PRINTED: 10/10/2024 FORM APPROVED

AND PLAN OF CORRECTION IDENTIFI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2024	
NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DOLUMBER OF A LAND CORRESPONDE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 09/24 Facility Number: 0 Provider Number: 100 At this Emergency Cathedral Health Cathedral Health Cathedral Health Cathedral Health Cathedral Provides 183.73 The facility has a cathedral a census of 63 and a census of 63 a	1/2024 00315 155720	E 00	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specif findings or allegations. We resulted the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact request that the plan of correct be considered our allegation of compliance effective October 2024 to the survey completed September 24th, 2024. We respectfully request a paper reand will provide any additional information requested.	erve s or dility tion of 11th, on	
K 0000							
Bidg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/24 Facility Number: 0 Provider Number: AIM Number: 1000	00315 155720	K 0	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specif findings 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 request that the plan of correct be considered our allegation of compliance effective October 19	ic serve s or sility tion	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURI	 3	TITLE		(X6) DATE

(X6) DATE

Allision Betz **HFA** 10/04/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155720		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/24/2024
	ROVIDER OR SUPPLIER		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This two story facilis	the and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.		2024 to the survey completed September 24th, 2024. We respectfully request a paper re and will provide any additiona information requested.	eview
	was fully sprinklere system with hard wi corridors, spaces op resident sleeping ro	Type II (222) construction and d. The facility has a fire alarm ired smoke detectors in the en to the corridors, and all oms. The facility has a had a census of 63 at the time			
	were sprinklered an services were sprink building, and a gree				
K 0200 SS=E Bldg. 01	Quality Review con NFPA 101 Means of Egress I	Requirements - Other			
	failed to ensure 1 of the social services of 1 bathroom shared be the ADON office, a between the sensory were able to be unlo outside in case of fir readily accessible in	on and interview, the facility I bathroom shared between office and activities office, 1 of between the MDS office and and 1 of 1 bathroom shared or room and exam room which beked from both the inside and are or other emergencies were accordance with LSC 7.1.10.1.	K 0200	K 200 The corrective action taken to those residents found to be affected by the deficient practice include: No residents, staff, or visitors were found to be affected by the deficient practice.	
	•	ice could affect at least 6 staff, rs occupying the bathrooms.		How other residents that ha the potential to be affected be the same defective practice	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155720	B. WI	B. WING 09/24/2		2024	
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
				520 W 9			
CATHED	RAL HEALTH CAR	E CENTER		JASPE	R, IN 47546		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	D	ons on 09/24/2024 between			will be identified and what		
	11:00 AM and 1:00				corrective action(s) will be taken:		
		raining and the Environmental			taken.		
		he following was observed:			Potentially all residents, staff,	and	
		nared between the social			visitors could be affected but r		
	services office and	the activities office had slide			were identified.		
	locks on the inside	of both of the bathroom doors.					
		r own door to the bathroom.			What measures will be put		
		nared between the MDS office			into place and what systemic	;	
		ad a slide lock on the outside			changes will be made to		
		oom doors. Each office has			ensure that the deficient		
	their own door to th				practice does not recur:		
		mared between the sensory m had a slide lock on the inside			Identified locks removed on		
		or on the exam room side, a key			doors.		
		de of the bathroom door on the			40013.		
	_	and a slide lock on the outside			How the corrective action(s))	
	-	ensory room side. The			will be monitored to ensure t		
	sensory room and tl	ne exam room have their own			deficient practice will not		
	door to the shared b	eathroom.			recur, i.e., what quality		
		at the time of observation, the			assurance program will be p	ut	
		vices Director agreed there were			into place:		
		n the aforementioned			A 19, 101.1		
		not allow for the doors to be			An audit will be completed by		
	event of an emerger	sides of the doors in the			maintenance or designee on a		
	event of an emerger	icy.			the second-floor office hallway Manager shared bathroom do		
	This finding was re	viewed with the Environmental			weekly, and any future negative		
	_	Administrator-in-Training, and			findings will be corrected		
	Administrator at the	_			immediately and the administr	ator	
					notified. The results of these		
	3.1-19(b)				audits will be reviewed by the		
					Quality Assurance Committee		
					monthly in the Quality Assurar	nce	
					Meeting.		
					The date the evetemic char	205	
					The date the systemic chang will be completed:	y c s	
					wiii be completed.		
			1				

