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

	OF DEFICIENCIES CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	l í	UILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/23/2022	
	OVIDER OR SUPPLIER	NIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD I JEFFERSON ST (LIN, IN 46131		
(X4) ID PREFIX TAG E 0000	(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
E 0006 SS=F Bldg	conducted by the In accordance with 42 Survey Date(s): 11/2 Facility Number: 0 Provider Number: 2002 At this Emergency I Otterbein Franklin S Care was found not Preparedness Requi Medicaid Participat CFR 483.73. The facility has 208 the survey, the cens Quality Review con The requirement at MET as evidenced I 403.748(a)(1)-(2), (1)-(2), 441.184(a) 483.475(a)(1)-(2), (1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2) S Plan Based on All	22/22 & 11/23/22 01127 155771 247220 Preparedness survey, Senior Life Comm Res & Com in compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 136. hpleted on 11/30/22 42 CFR Subpart 483.73 is NOT	E 00	000	The creation and submission this Plan of Correction do not constitute an admission by the provider of any conclusions in the statement of deficient any violation of the regulation. This provider respectfully rethat this 2567 Plan of Correct be considered the Letter of Credible Allegation of Compand requests a desk review of a post-survey review.	ot his et forth ies or n. quests ction	
	§460.84(a)(1)-(2), §483.73(a)(1)-(2),	§482.15(a)(1)-(2), §483.475(a)(1)-(2), //IDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	F	TITLE		(X6) DATE

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

(X6) DATE

Shannon Logan Administrator 12/19/2022

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155771	B. W	ING		11/23/	/2022
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF			1070 W	JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C.	ARE	FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t), §485.68(a)(1)-(2), t), §485.727(a)(1)-(2),					
	§485.920(a)(1)-(2), §486.360(a)(1)-(2),						
	§491.12(a)(1)-(2),	, §494.62(a)(1)-(2)					
		lan. The [facility] must					
	develop and maintain an emergency						
	preparedness plan that must be reviewed,						
	must do the follow	ast every 2 years. The plan					
	Thust do the follow	/ilig.j					
	1 ' '	and include a documented,					
	· -	community-based risk					
		ring an all-hazards					
	approach.*						
	(2) Include strate	gies for addressing					
	l ' '	s identified by the risk					
	assessment.						
	* [For Hospices at	t §418.113(a):] Emergency					
	Plan. The Hospice	e must develop and					
	l .	gency preparedness plan					
		ewed, and updated at least					
	1 7 7	e plan must do the					
	following:	and include a documented,					
	` '	community-based risk					
	· -	ring an all-hazards					
	approach.						
	(2) Include strateg	gies for addressing					
	1 -	s identified by the risk					
		iding the management of					
		s of power failures, natural					
		ner emergencies that would					
	aneci ine nospice	's ability to provide care.					
	*[For LTC facilities	s at §483.73(a):]					
	_	The LTC facility must					
	develop and main	itain an emergency					

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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	
		155771	B. WING		11/23/2022	
			- CTDEET	CADDRESS SITY STATE ZID SOD		
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
OTTEDD		NUODI IEE COMMA DEC 9 COM CA		W JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	ARE FRAN	KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	preparedness plai	n that must be reviewed,				
		ast annually. The plan must				
	do the following:	, ,				
		and include a documented,				
	facility-based and community-based risk assessment, utilizing an all-hazards					
	approach, including missing residents.					
	(2) Include strategies for addressing					
	emergency events identified by the risk assessment.					
	*[For ICF/IIDs at 8	§483.475(a):] Emergency				
	Plan. The ICF/IID must develop and maintain					
an emergency preparedness plan that must						
		updated at least every 2				
		nust do the following:				
	(1) Be based on a	and include a documented,				
	1 ' '	community-based risk				
	1	ring an all-hazards				
		ng missing clients.				
		gies for addressing				
	1 ' '	s identified by the risk				
	assessment.	,				
	Based on record rev	view and interview, the facility	E 0006	What corrective action(s) wi	II 12/16/2022	
		n emergency preparedness		be accomplished for those		
		ased on and includes a		residents found to have bee	n	
		y-based and community-based		affected by the deficient		
	l .	lizing an all-hazards approach,		practice?		
		residents and (2) included		No residents were identified a	ıs	
		ssing emergency events		being affected by this alleged		
	_	sk assessment in accordance		deficient practice.		
	1	3(a) (1) and 42 CFR 483.73(a) (2).		How other residents having	the	
	In the Survey & Ce	ertification memo QSO:		potential to be affected by the		
		2/01/19, the Centers for		same deficient practice will		
		icaid Services (CMS) updated		identified and what corrective		
		State Operations Manual to		action(s) will be taken?		
		dd emerging infectious		No other residents have been		
	_	nition of all-hazards approach		identified as having the poten		
		g for using an all-hazards		be affected by the alleged def		
	I		I	1	· ·	

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	OF CORRECTION	IDENTIFICATION NUMBER 155771		UILDING		COMPL 11/23	ETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD J JEFFERSON ST LIN, IN 46131		
(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)	ATE	(X5) COMPLETION DATE
	disease (EID) threat Influenza, Ebola, Zi deficient practice co Findings include: Based on review of Manual" documenta Main Building Main Building Services C review from 9:00 a. documented facility risk assessment add disease (EID) threat EID was not include 2021 Summary: Har for the facility. Bas record review, the M Manager agreed em program documenta infectious diseases (facility-based and co assessment as mand Certification memo This finding was rev the Main Building M	ommunity-based risk ated by the CMS Survey &			practice. The Kaiser-Permanente assessment (see attachment for the facility has been completed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Manager weducated (see attachment #3 the Administrator on the importance of developing and maintaining an emergency preparedness plan that must reviewed, and updated at least every 2 years. The plan must the following: (1) Be based or include a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach.* (2) Indistrategies for addressing emergency events identified by risk assessment. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place? The Kaiser-Permanente assessment for the facility and Emergency Action Plan will be reviewed each quarter by the committee each quarter for fo quarters and then annually thereafter.	as) by be st t do and clude by the ity out	

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	OF CORRECTION	IDENTIFICATION NUMBER 155771	A. B	BUILDING VING		COMPI 11/23	
	PROVIDER OR SUPPLIER EIN FRANKLIN SEI	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
					By what date the systemic changes for each deficient will be completed? 12/16/2022	; y	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.0 (e) Emergency and The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generate generator must be the location require Care Facilities Cool Interim Amendment 12-4, TIA 12-5, an Code (NFPA 101 a Amendments TIA and TIA 12-4), and structure is built or structure or buildin 482.15(e)(2), §483 Emergency genera The [hospital, CAF	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. Individual the CAH] must ency and standby power the emergency plan set (a) of this section. 63.73(e)(1), §485.625(e)(1) experiments found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing					

