		emergency scenario, and a					
	•	tements, directed					
	-	pared questions designed					
	to challenge an e	mergency plan. he [facility's] response to		1			
		umentation of all drills,					
		s, and emergency events					
	•	cility's] emergency plan, as					
	needed.	omity of office goriety plant, as					
	*[For PACE at §4	60.84(d):]					
	(2) Testing. The F	PACE organization must					
	conduct exercises	s to test the emergency		1			
	plan at least annu	ally. The PACE					
	organization mus	t do the following:					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					

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		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL		
		155820	B. WI	NG		03/26/	/2024	
NAME OF D	DOWNED OF CUIDNIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF P	PROVIDER OR SUPPLIER			1236 LI	NCOLN AVE			
APERION	N CARE LINCOLN			EVANS	VILLE, IN 47714			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE)		DATE	
	facility-based fund							
	, ,	rperiences an actual natural						
		ergency that requires						
		mergency plan, the PACE						
		gaging in its next required						
		nity based or individual,						
	onset of the emerg	tional exercise following the						
		n additional exercise every						
	, ,	he year the full-scale or						
		e under paragraph (d)(2)(i)						
		onducted that may include,						
	but is not limited to							
		scale exercise that is						
	, ,	or individual, a facility						
	based functional e							
	(B) A mock disast							
	, ,	ercise or workshop that is						
	, ,	and includes a group						
	discussion, using	- ·						
		emergency scenario, and a						
	set of problem sta							
	-	pared questions designed						
	to challenge an er							
	_	ACE's response to and						
	, ,	ntation of all drills, tabletop						
		nergency events and revise						
	· ·	gency plan, as needed.						
	*[For LTC Facilitie	•						
	. , -	ty] must conduct exercises						
	_	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do t	•						
	•	n annual full-scale exercise						
	that is community-							
	, ,	unity-based exercise is not						
		ct an annual individual,						
	facility-based fund	tional exercise	1				I	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155820	B. W	ING		03/26/	/2024
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		1236 LI	NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE)		DATE
	_ ` /	ility] facility experiences an nan-made emergency that					
		nan-made emergency that n of the emergency plan, the					
	-	mpt from engaging its next					
	· ·	lle community-based or					
	-	based functional exercise					
		et of the emergency event.					
	-	dditional annual exercise					
	' '	but is not limited to the					
	following:	but is not inniced to the					
	_	scale exercise that is					
		or an individual, facility					
	based functional e						
	(B) A mock disas	•					
	' '	ercise or workshop that is					
	led by a facilitator						
	discussion, using	— ·					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	nergency plan.					
	(iii) Analyze the [l	LTC facility] facility's					
	response to and n	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
	1 -	CF/IID must conduct					
	· ,	he emergency plan at least					
		e ICF/IID must do the					
	following:						
	(i) Participate in a	n annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
		ct an annual individual,					
		ctional exercise; or.					
	(B) If the ICF/IID 6	experiences an actual					
		ade emergency that requires					
	activation of the e	mergency plan, the ICF/IID					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIEI	R		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE.	DATE	
	is exempt from er full-scale community-based fund is exempt from er full-scale community facility-based fund onset of the emer (ii) Conduct an act that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the IC maintain docume exercises, and enthe ICF/IID's eme *[For HHAs at §44 (d)(2) Testing. The exercises to test to least annually. The following: (i) Participate in a community-based (A) When a cois not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-maintain or man-maintain or man-maintain or man-maintain or man-maintain or man-maintain distribution.	rigaging in its next required nity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the scale exercise that is for an individual, ctional exercise; or ter drill; or excise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. CF/IID's response to and natation of all drills, tabletop nergency events, and revise regency plan, as needed. 34.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is l; or community-based exercise conduct an annual based functional exercise			CROSS-REFERENCED TO THE APPROPRIA	TE		
	exempt from enga full-scale commun	aging in its next required nity-based or individual, ctional exercise following the						

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL		
		155820	B. W	ING		03/26/2024		
MANGOES	DOUDED OF CURRY		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	C		1236 LI	NCOLN AVE			
APERION	N CARE LINCOLN			EVANS	VILLE, IN 47714			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY (DATE	
	onset of the emer	ditional exercise every 2						
	, ,							
		e year the full-scale or e under paragraph (d)(2)(i)						
	of this section is c							
		limited to the following:						
		full-scale exercise that is						
	community-based							
	facility-based fund							
	•	isaster drill; or						
	, ,	exercise or workshop that						
	, ,	or and includes a group						
	discussion, using	• .						
	, ,	emergency scenario, and a						
	set of problem sta							
	messages, or prep	pared questions designed						
	to challenge an er	nergency plan.						
	(iii) Analyze the H	HA's response to and						
	maintain documer	ntation of all drills, tabletop						
	exercises, and em	nergency events, and revise						
	the HHA's emerge	ency plan, as needed.						