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STATEMEN				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL		
		155720	B. W	ING		09/24/	2024	
	ROVIDER OR SUPPLIER		•	520 W 9	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	•		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Based on observation failed to ensure the was provided with a device, and was not Findings include: Based on observation on 09/24/2024 betwowith the Environme Administrator-in-Tradining room was equivice, but was being cord. Based on interest observation, the Envagreed the door was bungee cord. This centre observation. Staff whaving to open the centre of the door was bunged the	on and interview, the facility corridor door to 1 of 1 kitchen a properly working self closing impeded from closing. One during a tour of the facility een 11:00 AM and 1:00 PM and 1:00	K 0		Cotober 11th, 2024 K 321 The corrective action taken f those residents found to be affected by the deficient practice include: No residents were found to be affected by the deficient practice. How other residents that has the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken: Potentially staff and residents could be affected but none we identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Deficient practice was correct immediately. Checks on main kitchen door weekly.	e dece. ve y ere	10/11/2024	
					How the corrective action(s) will be monitored to ensure t			

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

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	of correction (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER 155720	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(x3) date survey completed 09/24/2024
	PROVIDER OR SUPPLIER PRAL HEALTH CARE CENTER	520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice will not recur, i.e., what quality assurance program will be puinto place:	ut
			An audit will be completed by maintenance or designee on the main kitchen door weekly, and any future negative findings will corrected immediately and the administrator notified. The result of these audits will be reviewed the Quality Assurance Commits monthly in the Quality Assurant Meeting. The date the systemic change will be completed:	ne I I I III be sults d by ttee nce
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility	K 0345	October 11th, 2024 K 345	10/11/2024
	failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors.		The corrective action taken for those residents found to be affected by the deficient practice include: No staff, visitors, or residents were found to be affected by the deficient practice.	or
	Findings include: Based on observation of the fire alarm control panel on 09/24/2024 at 12:14 PM with the Environmental Services Director and		How other residents that have the potential to be affected by the same defective practice will be identified and what	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/24/2024 155720 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 520 W 9TH ST CATHEDRAL HEALTH CARE CENTER **JASPER, IN 47546** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Administrator in Training, the fire alarm control corrective action(s) will be panel indicated the date was 05/08/2015 at 7:29. taken: The fire panel did not indicate if the time was AM or PM. The Environmental Services Director was Potentially staff, visitors, and able to update the date and time to the correct residents could be affected but date and time. Based on interview at the time of none were identified. the observation, the Environmental Services Director stated the vendor had not corrected the What measures will be put time and date when they had changed the battery into place and what systemic on the fire panel. changes will be made to ensure that the deficient This finding was reviewed with the Administrator, practice does not recur: Administrator-in-Training, and Environmental Services Director at the exit conference. Deficient practice was immediately corrected. Fire panel 3.1-19(b) will be inspected monthly to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be completed by maintenance or designee of the Fire Panel date and time monthly in conjunction with monthly fire drills, and any future negative findings will be corrected immediately and the administrator notified. The results of these audits will be reviewed by the

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will be completed:

Meeting.