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STATEMEN	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMPL	ETED	
		155771	B. W	ING		11/23/	2022	
				CTDEET A	DDDESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
OTTERR		NIODLIEE COMM DES 9 COM C	A D.E.					
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	AKE	FRAINK	LIN, IN 46131			
(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	
	inspection, testing	, and [maintenance]						
	requirements foun	d in the Health Care						
	Facilities Code, N	FPA 110, and Life Safety						
	Code.							
	, , , , _	3.73(e)(3), §485.625(e)(3)						
		ator fuel. [Hospitals, CAHs						
		that maintain an onsite fuel						
	· ·	mergency generators must						
	•	w it will keep emergency						
	•	erational during the						
	emergency, unles	s it evacuates.						
	*r=	2400 45(b) LTO -t						
		§482.15(h), LTC at						
	_	AHs §485.625(g):]						
		orporated by reference in						
		proved 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							
		rce Center, 7500 Security						
		ore, MD or at the National						
		ords Administration						
		nation on the availability of						
	,	ARA, call 202-741-6030, or						
	go to:	,						
	•	es.gov/federal_register/code						
		ations/ibr_locations.html.						
		this edition of the Code are						
	, ,	ference, CMS will publish a						
	document in the F	•						
	announce the cha	•						
		Protection Association, 1						
	Batterymarch Parl							
	Quincy, MA 02169), www.nfpa.org,						
	1.617.770.3000.	-						
	(i) NFPA 99, Healt	th Care Facilities Code,						
	2012 edition, issue	ed August 11, 2011.						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/23/2022
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131	
(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
	NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to N 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 101, S Standby Power Sy including TIAs to C 2009 Based on record rev interview; the facili emergency power sy including TIAs to C 2009 Based on record rev interview; the facili emergency power sy maintenance require Care Facilities Code Code in accordance This deficient pract staff and visitors. Findings include: a. Based on observat Maintenance Manag from 8:30 a.m. to 1 battery-powered em	FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	E 0041	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what correctivaction(s) will be taken? No other residents have been identified as having the poten be affected by the alleged defined.	the ne be

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771		UILDING	ONSTRUCTION	(X3) DATE : COMPL 11/23/	ETED
NAME OF I	PROVIDER OR SUPPLIE	3	•		ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST	•	
OTTERE	EIN FRANKLIN SE	NIORLIFE COMM RES & COM	CARE	FRANK	KLIN, IN 46131		
(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)	ATE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION	_	TAG			DATE
		the facility. Based on interview observations, the Main Building			practice. Immediate Action Taken:		
						arad	
Maintenance Manager agreed no battery-powered emergency lighting systems were installed at the					a) Emergency battery order 12/13/2022 (attachment #2)	ereu	
					b) Monthly load test comple	atad	
	emergency generator location which was located inside the facility.				12/9/2022 (attachment #3)	Jiou	
	misrae the facility.				c) Annual fuel quality test		
	b. Based on review of Workxhub "Monthly				completed 1/24/2022 (attachr	ment	
		tor Load Test (30 Min)"			#4)		
		the most recent twelve month			Initial Audits:		
	period with the Ma	in Building Maintenance			a) An Audit will be complet	ted	
	Manager and the B	uilding Services Coordinator			on all emergency battery light	ing	
	during record revie	w from 9:00 a.m. to 12:45 a.m.			systems once installed.	_	
	on 11/22/22, monthly load testing documentation				b) Audit completed on		
	for the facility's diesel fired emergency generator				12/9/2022 on the Emergency		
		twelve month period was			generator for load test.		
	-	ad percent achieved for the			c) Audit completed on		
		hat maintains the minimum			1/24/2022 on annual fuel qua	-	
		atures as recommended by the			What measures will be put in	nto	
		not documented. Based on			place and what systemic		
		ne of record review, the Main			changes will be made to		
	-	nce Manager stated the facility			ensure that the deficient		
		keep generator testing			practice does not recur?	J	
		nin the last two year period to am entitled "Workxhub" which			Once installation is completed		
		odated to document the load			audits will be completed mont by maintenance staff.	uny	
		or a monthly load test and			How will the corrective		
	•	d testing documentation for			action(s) be monitored to		
	,	fired emergency generator for			ensure the deficient practice	a	
	_	elve month period was			will not recur, i.e., what qual		
	incomplete.	1			assurance program will be p	-	
					into place?		
	c. Based on record	review with the Main Building			Any identified deficiencies will	l be	
	Maintenance Mana	ger and the Building Services			corrected upon discovery and		
	Coordinator during	record review from 9:00 a.m. to			reviewed by the QA committe	e for	
		2/22, documentation of an			further recommendation.		
		test for the diesel fired			By what date the systemic		
		or was not available for review.			changes for each deficiency	'	
		at the time of record review,			will be completed?		
	the Main Building	Maintenance Manager stated			02/23/2023		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/23/2022	
	PROVIDER OR SUPPLIER EIN FRANKLIN SE	NIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131		
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	the facility has one generator and agree fuel quality test for generator was not a These findings were Administrator, the M	diesel fired emergency d documentation of an annual the diesel fired emergency vailable for review. e reviewed with the Main Building Maintenance uilding Services Coordinator					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date(s): 11/2 Facility Number: 0 Provider Number: 2002 At this Life Safety 0 Franklin Senior Life found not in compli Participation in Mes Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. Otterbein Franklin S Care consists of four buildings constructed Building 1, a NCC s story sprinklered bu	01127 155771	K	0000	The creation and submission this Plan of Correction do not constitute an admission by the provider of any conclusion in the statement of deficience any violation of the regulation. This provider respectfully resulted that this 2567 Plan of Corrective considered the Letter of Credible Allegation of Compand requests a desk review of a post-survey review.	ot his et forth ies or n. quests ction	

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted /2022
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD ' JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	1980 is a three story (332) construction of built in 1992 is a on Type I (332) construction of the facility was surveyed has a fire alarm system of the corridors and all Building 2, 47 batter provided in resident Health Center 3. All Building 2 are provided to the construction of the surveyed the survey of 208 and time of this survey.			TAG	DEFICIENCY		DATE
K 0225 SS=E Bldg. 01	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4, Based on observation failed to ensure iten escape stairways we LSC 7.2.2.5.3.1 state enclosure shall not be has the potential to deficient practice co	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 as stored in 1 of 4 interior fire ould not interfere with egress. the used for any purpose that interfere with egress. This ould affect over 10 residents, ing the third floor exit stairwell	K 0	2225	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice	n as	12/16/2022

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/23/2022	
	ROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	- VBE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131	-	
OTTEND	LINT KANKLIN OL	MICKEII E COMMINICES & COM CA	\\L_	LIVAININ	LIN, IN 40131		
(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
	by Room 356 in Bu	ilding 4.			How other residents having		
					potential to be affected by th		
Findings include:				same deficient practice will l			
	.	14 d 26 t D 111			identified and what correctiv	е	
	Based on observations with the Main Building				action(s) will be taken?		
		ger during a tour of the facility			No other residents have been		
	_	:20 p.m. on 11/22/22, the exit			identified as having the potent		
	stairwell on the third floor in Building 4 by Room				be affected by the alleged def practice.	ici c i it	
	356 was marked as a facility exit. A wooden chair and a cart with oxygen supplies and one 'E' type				The wooden chair and cart we	are	
	oxygen cylinder were stored in the exit stairwell on				immediately removed upon	,10	
	the third floor landing. Based on interview at the				identification on 11/22/2022.		
	time of observation, the Main Building				An audit was completed on all		
	Maintenance Manager agreed the aforementioned				escape stairways on 11/23/20		
	stairwell on the third floor in Building 4 was used				What measures will be put in		
		ould interfere with egress.			place and what systemic		
					changes will be made to		
	This finding was re-	viewed with the Administrator,			ensure that the deficient		
	the Main Building M	Maintenance Manager and the			practice does not recur?		
	Building Services C	Coordinator during the exit			All staff has been educated by	the	
	conference.				main building manager on the		
					importance of keeping exit		
	3.1-19(b)				egresses clear of obstacles.		
					(Attachment #5)		
					Beginning 12/15/2022 audits v	VIII	
					be initiated weekly by	4	
					maintenance staff. (Attachme	rit	
					#6) How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	_	
					into place?	•	
					Audits of the stairwells will be		
					completed once a week for for	ur	
					weeks, then once a month for		
					three months. The Maintenar		
					Director will bring the audits to	the	
					QA meetings for review. After		