	*[For OPOs at §48	-						
		e OPO must conduct						
		he emergency plan. The						
	OPO must do the							
		er-based, tabletop exercise						
	-	ast annually. A tabletop						
		a facilitator and includes a						
		using a narrated, clinically						
	_	cy scenario, and a set of						
	· ·	ts, directed messages, or						
		is designed to challenge an						
		f the OPO experiences an						
		nan-made emergency that						
		of the emergency plan, the						
		om engaging in its next						
		xercise following the onset						
	of the emergency							
	(ii) Analyze the Of	PO's response to and						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/26/2024			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the conduct a paperat least annually. It is group discussion in narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emel Based on record reversible for the conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based funct b. If the LTC facility or man-made emergy of the emergency pince from engaging its in community-based of full-scale functional the onset of the acture (ii) Conduct an additional conduct and designed in the conduct an additional conduct and designed in the conduct	e RNHCI must conduct the emergency plan. The the following: er-based, tabletop exercise A tabletop exercise is a ted by a facilitator, using a trelevant emergency the of problem statements, so, or prepared questions the an emergency plan. The original plants of the conduction of all tabletop the regency events, and revise tregency plan, as needed. The original plants of the temperature of the temperature the conduction of	E 0039	What corrective actions will be accomplished for those reside found to have been affected be the alleged deficient practice? Although no specific residents were affected, all residents has the potential to be affected by alleged deficient practice. On 4-2-2024 there was a tornado warning and our building rece damage from the storm. We worked as a group, including Fire Marshall, Dispatch and Center Point energy company ensure our residents were not affected by the damage and subsequent loss of electricity. had all departments working together to ensure residents in food, water and care as needs	ents Dy Save the ived the We mad			

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	ľ	UILDING	ONSTRUCTION	(X3) DATE COMPL 03/26/	ETED
	OF PROVIDER OR SUPPLIEI	.	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	a. A second full-sca community-based of functional exercise b. A mock disaster c. A tabletop exercifacilitator that inclua narrated, clinically and a set of probler messages, or preparchallenge an emerging (iii) Analyze the LT maintain document exercises, and emer LTC facility's emergacordance with 42 This deficient praction the facility. Findings include: Based on review of plan on 03/26/24 be with the Maintenant present, the facility documentation of a 03/08/24, however, documentation of a documentation of a past 12 months. Based documentation was past twelve month of the finding was record review, the facility documentation was past twelve month.	ale exercise that is or an individual, facility-based drill; or use or workshop that is led by a uses a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to ency plan. The facility's response to and ation of all drills, tabletop regency events, and revise the regency plan, as needed in CFR 483.73(d)(2). itee could affect all occupants The Emergency Preparedness retween 10:00 a.m. and 3:00 p.m. are Director and Administrator was able to provide table top exercise dated they were unable to provide community based exercise or in emergency event during the used on interview at the time of Administrator said no Exercise or Emergency Event available to review during the		IAU	despite the potential issues the arose. How will other residents with potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. On 4-2-2024 there was a tornadowarning and our building recedamage from the storm. We worked as a group, including Fire Marshall, Dispatch and Center Point energy company ensure our residents were no affected by the damage and subsequent loss of electricity, had all departments working together to ensure residents of food, water and care as need despite the potential issues the arose. The Maintenance Direwill work with community grout of set up additional in-house trainings outside of natural occurring events. What measures will be put into place and what systemic chain will be made to ensure that the alleged deficient practice does recur? The Maintenance Director will in-serviced to show understart that Emergency Plan exercises must be completed per regular and completed outside of any natural occurring events.	at the see be see be see be the see be see b	DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIE N CARE LINCOLN	R		1236 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Condi (e) Emergency ar The hospital muss standby power sy emergency plans this section and in procedures plans (i) and (ii) of this section and in procedures plans (ii) and (iii) of this section and in procedures plans (ii) and (iii) of this section and in gradual procedures plans (iii) and (iii) of this section and (iii) of this section and (iii) of this section and (iii) and (iii) of this section and (iii) of this	d LTC Emergency Power tition for Participation: and standby power systems. It implement emergency and restems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1) section.			How will the corrective actions monitored to ensure the allegy deficient practice will not recur what quality assurance prograwill be put into place? Maintenance Director/designed will complete an audit tool related to discussion over needed exercises and opportunities to complete Emergency Plan readiness moving forward. The tool will be completed by Maintenance Director/designed weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	ed or (ie am ee ated o nis ee	

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155820	B. W	ING		03/26/	/2024
NAME OF F	PROVIDER OR SUPPLIER	``````````````````````````````````````			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N CARE LINGOLNI				NCOLN AVE		
APERIO	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION e located in accordance with	+	TAG	DZI Telzive i		DATE
	~	ements found in the Health					
	· ·	de (NFPA 99 and Tentative					
		nts TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
		and Tentative Interim					
	Amendments TIA	12-1, TIA 12-2, TIA 12-3,					
	and TIA 12-4), and	d NFPA 110, when a new					
		r when an existing					
	structure or buildir	ng is renovated.					
	/82 15(a)(2) 8/8°	3 73(a)(2) 8485 625(a)(2)					
	482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing.						
	The [hospital, CAH and LTC facility] must						
		ergency power system					
		յ, and [maintenance]					
		nd in the Health Care					
	-	FPA 110, and Life Safety					
	Code.						
	192 15(0)(3) 849	3.73(e)(3), §485.625(e)(3)					
	, , , , =	rator fuel. [Hospitals, CAHs					
		that maintain an onsite fuel					
	_	mergency generators must					
	•	w it will keep emergency					
	-	perational during the					
	emergency, unles	_					
	*[[on been:t-!- ()	\$492.4E/b) LTO -4					
		§482.15(h), LTC at CAHs §485.625(g):]					
	(0)	corporated by reference in					
		oproved for incorporation by					
	·	Director of the Office of the					
		n accordance with 5 U.S.C.					