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Quality Assurance Committee monthly in the Quality Assurance

The date the systemic changes

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· /	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	F CORRECTION IDENTIFICATION NUMBER A. BUILDING 155720 B. WING		01 COMPLETED 09/24/202				
		155720	B. WI	NG		09/24/	2024
	PROVIDER OR SUPPLIER			520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST R, IN 47546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353 SS=E Bldg. 01	Based on observation	· Maintenance and Testing on and interview, the facility	K 0:	353	October 11th, 2024 K 353		10/11/2024
	basement janitor's c of 1 PPE closet, all 13, 2010 edition, Se ceiling as a continuous significant irregular The ceiling traps ho sprinkler and causes specified temperatu distance between th ceiling above shall l	le ceiling construction in 1 of 1 loset, 1 of 1 auditorium, and 1 on the basement level. NFPA action 3.3.5.4 defines a smooth ous ceiling free from ities, lumps, or indentations. It air and gases around the action 8.5.4.1.1 states the element sprinkler deflector and the one selected based on the type type of construction. This build affect staff.			The corrective action taken f those residents found to be affected by the deficient practice include: No residents, staff, or visitors were found to be affected by t deficient practice. How other residents that has the potential to be affected be the same defective practice will be identified and what corrective action(s) will be taken:	he ve	
	on 09/24/2024 between with the Administra Environmental Serve closet in the baseme inch by 6 inch peneropipes to the left of the penetration in the coroner to the right of penetration in the coroner to the right of the sink to the right in the basement was penetration in the coron of 2 incoroner of 2 incoroner to the right in the basement was penetration in the coron of 2 incoroner to the right in the basement was penetration in the coroner of 2 incoroner to the right in the basement was penetration in the coroner to the right in the basement was penetration of 2 incoroner to the right in the basement was penetration of 2 incoroner to the right in the basement was penetration of 2 incoroner to the right in the basement was penetration of 2 incoroner to the right in the basement was penetration of 2 incoroner to the right of the right in the basement was penetration of 2 incoroner to the right of 2 incoroner to the right of 3 incoroner to the right of 3 incoroner to 2 incoroner to 3 incoroner to 4	on during a tour of the facility teen 11:00 AM and 1:00 PM tor-in-Training and tices Director, the janitor's ent was observed to have a 3 tration in the ceiling around 2 the door, a 2 inch by 2 incheiling around the pipe in the f the door, and a 0.5 incheiling around the pipe above of the door. The auditorium is observed to have a seiling by the northwest corner the by 2 incheiling around the pipe above of the door. The PPE closet in observed to have a penetration			Potentially all residents, staff, visitors could be affected but r were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Fire caulking placed in deficient area identified. Monthly check initiated to ensure compliance How the corrective action(s)	ent s	

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING <u>01</u>	COMPLETED
		155720	B. WING	·	09/24/2024
	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CO 520 W 9TH ST IASPER, IN 47546	D
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D PROVIDER'S PLAN OF CORRI	ECTION (X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	CEIV (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	CROSS-REFERENCED TO THE AP DEFICIENCY)	DATE
	in the ceiling of 4 in black pipe and a what a penetration of 2 in silver pipe. Based to observation, the Emagreed there were paragreed there were paragreements.	nch by 6 inch surrounding a hite pipe. In this same location, hiches was located around a hor interview at the time of hivironmental Services Director heretrations in the ceiling in the hations and provided the hiviewed with the Environmental hadministrator-in-Training, and		will be monitored to endeficient practice will recur, i.e., what quality assurance program will into place: An audit will be comple maintenance director or monthly for ceiling peneand any future negative will be corrected immed the administrator notifier results of these audits we reviewed by the Quality Committee monthly in the Assurance Meeting. The date the systemic will be completed: October 11th, 2024	ted by designee trations, findings iately and d. The vill be Assurance ne Quality
K 0372 SS=E Bldg. 01	Barrie Based on observation failed to ensure the smoke barrier wall on the 1st floor was smoke resistance of Section 19.3.7.5 reconstructed in accordand shall have a minimum.	Iding Spaces - Smoke on and interview, the facility penetrations through 1 of 1 near the Pepsi vending machine protected to maintain the cach smoke barrier. LSC quires smoke barriers to be rdance with LSC Section 8.5 nimum ½ hour fire resistive nt practice could affect staff, sitors in this smoke	K 0372	2 K 372 The corrective action to those residents found affected by the deficient practice include: No residents, staff, or we were found to be affected deficient practice. How other residents to the potential to be affected to the potential to the	to be nt isitors ed by the