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DEPARTMENT	TOF HEALTH AND HUN	MAN SERVICES				FOE	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. WI	NG		11/23/	2022
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	RE	1070 W	DDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(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 APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					initial audits are completed and	d	

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 0291	initial audits are completed and 100% compliance has been achieved, the QA committee may discontinue the audits. By what date the systemic changes for each deficiency will be completed? 12/16/2022 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potential to be affected by the alleged deficient practice. Main Building Maintenance Manager was educated by the Administrator on 12/12/2022, (Attachment #7) on the importance of Emergency Lighting, citing: Section 7.9.3.1.1	02/23/2023
	This deficient practice could affect all residents,		states testing of emergency	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. WI	ING		11/23/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			JEFFERSON ST		
OTTERR	FIN FRANKI IN SF	NIORLIFE COMM RES & COM CA	RF		(LIN, IN 46131		
	T		·· _		I		
(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 APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	staff and visitors.				lighting systems shall be		
	Findings in ded.				permitted to be conducted as		
	Findings include:				follows: (1) Functional testing	-	
	Rosed on massed may	view with the Main Duilding			shall be conducted monthly, v		
		view with the Main Building ger and the Building Services			a minimum of 3 weeks and a maximum of 5 weeks betwee		
		:00 a.m. to 12:45 a.m. on			-	:11	
		and annual battery operated			tests, for not less than 30		
		entation for the most recent			seconds, except as otherwise		
		d was not available for review.			permitted by 7.9.3.1.1(2). (2) test interval shall be permitted		
	_	at the time of record review,			be extended beyond 30 days		
		Maintenance Manager and the			the approval of the authority I		
		Coordinator agreed monthly			jurisdiction. (3) Functional te	-	
	_	nal testing documentation for			shall be conducted annually f	•	
		hts located inside the facility			minimum of 1 1/2 hours if the		
		twelve month period was not			emergency lighting system is		
		7. Based on observations with			battery-powered. (4) The	'	
		Maintenance Manager during a			emergency lighting equipmer	nt	
		From 8:30 a.m. to 11:20 a.m. on			shall be fully operational for t		
	-	battery operated lighting			tests required by 7.9.3.1.1(1)		
	-	the facility which was			(3). (5) Written records of vis		
	_ ·	sign by Room 2 in the			inspections and tests shall be		
	Murphy's Special C	Care Area on the first floor in			kept by the owner for inspect		
	Building 3 which fa	niled to illuminate when its			by the authority having		
	respective test butto	on was pushed multiple times.			jurisdiction.		
					What measures will be put i	nto	
	_	viewed with the Administrator,			place and what systemic		
	_	Maintenance Manager and the			changes will be made to		
		Coordinator during the exit			ensure that the deficient		
	conference.				practice does not recur?		
					Once light is received and		
	3.1-19(b)				installed, audits will be compl		
					monthly by maintenance staf	f.	
		ation and interview, the facility			How will the corrective		
		f 1 battery powered emergency			action(s) be monitored to		
		as maintained in accordance			ensure the deficient practic		
		.9. LSC 7.9.2.6 states battery			will not recur, i.e., what qua	-	
		y lights shall use only reliable			assurance program will be p	out	
		le batteries provided with			into place?		
	suitable facilities fo	r maintaining them in properly	1		Any identified deficiencies will	ll be	

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	OF CORRECTION	IDENTIFICATION NUMBER 155771	A. E	BUILDING WING	01	COMPL 11/23	ETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	or units shall be app and shall comply wi Code. This deficien residents, staff and	Batteries used in such lights broved for their intended use ith NFPA 70 National Electric at practice could affect over 10 visitors in the "Murphy's on the first floor in Building 3.			corrected upon discovery and reviewed by the QAPI commi for further recommendation. By what date the systemic changes for each deficiency will be completed? 02/23/2023	ttee	
	Based on observation Maintenance Manage from 8:30 a.m. to 11 battery operated light facility which was a Room 2 in the Murry first floor in Building when its respective multiple times. Base the observations, the Manager agreed the powered emergency illuminate when its pushed multiple times.						
	the Main Building N	viewed with the Administrator, Maintenance Manager and the Coordinator during the exit					
K 0311 SS=E Bldg. 01	openings between construction havin	- Enclosure					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	r í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 11/23/	LETED
	PROVIDER OR SUPPLIEF SEIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131		
(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)	ATE .	(X5) COMPLETION DATE
	with construction fire resistance ratioox. Based on observation failed to maintain patairwells. LSC 19		K 0	311	What corrective action(s) will be accomplished for those residents found to have been offected by the deficient		12/16/2022
	Section 8.6. LSC 8 separates stories in constructed as a sm see 7.1.3.2.1 for end states the separation fire resistance rating stories or less. Fire accordance with NI	a building shall be oke barrier. LSC 8.6.5 states closures of exits. LSC 7.1.3.2.1 in shall have a minimum 1-hr g where the exit connects three doors assemblies are in FPA 80, Standard for Fire			affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will be identified and what corrective.	the ne be	
	Section 4.8.4.1 state bottom of of a door	pening Protectives. NFPA 80, es the clearance under to shall be a maximum of 3/4ths t practice could affect over 30 visitors.			action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged def practice. Audit completed on all emerge	tial to icient	
	Maintenance Mana from 1:20 p.m. to 2 being used to firest of the stairwell wal above the stairwell floor in Building 2. with a 90-minute fr latched into the doc the time of the obse Maintenance Mana	ations with the Main Building ger during a tour of the facility (20 p.m. on 11/22/22, foam was op one data cable penetration I above the suspended ceiling door by Room 386 on the third. The stairwell door was affixed the resistance rating label and for frame. Based on interview at the revations, the Main Building ger stated he was not aware of the resistance rating of the foam			stairwells on 11/23/2022. Pleasee before and after pictures (attachments #8, #9, #10) What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? After each contracted job, The Maintenance Manager will aud completion for any penetrated spots in the work area. (attachment #11) How will the corrective	ase nto	
		penetration of the stairwell			action(s) be monitored to		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ′		NSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155771	B. WI	NG		11/23/	2022
	ROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	RE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
WA ID	CLD G () DV	CT L TEL CENT OF DEPLOYENCE		<u> </u>	,		(715)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	LISC IDENTIFITING INFORMATION		IAG		41.	DATE
	Maintenance Manage from 8:30 a.m. to 12 separate one inch so in diameter hole we above the suspended door by Room 248 of 2. The stairwell door fire resistance rating door frame. Based observations, the M Manager agreed the stairwell wall did no rating of the stairwell This finding was rette Main Building M	ations with the Main Building ger during a tour of the facility 1:20 a.m. on 11/23/22, two quare holes plus a three inch are noted in the stairwell wall deciling above the stairwell on the second floor in Building for was affixed with a 90-minute glabel and latched into the on interview at the time of the ain Building Maintenance aforementioned holes in the fort maintain the fire resistance fell wall. Viewed with the Administrator, Maintenance Manager and the Coordinator during the exit			will not recur, i.e., what quali assurance program will be p into place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committ for further recommendation. By what date the systemic changes for each deficiency will be completed? 12/16/2022	u t be	
K 0345	NFPA 101						
SS=C	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	. Tooting and					
	Fire Alarm System Maintenance	ı - resung and					
	A fire alarm syster in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N	FPA 70, NFPA 72					
	failed to maintain the	on and interview, the facility the fire alarm system to assure time and date information in the requirements of NFPA 101-	K 03	345	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		12/16/2022