	_	part 51. You may obtain					
	, ,	the sources listed below.					
	You may inspect a	a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
	Archives and Rec	ords Administration					

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLETED 03/26/2024				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	(NARA). For informathis material at NA go to: http://www.archive.of_federal_regulal from comment in the Fannounce the character (1) National Fire Programment in the Fannounce the character (2) National Fire Programment (NFPA 99, Health 2012 edition, issued (ii) Technical interination (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (vi) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lifth edition, issued Aug (viii) TIA 12-1 to NF 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, Si Standby Power Sy including TIAs to C2009.	mation on the availability of aRA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are ference, CMS will publish a ederal Register to nges. Protection Association, 1 kg, p, www.nfpa.org, eth Care Facilities Code, ed August 11, 2011. Im amendment (TIA) 12-2 to August 11, 2011. Im August 12-2 to August 13, Impact 2011. Impact 2	E 0041	What corrective actions will be			
	24504 011 100014 101	12 and microscope, the facility	D 00-11	Titlat corrective actions will be	VT/20/2024		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	l í	UILDING	ONSTRUCTION	(X3) DATE COMPL 03/26/	ETED
	PROVIDER OR SUPPLIEI N CARE LINCOLN		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(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
	failed to implement inspection, testing, found in the Health 110, and Life Safet CFR 483.73(e)(2). Based on record refailed to provide contesting of 1 of 1 En System in accordant for Emergency and Section 8.4.9, as refacilities Code, Section 8.4.9 states Power Systems shadevery three years (3 assigned class is grapermitted to termin NFPA 99 Section 6. Type 2 essential electronial section 1. Type 2 essential electronial section 1. The se	the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 view and interview, the facility mplete documentation for the mergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care potion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency ll be tested at least once within 66 months). Where the meater than 4 hours, it shall be mate the test after 4 hours. 4.1.1.6.1 states that Type 1 and metrical system power sources t Type 10, Class X, Level 1 s deficient practice could			accomplished for those reside found to have been affected by the alleged deficient practice? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. A lot test of 4 hours will be completed by Evapar on 4-19-2024 to more criteria of completion. How will other residents with the potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. A lot test of 4 hours will be completed by Evapar on 4-19-24 to mean criteria of completion. What measures will be put into place and what systemic chain will be made to ensure that the alleged deficient practice does recur? An in-service was completed maintenance Director explaining need for a 4 hour load test with generator during the 36-month period per regulation and prociting that been completed properiod per regulation and prociting the seen completed proper	ents Py Save the bad eet the be save the bad eet the	

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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			COMPLETED		
		155820	B. WI	B. WING			03/26/2024	
	PROVIDER OR SUPPLIEF	<u>.</u>	•	1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE SVILLE, IN 47714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DD OVIDEDIG TV AV OT CONTROL		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	TE .	DATE	
					Maintenance Director/designe will complete an audit tool relato ensuring that a load test has been completed per regulation additional tests will be done if necessary within next 36 mon. This tool will be completed by Maintenance Director/designe weekly for eight weeks and monthly for four months. The outcome of this tool will be	ited s n and ths.		
					reviewed at the Quality Assura	ance		
					meeting to determine if any			
					additional action is warranted.			
K 0000								
Bldg. 01	Licensure Survey w Department of Head 483.90(a). Survey Date: 03/20 Facility Number: 0 Provider Number: 100 At this Life Safety of Lincoln was found Requirements for P CFR Subpart 483.9 the 2012 edition of Association (NFPA Chapter 19, Existin 410 IAC 16.2.	155820 289580 Code survey, Aperion Care not in compliance with articipation in Medicaid, 42 0(a), Life Safety from Fire and the National Fire Protection 1) 101, Life Safety Code (LSC), g Health Care Occupancies and ity with a ground level was	K 00	000	By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact respectively requests the 2567 plan of correction to be considered our allegation of compliance effective April 20, 2024 to the State findings of the Annual suconducted on March 26, 2024 respectfully request a desk revin lieu of a post-survey review	cic serve s or sility r lered urvey . We view		
		Type II (222) construction and						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING 01 COMPL B. WING 03/26/		COMPLETED 03/26/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0225 SS=E Bldg. 01	system with hard will levels including the corridors, and all restacility has a capaci 36 at the time of this All areas where the access were sprinkle facility services wer framed garage used Quality Review con NFPA 101 Stairways and Sm stairways and shoot swould close c deficient practice costaff, and visitors. Findings include: Based on observation p.m. and 5:15 p.m. of Maintenance Direct doors at ground level lobby stairs was equ When tested several close completely an arm being set to low door to close. There the doors when close interview at the time of the corridors and the time of the corridors are the time of the corridors.	residents have customary ered and all areas providing re sprinklered, except one brick for facility storage. Inpleted on 04/03/24 Okeproof Enclosures okeproof Enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility 5 sets of stairway enclosure ompletely and latch. This ould affect at least 10 residents, and affect at least 10 residents, the set of stairway double the between the front lobby and thipped with a coordinator. It times, the doors did not did latch due to the coordinator of and not rolling up the second the was a six inch gap between end to their fullest. Based on	K 0225	What corrective actions will be accomplished for those reside found to have been affected be the alleged deficient practice? Although no specific residents were affected, all residents has the potential to be affected by alleged deficient practice. The stairway coordinator was fixed the doors are able to close an completely latch now. How will other residents with the potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents has the potential to be affected by alleged deficient practice. The	ents By Bave I the I and I the Be be Bave I the Bave I the Bave I the Bave I the Bave I the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIER		1236 L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ors between the front lobby	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) Stairway coordinator was fixe	DATE