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Findings include:

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the same defective practice

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155720	B. W	ING		09/24/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		520 W 9			
CATHED	RAL HEALTH CAR	E CENTER			R, IN 47546		
CATHED	INAL HEALTH CAR	L OLNIER		JASFEI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. –	DATE
					will be identified and what		
	Based on observation	on during a tour of the facility			corrective action(s) will be		
	on 09/24/2024 betw	veen 11:00 AM and 1:00 PM			taken:		
	with the Administra	ator-in-Training and					
	Environmental Serv	vices Director, the barrier wall			Potentially all residents, staff,	and	
	near the Pepsi vend	ing machine on the first floor			visitors could be affected but r	none	
	was observed to har	ve 1 penetration of 0.5 inch			were identified.		
	around 4 wires. Ba	sed on interview at the time of				ļ	
	observation, the En	vironmental Services Director			What measures will be put		
	agreed there was a				into place and what systemic	:	
	aforementioned loc	ation and provided the			changes will be made to		
	measurement.				ensure that the deficient		
					practice does not recur:		
	This finding was re						
	Administrator-in-T	raining, Environmental Services			Fire caulking placed in area c	ıf	
	Director, and Admi	nistrator at the exit conference.			deficient practice identified.		
					Monthly checks of area initiate	ed.	
	3.1-19(b)						
					How the corrective action(s))	
					will be monitored to ensure t	:he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					An audit will be completed by		
					maintenance director or desig		
					monthly for smoke barrier wall	1	
					penetrations, and any future		
					negative findings will be corre		
					immediately and the administr		
					notified. The results of these		
					audits will be reviewed by the		
					Quality Assurance Committee		
					monthly in the Quality Assurar	nce	
					Meeting.		
					<u> </u>		
					The date the systemic chang	jes	
					will be completed:		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/24/2024	
	PROVIDER OR SUPPLIED		520 W	ADDRESS, CITY, STATE, ZIP COD 9TH ST ER, IN 47546	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=E		ent - Power Cords and		October 11th, 2024	
Bldg. 01	failed to ensure por substitute for fixed manager's office. I comply with Sectic electrical wiring an NFPA 70, National NFPA 70, Article 4 specifically permitt shall not be used as a structure. This deleast 3 staff. Findings include: Based on observati 11:00 AM and 1:00 Services Director a mini fridge was plu business manager's the time of observatime of observation Director agreed the the power strip in the This finding was readministrator-in-T	on and interview, the facility wer strips were not used as a wiring in 1 of 1 business LSC 19.5.1 requires utilities to on 9.1. LSC 9.1.2 requires dequipment to comply with Electrical Code, 2011 Edition. 100.8 requires that, unless ted, flexible cords and cables as a substitute for fixed wiring of efficient practice could affect at ons on 09/24/2024 between DPM with the Environmental and Administrator-in-Training, a tegged into a power strip in the office. Staff corrected this at tion. Based on interview at the at tion. Based on interview at the at the Environmental Services armini fridge was plugged into the aforementioned location.	K 0920	The corrective action taken for those residents found to be affected by the deficient practice include: No staff were found to be affected by the deficient practice. How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken: Potentially staff could be affected by defective practice. None identified. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Defici practice was corrected immediately. Weekly checks initiated to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be completed by maintenance director or designee weekly to ensure power strips are not be used as a substitute for fixed wiring, and any future negative	es e

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155720	ì í	ILDING	onstruction 01	(X3) DATE COMPL 09/24 /	ETED
NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 520 W 9TH ST JASPER, IN 47546				
(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) findings will be corrected immediately and the administration of the control of the contr		(X5) COMPLETION DATE
					audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurar Meeting. The date the systemichanges will be completed: October 11th, 2024	ic	

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