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155771	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 11/23/2022
	PROVIDER OR SUPPLIER EIN FRANKLIN SENIORLIFE COMM RES & COM CA	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131	
(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
	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. Findings include: Based on observations with the Main Building Maintenance Manager during a tour of the facility from 8:30 a.m. to 11:20 a.m. on 11/23/22, the date and the time of day for the main fire alarm control panel were incorrect. The display read the date as November 24, 2022 and the time of day as 9:56 a.m. at 10:55 a.m Based on interview at the time of the observations, the Main Building Maintenance Manager agreed the main fire alarm control panel did not display the correct date and the correct time of day. This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the Building Services Coordinator during the exit conference. 3.1-19(b)		practice? No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged defipractice. Contractor programmed correctime and date into the Fire Ala Panel on 12/8/2022. (attachment and date into the Fire Ala Panel on 12/8/2022. (attachment practice does not recur? An audit will be made to ensure that the deficient practice does not recur? An audit will be completed after each fire drill to ensure accurate of date and time. (attachment #13) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualities assurance program will be printo place? The audit will be reviewed eact month at QAPI for at least six months. After six months and 100% compliance, the QA committee may decide to stop audits. By what date the systemic changes for each deficiency	the e pe e ial to cicient ct rrm eent ito

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MUL A. BUIL B. WINC	DING	nstruction <u>01</u>	(X3) DATE COMPL 11/23	LETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C		1070 W	.DDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, at by construction ty, throughout by an a sprinkler system ir 13, Standard for th Systems. In Type I and II co protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to maintain th 75 rooms in accorda for the Installation of	Installation Installation Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler Instruction, alternative hes are permitted to be inkler protection in specific or local regulations prohibit alternative are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers tas required by NFPA 13,	K 035		will be completed? 12/16/2022 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		02/23/2023
	annular space aroun or shall be listed for deficient practice co staff and visitors in	er devices used to cover the d a sprinkler shall be metallic, t use around a sprinkler. This buld affect over 10 residents, the vicinity of resident on the third floor in Building 2.			No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action(s) will be taken?	the ne oe	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETE	ΞD
		155771	B. W	ING		11/23/20	22
				CTREET	ADDRESS OF VICTATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
OTTERR		NUODI IEE OOMMA DEG 8 OOM O			W JEFFERSON ST		
UTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	AKE.	FRAN	KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					No other residents have been		
	Based on observation	ons with the Main Building			identified as having the potent	ial to	
	Maintenance Mana	ger during a tour of the facility			be affected by the alleged def	cient	
	from 1:20 p.m. to 2	2:20 p.m. on 11/22/22, one of two			practice.		
	ceiling mounted sp	rinklers in resident sleeping			The Maintenance Manager		
	Room 303 on the th	nird floor in Building 2 was			educated by the Administrator		
	missing its escutche	eon. In addition, one of the			(see attachment #14) on NFF	PA	
	ceiling mounted sp	rinklers in the Shower Room by			13, 2010 edition, Section 6.2.7	7.1	
	Room 304 on the th	nird floor in Building 2 was also			states plates, escutcheons, or		
	missing its escutche	eon. Based on interview at the			other devices used to cover th	е	
		tions, the Main Building			annular space around a sprint	der	
		ger agreed the aforementioned			shall be metallic, or shall be lis	sted	
	ceiling mounted sp	rinkler locations were missing			for use around a sprinkler.		
	its escutcheon.				2 Escutcheons were ordered to	rom	
					Koorsen but the wrong size		
	1	eviewed with the Administrator,			arrived. New ones are to arriv		
	_	Maintenance Manager and the			and be replaced by 12/23/202		
		Coordinator during the exit			Room 303 and the shower room	om	
	conference.				by 304.		
					What measures will be put in	ito	
	3.1-19(b)				place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					Once the installation has beer	1	
					completed, audits will be		
					conducted weekly for four weekly	eks,	
					then continue random for one		
					month and thereafter for three		
					months. (attachment #15)		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	-	
					assurance program will be p	ut	
					into place?		
					Audits will be reviewed by the		
					committee. Once initial audits		
					have been completed, and 10		
1					compliance has been met, the	· [

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. W	NG _		11/23/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .			JEFFERSON ST		
OTTERB	EIN FRANKLIN SEI	NIORLIFE COMM RES & COM C	ARE		ILIN, IN 46131		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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
					committee may decide to		
					discontinue audits.		
					By what date the systemic		
					changes for each deficiency		
					will be completed?		
					02/23/2023		
IX 0000	NIEDA 404						
K 0363 SS=E	NFPA 101						
	Corridor - Doors						
Bldg. 01	Corridor - Doors	corridor openings in other					
		osures of vertical openings,					
		s areas resist the passage					
	· ·	made of 1 3/4 inch					
		wood or other material					
		ig fire for at least 20					
	-	fully sprinklered smoke					
		only required to resist the					
	-	e. Corridor doors and doors					
	to rooms containin						
		rials have positive latching					
		atches are prohibited by					
	CMS regulation. T	hese requirements do not					
	apply to auxiliary s	spaces that do not contain					
	flammable or com	bustible material.					
	Clearance betwee	n bottom of door and floor					
	covering is not exc	ceeding 1 inch. Powered					
	doors complying w	vith 7.2.1.9 are permissible					
	if provided with a	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	-	rs. Hold open devices that					
		door is pushed or pulled are					
		ed protective plates of					
		re permitted. Dutch doors					
	-	6 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	-					
	sprinklered. Fixed	fire window assemblies are	1				I

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155771	B. W	ING		11/23	/2022
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
077500					/ JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE	FRANK	(LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	·	n sprinklered compartments					
		ctions in area or fire					
	_	s or frames in window					
	assemblies.						
	40000 4005	D 1 100 110 100 100					
		Parts 403, 418, 460, 482,					
	483, and 485	(S details of doors such as					
		ngs, automatics closing					
	devices, etc.	ngs, automatics closing					
		on and interview, the facility	K 0	363	What corrective action(s) wil	ı	12/16/2022
		f over 15 corridor doors to	100	303	be accomplished for those	-	12/10/2022
		oms on the second floor in			residents found to have been	า	
		esist the passage of smoke.			affected by the deficient		
	This deficient pract	ice could affect over 15			practice?		
	residents, staff and	visitors in the vicinity of			No residents were identified a	s	
	Room A258 on the	second floor in Building 4.			being affected by this alleged		
					deficient practice.		
	Findings include:				How other residents having t		
	D 1 1	14 4 M 1 D 111			potential to be affected by th		
		ons with the Main Building			same deficient practice will be		
		ger during a tour of the facility 1:20 a.m. on 11/23/22, a one inch			identified and what correctiv	е	
		etween the face of the corridor			action(s) will be taken? No other residents have been		
		top on the door frame to			identified as having the potent	ial to	
		om A258 and A260 on the			be affected by the alleged defi		
		lding 4 when the doors were in			practice.		
		l latched position and would			The Maintenance Manager wa	as	
	-	ge of smoke. Based on			educated by the Administrator		
	interview at the tim	e of the observations, the Main			(see attachment #16) on Doo		
	Building Maintenar	nce Manager agreed the			protecting corridor openings ir	1	
		ridor doors would not resist			other than required enclosures	s of	
	the passage of smol	ke.			vertical openings, exits, or		
					hazardous areas that resist th		
	_	viewed with the Administrator,			passage of smoke and are ma		
	_	Maintenance Manager and the			of 1 3/4 inch solid-bonded core		
		Coordinator during the exit			wood or other material capable	e ot	
	conference.				resisting fire for at least 20		
	2 1 10(b)				minutes. Doors in fully sprinkle		
	3.1-19(b)				smoke compartments are only	'	