	and latch due to the low on the door fran This finding was re	vay did not close completely coordinator arm being set to me. viewed with the Administrator irector during the exit		the doors are able to close and completely latch now. What measures will be put interpolate and what systemic characteristics will be made to ensure that the alleged deficient practice does	nges ne
	3.1-19(b)			recur? An in-service was completed the Maintenance Director relator making sure the coordinate all stairway enclosures are checked regularly so that the close and latch appropriately.	ated or on
				How will the corrective action monitored to ensure the alleg deficient practice will not recu what quality assurance prograwill be put into place? Maintenance Director/designs	s be ed ir (ie am
				will complete an audit tool rel to ensuring that all enclosure doors are set accordingly to a for closing and latching as expected. This tool will be completed by Maintenance Director/designee weekly for weeks and monthly for four months. The outcome of this	eight
				will be reviewed at the Quality Assurance meeting to determ any additional action is warra	/ vine if
K 0324 SS=D Bldg. 01	Ventilation Contro	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless:			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u> completed			ETED	
		155820	B. W	ING		03/26/	2024
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714			
(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'	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facilities with 30 or fewer proditions under 10 Cooking facility through 19.3.2.5.5 Based on observation facility compartment, reside equipment that is us fewer persons shall the cooking facility conditions: (1) The space contains is not a sleeping rodition (2) The space contains not a sleeping rodition (2) The space contains and (3) are met. 19.3.2.5.3(9) states following is provided (a) A locked switch restricted location, if facility that deactive facility that deactive facility that deactive cooking in provided (a) A locked switch restricted location, if facility that deactive facility facility that deactive facility	tin smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be rdous areas, but shall not rridor. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility cook top for 1 of 1 stove in the nut off at the switch when not 5.4 states within a smoke ential or commercial cooking sed to prepare meals for 30 or be permitted, provided that complies with all the following ining the cooking equipment om. ining the cooking equipment rom the corridor by partitions 3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10)	K 0	324	What corrective actions will be accomplished for those reside found to have been affected by the alleged deficient practice? Although no specific residents were affected, all residents ha the potential to be affected by alleged deficient practice. The stove has been turned off at the breaker and has signs posted showing it is inoperable at this time. How will other residents with the potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents ha the potential to be affected by alleged deficient practice. The stove has been turned off at the	nts y ve the he be the ve the	04/20/2024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING B. WING	01	COMPLETED 03/26/2024	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
APERION	N CARE LINCOLN			SVILLE, IN 47714	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	or range whenever to supervision. This deficient practice resident, staff and vision. Room. Findings include: Based on observation p.m. and 5:15 p.m. of the Maintenance Distove in the ground. The corridor doors to all times. The stove time of observation was on. Based on in observation, the Mathe cooktop stove win use, furthermore, he didn't think there the Break Room stoffrom the receptacle. also said he didn't the stove is ever used by This finding was reversident.	the kitchen is not under staff ce could affect at least one isitors while in the Break ons on 03/26/24 between 3:00 during a tour of the facility with rector, there was a cooktop level general Break Room. To this room were kept open at a was not being used at the and the power to the stove enterview at the time of intenance Director confirmed as not deactivated when not the Maintenance Director said was a deactivation switch for ve other than unplugging it The Maintenance Director in the Break Room cooktop y staff or residents.	TAG	breaker and has signs posted showing it is inoperable at this time. What measures will be put into place and what systemic charwill be made to ensure that the alleged deficient practice does recur? An in-service was completed to the Maintenance Director related to checking cooking areas in the building that are not in use an securing the safety of the deviby having it turned off and distifuted for use. How will the corrective actions monitored to ensure the alleged deficient practice will not recur what quality assurance prograwill be put into place? Maintenance Director/designed will complete an audit tool related to ensuring that any cooking devices that need to be disabled are off and not being used. The tool will be completed by Maintenance Director/designed weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.	o orges e s not with ted he d dice abled s be ed or (ie am ee ated ed e
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm syster				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/26/2024			
APERIO	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	in accordance with complying with the National Electric C National Fire Alart Records of system and testing are re 9.6.1.3, 9.6.1.5, N 1. Based on record facility failed to ensavailable to show the sensitivity tested with NFPA 72, National Section 14.4.5.3.1 see checked within alternate year there required calibration indicate that the del listed and marked see time between calibration to be extended to a frequency is extend nuisance alarms shall be main where nuisance alarms and alarms shall be main where nuisance alarms and alarms and alarms and alarms and alarms and alarms and alarms shall be main where nuisance alarms and alarms alarms and alarms and alarms alarms and alarms and alarms alarms and alarms alarms and alarms and alarms alarms and alarms alarms and alarms and alarms alarms and alarms and alarms alarms and alarms alarms alarms alarms and alarms and alarms alarms and alarms and alarms and alarms and alarms and alarms and alarms alarms and alarms and alarms alarms and alarms alarms and alarms and alarms and alarms and alarms alarms and alar	h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. IFPA 70, NFPA 72 review and interview, the sure documentation was nat all smoke detectors were ithin the past 24 month period. Fire Alarm Code, 2010 Edition, states detector sensitivity shall l year of installation, and every after. After the second test, if sensitivity tests fector has remained within its ensitivity range, the length of ration tests shall be permitted maximum of 5 years. If the fied, records of detector caused d subsequent trends of these ntained. In zones or areas rms show an increase over the foration tests shall be performed. In smoke detector is within its ensitivity range, it shall be the methods: method. calibrated sensitivity test diploment arranged for the fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ring jurisdiction.	K 0345	What corrective actions will be accomplished for those reside found to have been affected by the alleged deficient practice. Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. A cowast placed to complete the smoke detector sensitivity test that had not been done within 24 months. This was complet on 3/30/24. The Maintenance Director completed an itemized list showing where each of the devices connected to the fire alarm system was located. How will other residents with potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. A cowast placed to complete the smoke detector sensitivity test that had not been done within 24 months. This will be compand back in compliance by 4-20-24. The Maintenance Director in the potential compliance by 4-20-24. The Maintenance Director in the potential compliance by 4-20-24. The Maintenance Director in the potential compliance by 4-20-24. The Maintenance Director in the potential compliance by 4-20-24. The Maintenance Director in the potential compliance by 4-20-24.	e 04/20/2024 ents by es ave / the eall sting n last eed e the ece be save / the call sting n last leted		
	Detectors found to	have sensitivity outside the		completed an itemized list			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETI			ETED	
		155820	B. WING 03/26/2024			/2024	
		l		CTD PET 4	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	U OADE LINGOLNI				NCOLN AVE		
APERIOI	N CARE LINCOLN			EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	listed and marked s	ensitivity range shall be			showing where each of the de	vices	
	cleaned and recalib	rated, or replaced.			connected to the fire alarm		
	The detector sensiti	vity cannot be tested or			system was located.		
	measured using any	spray device that administers			What measures will be put into	0	
	an unmeasured con-	centration of aerosol into the			place and what systemic chan	iges	
	detector. This defic	cient practice could affect all			will be made to ensure that the	e	
	residents, staff, and	visitors in the facility.			alleged deficient practice does	s not	
					recur?		
	Findings include:				An in-service was completed v	with	
					the Maintenance Director rela		
	Based on record review on 03/26/24 between 10:00				to completion of smoke detect	or	
	a.m. and 3:00 p.m. with the Maintenance Director				sensitivity documentation and	how	
	present, the facility was unable to produce a				it needs to be available in Life		
	smoke detector sens	sitivity report for all smoke			Safety binder showing it is dor	ne	
	detectors for the pas	st 24 month period. Based on			within 24 months to meet		
	interview at the tim	e of record review, the		requirements. He was in-serviced			
	Maintenance Direct	for confirmed there was no		on maintaining an up to date			
	smoke detector sens	sitivity testing documentation			itemized list of devices connec	cted	
	available for the pas	st 24 months.			to the fire alarm system.		
					How will the corrective actions	s be	
	This finding was re	viewed with the Administrator			monitored to ensure the allege	ed	
	and Maintenance D	irector during the exit			deficient practice will not recui	r (ie	
	conference.				what quality assurance progra	nm	
					will be put into place?		
	3.1-19(b)				Maintenance Director/designe	e	
					will complete an audit tool rela	ited	
	2. Based on record	review and interview, the			to ensuring that smoke detect	or	
	facility failed to ma	intain 1 of 1 fire alarm system in			sensitivity has been completed	d	
	accordance with NI	FPA 72, as required by LSC 101			and itemized list of devices		
	Sections 19.3.4.5.1	and 9.6. NFPA 72, Section			connected to fire alarm systen	n is	
	14.3.1 states that un	less otherwise permitted by			up to date. This tool will be		
	14.3.2, visual inspe	ctions shall be performed in			completed by Maintenance		
		e schedules in Table 14.3.1, or			Director/designee weekly for e	eight	
	more often if requir	ed by the authority having			weeks and monthly for four		
	1 ·	14.3.1 states that the following			months. The outcome of this to	ool	
	must be visually ins	spected semi-annually:			will be reviewed at the Quality		
	a. Control unit troul	ble signals			Assurance meeting to determi	ne if	
	b. Remote annuncia	ators			any additional action is warrar	nted.	
	c. Initiating devices	(e.g. duct detectors, manual					
	fire alarm boxes, he	eat detectors, smoke detectors,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUILDING 01 COMPLETED B. WING 03/26/2024			ETED		
	ROVIDER OR SUPPLIER			1236 LII	DDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(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)	ΓE	(X5) COMPLETION DATE
	etc.) d. Notification appl e. Magnetic hold-op This deficient pract in the facility.						