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 155771 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 11/23/2022 STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO SUMMARY STATEMENT OF DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO SUMMARY STATEMENT OF DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO SUMMARY STATEMENT OF DEFICIENCY DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE DEFICIENCY DESCRIPTION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE DEFICIENCY DESCRIPTION DATE TO SUMMARY STATEMENT OF DEFICIENCY COMPLETION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE DEFICIENCY DESCRIPTION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE DEFICIENCY DESCRIPTION SHOULD BE CROSS-REFERENCED TO HEAPPROPRIATE DEFICIENCY ACTION SHOULD
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE (X4) ID PREFIX TAG TAG TAG TAG TAG TAG TAG TA
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE (X4) ID PREFIX TAG TAG TAG TAG TAG TAG TAG TA
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TEQUIFER DEFICIENCY TAG 1070 W JEFFERSON ST FRANKLIN, IN 46131 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TEQUIFER DEFICE OF THE APPROPRIATE DEFICIENCY TAG TEQUIFER DEFICIENCY TAG TO W JEFFERSON ST FRANKLIN, IN 46131 (X5) COMPLETION DATE TO ROW JEFFERSON ST FRANKLIN, IN 46131 (X5) COMPLETION DATE TO ROW JEFFERSON ST FRANKLIN, IN 46131
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION FRANKLIN, IN 46131 (X5) PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TREQUIRED TO THE APPROPRIATE DEFICIENCY DEFICIENCY DATE REQUIRED TO THE APPROPRIATE DEFICIENCY DATE REQUIRED TO THE APPROPRIATE DEFICIENCY TO commode and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION REQUIRED TO THE APPROPRIATE DEFICIENCY TAG REQUIRED TO THE APPROPRIATE DEFICIENCY REQUIRED TO THE APPROPRIATE DEFICIENCY TAG REQUIRED TO THE APPROPRIATE DEFICIENCY TAG REQUIRED TO THE APPROPRIATE DEFICIENCY TAG REQUIRED TO THE APPROPRIATE DEFICIENCY TO THE TAG T
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY) TAG Tequired to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFY IN TAG REGUL
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROJUCTION TO THE PROJUCTION TO T
smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
not apply to auxiliary spaces that do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
do not contain flammable or combustible material. The clearance between the bottom of the door and floor covering is not
combustible material. The clearance between the bottom of the door and floor covering is not
clearance between the bottom of the door and floor covering is not
the door and floor covering is not
complying with 7.2.1.9 are
permissible if provided with a
device capable of keeping the door
closed when a force of 5 lbs is
applied. There is no impediment to
the closing of the doors. Hold
open devices that release when
the door is pushed or pulled is
permitted. Nonrated protective
plates of unlimited height are
permitted. Dutch doors meeting
19.3.6.3.6 are permitted. Door
frames shall be labeled and made
of steel or other materials in
compliance with 8.3 unless the
smoke compartment is
sprinklered. Fixed fire window
assemblies are allowed per 8.3. In
sprinklered compartments, there
are no restrictions in the area or
fire resistance of glass or frames
in window assemblies.
Gaps in doors A258 and A260
were repaired on 12/16/2022.
(Attachments #17 and #18)
Audit of doors for gaps completed
by maintenance on 11/23/2022.