	a.m. and 3:00 p.m. or present, there was dregarding an annual dated 03/20/24 by the inspection vendor, a semi-annual visual of "Annual Visual Instead to 7/27/23 and 00 the facility's mainter inspection document devices connected to of the facility's smoon itemized list of with Based on interview the Maintenance Distinspection document.	riew on 03/26/24 between 10:00 with the Maintenance Director ocumentation provided fire alarm system inspection he facility's fire alarm furthermore, there were inspection documents labeled ocction of Fire Equipment" 1/29/24 that were performed by nance personnel. These two its only listed the number of the fire alarm system in each ke compartments, and was not where each device was located, at the time of record review, rector agreed the semi-annual its did not provide an itemized onnected to the facility's fire					
	_	viewed with the Administrator irector during the exit					
K 0346 SS=F Bldg. 01	services for more						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIER N CARE LINCOLN	.	1236 L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE SVILLE, IN 47714	
(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)	
IAU	be notified, and the evacuated or an aprovided for all pashutdown until the been returned to 9.6.1.6 Based on record refailed to provide a design of the second record record to the second record record to the second record re	pe building shall be approved fire watch shall be urties left unprotected by the effice alarm system has service. View and interview, the facility complete written policy for the	K 0346	What corrective actions will be accomplished for those reside	ents
	to be followed in the has to be placed ou more in a twenty fo	cupants indicating procedures are event the fire alarm system to f service for four hours or our hour period in accordance 9.6.1.6. This deficient practice in the facility.		found to have been affected by the alleged deficient practice? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. The policy related to fire watch or the property alarm system being out of services updated to reflect the	the
	a.m. and 3:00 p.m. present, the facility documentation, how plan failed to include alarm system being hours or more in a ton interview at the	wiew on 03/26/24 between 10:00 with the Maintenance Director provided fire watch wever, it was incomplete. The de information about the fire placed out of service for four twenty four hour period. Based time of record review, the tor confirmed the fire watch		was updated to reflect the requirement. How will other residents with t potential to be affected by the same alleged deficient practic identified and what corrective actions will be taken? Although no specific residents were affected, all residents had the potential to be affected by	e be
	being placed out of in a twenty four hor This finding was re	about the fire alarm system service for four hours or more ur period. viewed with the Administrator birector during the exit		alleged deficient practice. The policy related to fire watch or talarm system being out of ser was updated to reflect the requirement. What measures will be put into place and what systemic charmwill be made to ensure that the alleged deficient practice does recur? An in-service was completed to the Maintenance Director relations.	the vice o oges e s not with
				to using the updated policy an procedure information to meet	nd

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> C			(X3) DATE COMPL	LETED
	155820			NG	_	03/26	/2024
	PROVIDER OR SUPPLIE N CARE LINCOLN	R		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE SVILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Where the sprink extent and durative deen determined are inspected and recommendations management or commendations management o	- Out of Service - Out of Service ler system is impaired, the on of the impairment has areas or buildings involved drisks are determined, are submitted to designated representative, rtment and other authorities in have been notified. Where the is out of service for more a 24-hour period, the of the building affected are approved fire watch is sprinkler system has been	K 03		out of service requirement. How will the corrective actions monitored to ensure the allege deficient practice will not recur what quality assurance prograwill be put into place? Maintenance Director/designed will complete an audit tool related to using the updated policy and teaching staff as needed on expectation. This tool will be completed by Maintenance Director/designee weekly for expectations. The outcome of this to will be reviewed at the Quality Assurance meeting to determ any additional action is warrance and accomplished for those reside found to have been affected by the service of the	ed r (ie am ee ated ad eight tool r ine if anted.	04/20/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 03/26/2024
	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	1236 L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE SVILLE, IN 47714	
(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 CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
TAG	protection of all occautomatic sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprin comply with NFPA for the Inspection, Water-Based Fire F 15.5.2 requires nine impairment coordir (b) states a fire wat personnel who contarea. Ready access ability to promptly important items to the area, the person for fire, but making protection features routes and alarm sy functioning properl could affect all occi. Findings include: Based on record reva.m. and 3:00 p.m. present, the facility documentation, how plan failed to include sprinkler system be ten hours or more in	expants in the event the system has to be placed 0 hours or more in a 24-hour the with LSC, Section 9.7.5. LSC kler impairment procedures .25, 2011 Edition, the Standard Festing and Maintenance of Protection Systems. NFPA 25, the procedures that the later shall follow. A.15.5.2 (4) the should consist of trained inuously patrol the affected to fire extinguishers and the motify the fire department are consider. During the patrol of should not only be looking as sure that the other fire of the building such as egress stems are available and y. This deficient practice upants in the facility. Aview on 03/26/24 between 10:00 with the Maintenance Director provided fire watch evever, it was incomplete. The de information about the ing placed out of service for a a twenty four hour period. at the time of record review,	TAG	the alleged deficient practice. Although no specific reside were affected, all residents the potential to be affected alleged deficient practice. It policy related to the sprinkly system being out of service updated to reflect the requited How will other residents with potential to be affected by a same alleged deficient practice actions will be taken? Although no specific resided were affected, all residents the potential to be affected alleged deficient practice. It policy related to the sprinkly system being out of service updated to reflect the requited what measures will be putential be made to ensure that alleged deficient practice directly. An in-service was complete the Maintenance Director reto using the updated policy procedure information to mout of service requirement. How will the corrective action monitored to ensure the alleged to the sure the alleged to ensure the alleged to ensure the alleged will the corrective action monitored to ensure the alleged to ens	nts have by the The er e was rement. th the the ctice be ve nts have by the The er e was rement. into nanges rement. into nanges the oes not ed with elated and eet the ons be