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	AN OF CORRECTION LAN OF CORRECTION		A. BUILDING B. WING	01	COMPLETED 11/23/2022
	ROVIDER OR SUPPLIER EIN FRANKLIN SEI	NIORLIFE COMM RES & COM CA	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131	
(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
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Buil Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers sh 1/2-hour fire resist	ding Spaces - Smoke ding Spaces - Smoke on all be constructed to a ance rating per 8.5. Smoke		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be conducted week for four weeks and then month for three months. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be p into place? Audit will be reviewed by the Committee. Once initial audit is completed and 100% compliant is met, the committee may choose to discontinue the audit By what date the systemic changes for each deficiency will be completed? 12/16/2022	ty ut QA is nce
	atrium wall. Smoke in duct penetration systems where an is installed for smo to the smoke barri 19.3.7.3, 8.6.7.1(1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. WI	B. WING 11/23/202			2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	NAME OF PROVIDER OR SUPPLIER				V JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE		KLIN, IN 46131		
	1		1		, · · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	 			IAU			DATE
	system in REMAR	on and interview, the facility	K 0	272	What corrective action(s) wil		12/16/2022
		f 10 smoke barrier walls were	I K U.	312	be accomplished for those		12/10/2022
		in the fire resistance of the			residents found to have been	•	
		C Section 19.3.7.5 requires			affected by the deficient	•	
		e constructed in accordance			practice?		
		3.5 and shall have a minimum ½			No residents were identified a	c	
		ating. This deficient practice			being affected by this alleged	J	
		residents, staff and visitors.			deficient practice.		
	Coura arrest over 10	residents, start and visitors.			How other residents having	the	
	Findings include:				potential to be affected by th		
					same deficient practice will be		
	a. Based on observa	ations with the Main Building			identified and what correctiv		
		ger during a tour of the facility			action(s) will be taken?		
		:20 p.m. on 11/22/22, foam was			No other residents have been		
	_	op one hole for multiple data			identified as having the potent		
	_	rated the smoke barrier wall			be affected by the alleged defi		
	_	d ceiling above the corridor			practice.		
	door set in the third	floor corridor wall separating			Audit completed on all emerge	ency	
	Building 2 from Bu	ailding 4. Each door in the			stairwells on 11/23/2022. Plea	-	
	corridor door set wa	as affixed with a 90-minute fire			see before and after pictures		
	resistance rating lab	pel and latched into the door			(attachments #8, #9, #10).		
	frame. Based on in	terview at the time of the			What measures will be put in	ito	
	observations, the M	Iain Building Maintenance			place and what systemic		
	_	was not aware of the UL listing			changes will be made to		
		ting of the foam used to			ensure that the deficient		
	firestop the penetra	tion of the smoke barrier wall.			practice does not recur?		
					After each contracted job, The		
		ations with the Main Building			Maintenance Manager will aud		
		ger during a tour of the facility			any penetrated spots in the we	ork	
		1:20 a.m. on 11/23/22, a six inch			area. (attachment #11)		
		he passage of two copper			How will the corrective		
		the smoke barrier wall above			action(s) be monitored to		
	_	ng above the corridor door set			ensure the deficient practice		
		corridor wall separating			will not recur, i.e., what quali		
		illding 4. A separate one inch			assurance program will be p	ut	
		above the suspended ceiling			into place?	L .	
		r wall. Two layers of 5/8ths			Any identified deficiencies will	ре	
		was noted on each side of the			corrected upon discovery and		
	smoke barrier wall	and each door in the corridor	I		reviewed by the QAPI commit	tee	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771			ì	UILDING	onstruction 01	(X3) DATE COMPL 11/23/	ETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM (STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST CARE FRANKLIN, IN 46131		JEFFERSON ST		
(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)	ATE	(X5) COMPLETION DATE
	resistance rating lab frame. Based on in observations, the M Manager agreed the the smoke barrier w maintain the fire res This finding was re the Main Building M	I with a 90-minute fire bel and latched into the door terview at the time of the ain Building Maintenance aforementioned openings in wall were not firestopped to sistance of the smoke barrier. Viewed with the Administrator, Maintenance Manager and the Coordinator during the exit			for further recommendation. By what date the systemic changes for each deficiency will be completed? 12/16/2022		
K 0541 SS=D Bldg. 01	Chu Rubbish Chutes, I Chutes 2012 EXISTING (1) Any existing lir including pneumar systems, that oper corridor shall be soonstruction to pre provided with a fir- fire protection ration shall comply with service (2) Any rubbish chrincluding pneumar systems, shall be extinguishing prote 9.7. (3) Any trash chut trash collection ro- purpose and prote 8.4. (Existing laun discharge into sar	ncinerators, and Laundry ncinerators, and Laundry nen and trash chute, tic rubbish and linen ns directly onto any ealed by fire resistive event further use or shall be e door assembly having a ng of 1-hour. All new chutes 9.5. nute or linen chute, tic rubbish and linen provided with automatic ection in accordance with e shall discharge into a om used for no other ected in accordance with dry chutes permitted to ne room are protected by ers in accordance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/23/2022							
		ROVIDER OR SUPPLIER EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131			
	(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	
		sealed by fire resifurther use. 19.5.4, 9.5, 8.4, N Based on observation failed to ensure 1 or maintained in accord 82, Standard on Inch Handling Systems at Section 5.2.3.2.2 standard on Inch Handling Systems at Section 5.2.3.1. Section 5.2 as follows: (1) 1 1/2 fire resistate enclosures. (2) 1-hour fire resistate enclosures. This deficient praction the basement. Findings include: Based on observation Maintenance Manager from 8:30 a.m. to 1 by one foot hole was laundry chute room interview at the tim Building Maintenar had been doing plus which were now co of the laundry chute a minimum of 1-hour This finding was rethe Main Building Maintenar than Building Maintenar than Building Maintenar had been doing plus which were now co of the laundry chute a minimum of 1-hour This finding was rethe Main Building Maintenar than Building M	ed incinerators shall be stive construction to prevent	K	0541	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified a being affected by this alleged deficient practice. How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action(s) will be taken? No other residents have been identified as having the potential be affected by the alleged defipractice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The alleged deficient areas were paired 11/24/2022. Please before and after photos (attachment #19) After each contracted job, the Maintenance Manager will aud completion for any penetrated spots in the work area. (attachment #11) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality and the corrective action(s) the monitored to ensure the deficient practice will not recur, i.e., what quality and the corrective action(s) the corrective action(s) the monitored to ensure the deficient practice will not recur, i.e., what quality and the corrective action(s) the correc	the ne be ve tial to ficient nto	12/16/2022	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	ľ	UILDING	onstruction 01	(X3) DATE COMPL 11/23	LETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD Z JEFFERSON ST LIN, IN 46131		
(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 B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	B RIATE	(X5) COMPLETION DATE
K 0704	3.1-19(b)				assurance program will be into place? Any identified deficiencies w corrected upon discovery an reviewed by the QAPI comm for further recommendation. By what date the systemic changes for each deficience will be completed? 12/16/2022	ill be d ittee	
K 0761 SS=F Bldg. 01	failed to ensure ann all fire door assemble accordance of LSC openings in dividing 19.1.1.4.1 shall be pure shall be protected by door assemblies. (Section 19.3.3.1 Openings resulting by Table 8.3. approved, listed, labeling fire window assemble hardware, including anchorage, and sills requirements of NF and Other Opening otherwise specified states fire door asset tested not less than of the inspection by the Affunctional testing of assemblies shall be knowledge and undicomponents of the transportance.	iew and interview, the facility ual inspection and testing of lies were completed in 19.1.1.4.1.1. Communicating gifre barriers required by permitted only in corridors and y approved self-closing fire ee also Section 8.3.) LSC quired to have a fire protection 4.2 shall be protected by peled fire door assemblies and their accompanying all frames, closing devices, in accordance with the PA 80, Standard for Fire Doors Protectives, except as in this Code. NFPA 80 5.2.1 mblies shall be inspected and annually, and a written record all be signed and kept for HJ. NFPA 80, 5.2.3.1 states of fire door and window performed by individuals with terstanding of the operating type of door being subject to .2.4.1 states fire door	K	0761	What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice? No residents were identified being affected by this allege deficient practice. How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken? No other residents have bee identified as having the pote be affected by the alleged depractice. Initial door inspection of small fire doors completed on 12/15/2022. (attachment #2 What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be completed through the same accompleted through the same accomplete through the same ac	en as d g the the l be ive n ntial to efficient ke 0)	12/16/2022

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Event ID:

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01/05/2023 PRINTED:

	T OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771			(X2) MUI A. BUII B. WIN	LDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/23/2022	
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM (CARE	1070 W	DDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	assemblies shall be sides to assess the cassembly. NFPA 80, Section 5 following items shall to either the door or from the door, frame noncombustible through and in working orded damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open processes before the active door when it is in the (9) Auxiliary hardwork prohibit operation a frame. (10) No field modification and inspected to verify the assessment of the control of the self-closing the active door comfrom the full open prohibit operation and the control of the self-closing the active door when it is in the (9) Auxiliary hardwork door when it is in the (9) Auxiliary hardwork prohibit operation and frame.	or breaks exist in surfaces of ame. light frames, and glazing beads ely fastened in place, if so a, hinges, hardware, and eshold are secured, aligned, er with no visible signs of assing or broken. a do not exceed clearances as 3.1.7. a device is operational; that is, appletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) Worxhub by maintenance state annually. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quates assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI commit for further recommendation. By what date the systemic changes for each deficiency will be completed? 12/16/2022	e lity out Il be	(X5) COMPLETION DATE

Findings include:

Based on record review with the Main Building Maintenance Manager and the Building Services Coordinator from 9:00 a.m. to 12:45 a.m. on

		IDENTIFICATION NUMBER 155771	A. B	UILDING VING	01	COMPL 11/23/	ETED
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0907 SS=E Bldg. 01	door assemblies in trecent twelve month review. Based on in review, the Main Bustated the facility has inspections and testidue to maintenance annual inspection do assemblies in the fact twelve month period. This finding was revite Main Building Maintenance Programs. The proof all source system anufactured assemblies in the fact twelve month period. NFPA 101 Gas and Vacuum Maintenance Programs. The proof all source system shave door programs. The proof all source system anufactured assemblished through considering manufactured are established through considering manufactured assemblished through considering manufactured are established through considering manufactured by the credentialing to the 6030 or 6040.	Piped Systems - gram um, WAGD, or support gas umented maintenance ogram includes an inventory ms, control valves, alarms, emblies, and outlets. sintenance schedules are gh risk assessment facturer recommendations. ures and testing methods rough risk assessment. ng systems are qualified as raining and certification or e requirements of AASE 2.2, 5.1.15, 5.2.14,					