	lacked information	rector confirmed the fire watch about the sprinkler system service for ten hours or more ar period.		deficient practice will not re what quality assurance pro will be put into place? Maintenance Director/desig will complete an audit tool i	gram gnee
		viewed with the Administrator irector during the exit		to using the updated policy teaching staff as needed or expectation . This tool will be	and n

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NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ILD BE ROPRIATE	(X5) COMPLETION DATE		
	3.1-19(b)			completed by Maintenan Director/designee weekly weeks and monthly for for months. The outcome of will be reviewed at the Q Assurance meeting to de any additional action is weekly	of for eight our this tool uality stermine if			
K 0511 SS=D Bldg. 01	complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure elect of 1 first floor show Edition. Article 406 (Cover Plates), requibe installed so as to and seat against the 2011 Edition. Article Receptacles shall be terminals are not ext deficient practice constant. Findings include: Based on observation p.m. and 5:15 p.m. the Maintenance Di electrical receptacle was missing a covertime of observation.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511	What corrective actions of accomplished for those of found to have been affect the alleged deficient practice. Although no specific resist were affected, all resident the potential to be affected alleged deficient practice faceplate cover was replay to the maintenance Director on thow will other residents potential to be affected be same alleged deficient pridentified and what corresidentified and what corresidents will be taken? Although no specific resist were affected, all resident the potential to be affected alleged deficient practice faceplate cover was replay that measures will be potential to be affected alleged deficient practices faceplate cover was replayed to the potential to be affected alleged deficient practices faceplate cover was replayed to the potential to be affected alleged deficient practices faceplate cover was replayed to the process of the	esidents ted by tice? dents its have ed by the The acced by 3-27-24. with the y the ractice be ctive dents its have ed by the 3-27-24.	04/20/2024		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/26/2024	
	PROVIDER OR SUPPLIER	X		1236 LI	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	shower room and sa on by the end of the This finding was re and Maintenance D conference. 3.1-19(b)	e on the wall in the first floor aid he would have a new cover e day. viewed with the Administrator irector during the exit			place and what systemic chan will be made to ensure that the alleged deficient practice does recur? An in-service was completed to the Maintenance Director related to checking all covers of electroreceptacles so they meet requirement and are in place. How will the corrective actions monitored to ensure the alleged deficient practice will not recur what quality assurance prograwill be put into place? Maintenance Director/designe will complete an audit tool related to ensuring that all covers are place appropriately with electroreceptacles. This tool will be completed by Maintenance Director/designee weekly for expect and monthly for four months. The outcome of this towill be reviewed at the Quality Assurance meeting to determine any additional action is warrance.	e in not vith ed ical be ed ic (ie m ee ted in ical ight pool	
K 0712 SS=C Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying at quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155820	B. WING 03/26/2024				/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
PREFIX	audible alarms. 19.7.1.4 through 1 Based on record reversitied to ensure fire for 1 of 3 employee This deficient practite facility. Findings include: Based on review of on 03/26/24 betwee the Maintenance Dishift (night) fire drill 12:00 a.m. and 12:00 the time of record re	9.7.1.7 view and interview, the facility drills were held at varied times shifts during 3 of 4 quarters. ice could affect all residents in the facility's fire drill reports in 10:00 a.m. and 3:00 p.m. with rector present, 3 of 4 third lls were performed between 5 a.m. Based on interview at eview, the Maintenance ged the times the third shift formed and agreed the times	K 0	TAG	What corrective actions will be accomplished for those reside found to have been affected be the alleged deficient practice? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. Fire drills have now been conducted shifts with appropriate time variance to meet requirement. How will other residents with the potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents had the potential to be affected by alleged deficient practice. Fire drills have now been conducted shifts with appropriate time variance to meet requirement. What measures will be put into place and what systemic chain will be made to ensure that the alleged deficient practice does recur? An in-service was completed to the Maintenance Director relation.	e ents y ve the ed on he ed on onges e s not with	COMPLETION
					to creating a fire drill program supporting documentation that meets the requirement for varitimes. How will the corrective actions monitored to ensure the alleged deficient practice will not recurrently what quality assurance program.	t ied s be ed r (ie	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION 01	(X3) DATE : COMPL 03/26/	ETED	
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
K 0761 SS=F Bldg. 01					will be put into place? Maintenance Director/designed will complete an audit tool relatifire drills being completed according to requirement. This will be completed by Maintenan Director/designee weekly for eweeks and monthly for four months. The outcome of this to will be reviewed at the Quality Assurance meeting to determinany additional action is warrance.	ted tool nce ight ool	
Didg. 01	interview; the facilitinspection and testin door assemblies, 5 cassemblies, and 4 or door assemblies was with LSC 19.1.1.4.1 dividing fire barrier permitted only in coby approved self-cle (See also Section 8. required to have a fix 8.3.4.2 shall be protabled fire door assemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protectives specified in this Codor assemblies shalless than annually, a	on, record review, and ty failed to ensure an annual ag of 7 of 7 single stairway fire of 5 double stairway fire door of 4 laundry chute/trash chute s completed in accordance on. 1. Communicating openings in s required by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. One of the stairway fire door stair protection rating by Table sected by approved, listed, semblies and fire window or accompanying hardware, one with the requirements of for Fire Doors and Other one, except as otherwise de. NFPA 80 5.2.1 states fire ll be inspected and tested not and a written record of the signed and kept for inspection	K 0761		What corrective actions will be accomplished for those resider found to have been affected by the alleged deficient practice? Although no specific residents were affected, all residents have the potential to be affected by alleged deficient practice. An annual audit was completed by Maintenance Director to show documentation related to staire door assemblies and laundry/to chutes door assemblies. How will other