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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. BU	ILDING	01	COMPLI	ETED
		155771	B. WI	NG		11/23/	2022
				CTDEET	T ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			W JEFFERSON ST		
OTTERR	REIN EDANKI INI SE	NIORLIFE COMM RES & COM C	۸DE		KLIN, IN 46131		
OTTLINE		INIONEII E COMMININES & COM CA	~! \L	LIVAIN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record review, observation and		K 0	907	What corrective action(s) wi	ill	12/16/2022
	interview; the facility failed to maintain the				be accomplished for those		
	facility's piped gas systems in accordance with				residents found to have bee	n	
	NFPA 99, Health Care Facilities Code, 2012				affected by the deficient		
		eient practice could affect over			practice?		
		the facility's pipe gas system			No residents were identified a		
	not be operational.				being affected by this alleged	ı	
					deficient practice.		
	Findings include:				How other residents having		
					potential to be affected by the		
		view with the Main Building			same deficient practice will		
		ger and the Building Services			identified and what corrective	∕e	
		0:00 a.m. to 12:45 a.m. on			action(s) will be taken?		
		spection documentation for the			No other residents have been		
		systems within the most recent			identified as having the poten		
	_	od was not available for review.			be affected by the alleged de	ficient	
		cation of the Medical Gas			practice.		
		tation dated September 10,			Inspector certifying oxygen or		
		most recent inspection			12/16/2022. (attachment #21		
		the facility's piped gas systems			What measures will be put in	nto	
		years old. Based on interview at			place and what systemic		
		review, the Main Building			changes will be made to		
		ger agreed annual inspection			ensure that the deficient		
		the facility's piped gas systems			practice does not recur?		
		ent twelve month period was			Annual inspection set up in		
		view. Based on observations			Worxhub for maintenance sta	1	
		ding Maintenance Manager			ensure completion. (attachm	ent	
	_	e facility from 1:20 p.m. to 2:20			#22)		
	_	nd from 8:30 a.m. to 11:20 a.m.			How will the corrective		
		cility has piped gas systems			action(s) be monitored to		
	_	seping rooms on the second			ensure the deficient practice		
	and third floor of B	ounding 2.			will not recur, i.e., what qual	-	
	This finding was ==	wiewed with the Administrator			assurance program will be p	Jut	
	This finding was reviewed with the Administrator, the Main Building Maintenance Manager and the				into place?	l bo	
	_	_			Any identified deficiencies wil		
	Building Services Coordinator during the exit conference.				corrected upon discovery and		
	Connecence.				reviewed by the QAPI commi for further recommendation.	iiee	
	3.1-19(b)						
	3.1-17(0)				By what date the systemic	,	

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<u> </u>	THE CHIEF CONTENTS	THE SERVICES				0.11	21.0.0,00
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPL	ETED
		155771	B. W	ING		11/23/	
						I	
NAME OF 1	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
OTT		NIODI IEE OOMAA DEG A OOM	0405		/ JEFFERSON ST		
OTTERE	SEIN FRANKLIN SE	NIORLIFE COMM RES & COM	JAKE	FRANK	(LIN, IN 46131		
(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 APPROPRI		TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					will be completed?		
					12/16/2022		
K 0914	NFPA 101						
SS=F	_	s - Maintenance and					
Bldg. 01	Testing	5 - Maintenance and					
Diag. 01		s - Maintenance and					
	Testing	5 - Maillenance and					
	•	ceptacles at patient bed					
		ere deep sedation or general					
		ninistered, are tested after					
		replacement or servicing.					
		is performed at intervals					
	_	ented performance data.					
	1	sted as hospital-grade at					
	· ·	e tested at intervals not					
		nths. Line isolation monitors					
	_	are tested at intervals of					
	, ,	to 1 month by actuating					
	1	h per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
	LIM circuits with a	utomated self-testing, this					
		formed at intervals less					
	than or equal to 1	2 months. LIM circuits are					
	tested per 6.3.3.3	.2 after any repair or					
	renovation to the	electric distribution system.					
	Records are main	tained of required tests and					
	associated repairs	s or modifications,					
	containing date, re	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
		view and interview, the facility	K 0	914	What corrective action(s) wil	I	02/23/2023
		rumentation of electrical outlet			be accomplished for those		
		or all resident sleeping rooms			residents found to have been	n	
		view in accordance with NFPA			affected by the deficient		
		Ith Care Facilities Code, 2012			practice?		
		3.4.1.3 states receptacles not			No residents were identified a	S	
		rade at patient bed locations			being affected by this alleged		
		ere deep sedation or general			deficient practice.		
	anesthesia shall be	tested at intervals not			How other residents having	the	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/23/2022	
	OF PROVIDER OR SUPPLIEI RBEIN FRANKLIN SE	NIORLIFE COMM RES & COM C	CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD J JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Facilities Code, 20 states hospital-grad performed after init servicing of the dev Receptacle Testing the physical integric confirmed by visual the grounding circus shall be verified. Oneutral connections shall be confirmed; grounding blade of (except locking-typt than 115 grams (4 of states, at a minimum date, the rooms or a of which items have the performance recently than 115 grams (4 of states). This could affect all affect all the performance recently than 115 grams (4 of states) at a minimum date, the rooms or a of which items have the performance recently than 115 grams (4 of states). This could affect all findings include: Based on record record record from 9 11/22/22, annual eleand testing document twelve month period based on interview the Main Building of the facility had star receptacle inspectic complete it due to a greed electrical record documentation with month period was record.	hs. NFPA 99, Health Care 12 Edition, Section 6.3.4.1.1 re receptacles testing shall be ital installation, replacement or rice. Section 6.3.3.2, in Patient Care Rooms requires by of each receptacle shall be it inspection. The continuity of it in each electrical receptacle for receptacle and retention force of the each electrical receptacle and retention force of the each electrical receptacle erceptacles) shall be not less bunces). Section 6.3.4.2.1.2 In, the record shall contain the areas tested, and an indication ermet, or have failed to meet, quirements of this chapter. I residents. I residents. I residents. I residents expection matation for the most recent d was not available for review. At the time of record review, Maintenance Manager stated ted to perform electrical on and testing but did not maintenance staff turnover and ceptacle inspection and testing thin the most recent twelve not available for review. Viewed with the Administrator, Maintenance Manager and the viewed with the Administrator, Maintenance Manager and the			potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged defipractice. Initial audit of all receptacles to completed by 12/31/2022. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Annual audit created in Worxh for preventative maintenance completed by maintenance state (attachment #23) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be pinto place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committ for further recommendation. By what date the systemic changes for each deficiency will be completed? 02/23/2023	cial to icient to be atto	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155771	B. WING 11/23/2022		/2022		
NAME OF D	DOLUBER OR GURRU IER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L		1070 W	JEFFERSON ST		
OTTERB	EIN FRANKLIN SEI	NIORLIFE COMM RES & COM CA	RE	FRANK	LIN, IN 46131		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	Coordinator during the exit					
	conference.						
	2.1.10(1-)						
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	•	s - Essential Electric Syste					
Bldg. 01	_	s - Essential Electric					
	System Maintenar	-					
	_	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	-	his capability for the life					
	-	branches. Maintenance					
	_	generator and transfer					
		ormed in accordance with					
	NFPA 110.	a inapacted weakly					
		e inspected weekly, pad 30 minutes 12 times a					
		intervals, and exercised					
		nths for 4 continuous hours.					
		der load conditions include					
	a complete simula						
	· •	ual transfer of all EES					
		nducted by competent					
		nance and testing of stored					
	-	rces (Type 3 EES) are in					
		IFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
		tablished according to					
	•	irements. Written records					
	of maintenance ar	nd testing are maintained					
		ble. EES electrical panels					
	· ·	arked, readily identifiable,					
		n normal power circuits.					
	Minimizing the pos	ssibility of damage of the					
	emergency power	source is a design					