residents with the potential to be affected by the same alleged deficient practice identified and what corrective actions will be taken? Although no specific residents were affected, all residents have the potential to be affected by alleged deficient practice. An annual audit was completed by	nts / /e the / vay rash ne e be	04/20/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/26/2024 155820 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1236 LINCOLN AVE APERION CARE LINCOLN **EVANSVILLE, IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE by the AHJ. NFPA 80, 5.2.4.1 states fire door Maintenance Director to show assemblies shall be visually inspected from both documentation related to stairway sides to assess the overall condition of door door assemblies and laundry/trash assembly. chutes door assemblies. What measures will be put into NFPA 80, 5.2.4.2 states as a minimum, the place and what systemic changes following items shall be verified: will be made to ensure that the (1) No open holes or breaks exist in surfaces of alleged deficient practice does not either the door or frame. recur? (2) Glazing, vision light frames, and glazing beads An in-service was completed with are intact and securely fastened in place, if so the Maintenance Director related equipped. to annual inspection of all fire door (3) The door, frame, hinges, hardware, and assemblies. noncombustible threshold are secured, aligned, How will the corrective actions be and in working order with no visible signs of monitored to ensure the alleged deficient practice will not recur (ie (4) No parts are missing or broken. what quality assurance program (5) Door clearances do not exceed clearances will be put into place? listed in 4.8.4 and 6.3.1.7. Maintenance Director/designee (6) The self-closing device is operational; that is, will complete an audit tool related the active door completely closes when operated to ensuring that documentation is from the full open position. up to date and changed if any (7) If a coordinator is installed, the inactive leaf variances in building set up. This closes before the active leaf. tool will be completed by (8) Latching hardware operates and secures the Maintenance Director/designee door when it is in the closed position. weekly for eight weeks and (9) Auxiliary hardware items that interfere or monthly for four months. The prohibit operation are not installed on the door or outcome of this tool will be reviewed at the Quality Assurance (10) No field modifications to the door assembly meeting to determine if any have been performed that void the label. additional action is warranted. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors.

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Findings include:

Based on record review on 03/26/24 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		î ´	JILDING	nstruction 01	(X3) DATE : COMPL 03/26/	ETED		
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(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 OF T	λΤΕ	(X5) COMPLETION DATE	
	present, the facility documentation for t sets of the facility's and oxygen transfill however, the facility documentation for a stairway fire door as chute/trash chute fir interview at the time Maintenance Direct documentation of a facility's stairway affire door assemblies during a tour of the Director between 3: were 7 single, and 5 assemblies and 4 lardoor assemblies not This finding was reand Maintenance D conference. 3.1-19(b)	was able to provide the annual inspection of all smoke barrier door assemblies ing room fire door assembly, y was unable to provide an annual inspection of all ssemblies and 4 laundry the door assemblies. Based on the of record review, the for said there was no annual inspection of the and laundry chute/trash chute the Based on observations facility with the Maintenance facility with the Maintenance for p.m. and 5:00 p.m., there double stairway fire door undry chute/trash chute fire		IAU			DATE	
K 0918 SS=F Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the n is capability for the life branches. Maintenance generator and transfer rmed in accordance with						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155820	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/26/2024				
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN			1236 L	STREET ADDRESS, CITY, STATE, ZIP COD 1236 LINCOLN AVE EVANSVILLE, IN 47714					
(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					
	year in 20-40 day once every 36 mc Scheduled test ur a complete simula automatic or man loads, and are corpersonnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is es manufacturer required of maintenance are and readily availa and circuits are mand separate from Minimizing the poemergency power consideration for 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record refailed to provide contesting of 1 of 1 En System in accordant for Emergency and Section 8.4.9, as refacilities Code, Section 8.4.9 states Power Systems shale every three years (3 assigned class is gropermitted to termin NFPA 99 Section 6 Type 2 essential elesshall be classified as signed classified as shall be classified as signed states of the content	ual transfer of all EES inducted by competent inance and testing of stored irces (Type 3 EES) are in NFPA 111. Main and feeder is e inspected annually, and a dically exercising the tablished according to direments. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, in normal power circuits. ssibility of damage of the is source is a design hew installations. (NFPA 99), NFPA 110, 0 (NFPA 70) View and interview, the facility implete documentation for the hergency Power Standby ice with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care cition 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency ll be tested at least once within in months). Where the heater than 4 hours, it shall be hate the test after 4 hours. i.4.1.1.6.1 states that Type 1 and hercical system power sources hercical system power sources hercical type 10, Class X, Level 1 hercical system power sources	K 0918	What corrective actions will be accomplished for those resident found to have been affected at the alleged deficient practice. Although no specific resident were affected, all residents have been affected by alleged deficient practice. A let test of 4 hours will be comple by Evapar by 4-19-2024 to moriteria of completion. How will other residents with potential to be affected by the same alleged deficient practicidentified and what corrective actions will be taken? Although no specific resident	ents by ? s ave / the bad ted eet the ce be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155820		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2024		
NAME OF PROVIDER OR SUPPLIER APERION CARE LINCOLN				1236 LII	ADDRESS, CITY, STATE, ZIP COD NCOLN AVE VILLE, IN 47714		
					PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLE		(X5) COMPLETION DATE
					monitored to ensure the allegal deficient practice will not reculumnate quality assurance prograwill be put into place? Maintenance Director/designed will complete an audit tool related to ensuring that a load test has been completed per regulation additional tests will be done if necessary within next 36 month and the standard work of the standard work of the standard monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance inglined to determine if any additional action is warranted.	r (ie am ee ated as n and ths.	

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