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155771	B. WI	NG		11/23/	2022
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST		
OTTEDD	DEINI EDANIZI INI GE	NIODI IEE COMM DES 8 COM CA					
UTTERD	DEIN FRANKLIN SE	ENIORLIFE COMM RES & COM CA	NKE.	FRAIN	(LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF COR		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	consideration for	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.1	0 (NFPA 70)					
	Based on observation	ation and interview, the facility	K 0	918	What corrective action(s) wil	ll l	02/23/2023
	failed to ensure 1 o	f 1 emergency generator			be accomplished for those		
	locations inside the	facility was provided with			residents found to have been	n	
	task battery backup	lights. NFPA 110, Standard			affected by the deficient		
	for Emergency and	Standby Power Systems, 2010			practice?		
	Edition at section 7	7.3.1 requires the Level 1 or			No residents were identified a	IS	
	Level 2 EPS equips	ment location(s) shall be			being affected by this alleged		
	_	ery-powered emergency			deficient practice.		
	lighting. This requ	irement shall not apply to units			How other residents having	the	
	located outdoors in	enclosures that do not			potential to be affected by the	ie	
	include walk-in acc	cess. Section 7.9.3.1.1 (1)			same deficient practice will I	be	
	_	testing shall be conducted			identified and what correctiv	e e	
		nimum of 3 weeks and a			action(s) will be taken?		
		eks between tests, for not less			No other residents have been		
	1) Functional testing shall be			identified as having the potent	tial to	
	1	for a minimum of 1 1/2 hours			be affected by the alleged def	icient	
		ghting system is battery			practice.		
		ritten records of visual			Immediate Action Taken:		
	_	ts shall be kept by the owner			a) Emergency battery orde	red	
	for inspection by th	· -			12/13/2022 (attachment #2)		
	1 -	deficient practice could affect all			b) Monthly load test comple	eted	
	residents, staff and	visitors in the facility.			12/9/2022 (attachment #3)		
					c) Annual fuel quality test		
	Findings include:				completed 1/24/2022 (attachn	nent	
	D 1	24 d M 1 D 22			#4)		
		ons with the Main Building			Initial Audits:		
		ger during a tour of the facility			a) An Audit will be complet		
		1:20 a.m. on 11/23/22, no			on all emergency battery light	ıng	
		nergency lighting systems were			systems once installed.		
	_	ency generator location which			b) Audit completed on		
		the facility. Based on interview			12/9/2022 on the Emergency		
		bservations, the Main Building			generator for load test.		
		ger agreed no battery-powered			c) Audit completed on	I:4	
		systems were installed at the			1/24/2022 on annual fuel qual	-	
		or location which was located			What measures will be put in	ITO	
	inside the facility.				place and what systemic		
	1				changes will be made to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/23/2022		
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CAR			STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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	N
Thi the Bui con 3.1- 2. If faci more periodic states a system of the states are states as a single state and the states are states as a single state and the states are states	Is finding was rev Main Building M ilding Services Conference. -19(b) Based on record re ility failed to doe inthly load testing iod to meet the re indard for Emerge stems, 2010 Editie tes diesel generate st once monthly, in ing one of the follo Loading that main is temperatures as in infacturer Under operating tess than 30 perc wer Supply) name is temperatures as in infacturer Under operating tess than 30 perc wer Supply) name is temperatures set (Emergency P ill be exercised an dis at not less than ineplate kW rating at a not less than ineplate kW rating at test duration of irs. This deficien idents, staff and v idergency Generate is ded on review of the idents of r	riewed with the Administrator, faintenance Manager and the coordinator during the exit eview and interview, the tument emergency generator of or the most recent 12 month requirements of NFPA 110, tency and Standby Powers on, Chapter 8.4.2. Section 8.4.2 or sets shall be exercised at for a minimum of 30 minutes, towing methods: fintains the minimum exhaust frecommended by the temperature conditions and at tent of the EPS (Emergency teplate kW rating. The sed monthly with the available frower Supply System) load and fintains the minimum sinutes for a for 1 continuous minutes for percent of the EPS of for 30 continuous minutes for percent of the EPS of for 1 continuous hour for a fintal less than 1.5 continuous of t practice could affect all			ensure that the deficient practice does not recur? Once installation is completed audits will be completed month by maintenance staff. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualit assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committ for further recommendation. By what date the systemic changes for each deficiency will be completed? 02/23/2023	ty ut	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155771 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		l í	UILDING	onstruction 01	(X3) DATE COMPL 11/23/	ETED		
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST ARE FRANKLIN, IN 46131					
(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)	NTE.	(X5) COMPLETION DATE	
	Manager and the Briduring record review on 11/22/22, month for the facility's die for the most recent incomplete. The lot test or the loading the exhaust gas temperate manufacturer was not interview at the time Building Maintenart changed how they be documentation with the computer prograshad not yet been uppercent achieved for agreed monthly load the facility's dieseld the most recent two incomplete. This finding was rette the Main Building Is Building Services Conference. 3.1-19(b) 3. Based on record facility failed to enswas performed for the generator. NFPA 92012 Edition, Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA 110, States.	in Building Maintenance uilding Services Coordinator w from 9:00 a.m. to 12:45 a.m. Ily load testing documentation sel fired emergency generator twelve month period was ad percent achieved for the hat maintains the minimum atures as recommended by the tot documented. Based on e of record review, the Main nee Manager stated the facility teep generator testing tin the last two year period to tam entitled "Workxhub" which dated to document the load r a monthly load test and d testing documentation for fired emergency generator for live month period was viewed with the Administrator, Maintenance Manager and the Coordinator during the exit review and interview, the sure an annual fuel quality test the facility's diesel-powered 9, Health Care Facilities Code, ton 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states the performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8.						

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		IDENTIFICATION NUMBER 155771	r í	UILDING	01	COMPL 11/23/	ETED	
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CA			STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131					
(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	
	shall be performed a approved by ASTM practice could affec- visitors.	8.3.8 states a fuel quality test at least annually using tests standards. This deficient t all residents, staff and						
	Maintenance Manage Coordinator during 12:45 a.m. on 11/22 annual fuel quality to emergency generated Based on interview the Main Building Mathefacility has one of generator and agreed fuel quality test for generator was not at This finding was revenue the Main Building Main Buildin	riew with the Main Building ger and the Building Services record review from 9:00 a.m. to 1/22, documentation of an rest for the diesel fired or was not available for review. At the time of record review, Maintenance Manager stated diesel fired emergency d documentation of an annual the diesel fired emergency vailable for review.						
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1	d electrical equipment						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COMPL	x3) date survey completed 11/23/2022		
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CAI				STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131				
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)		TE	(X5) COMPLETION DATE
		except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 Based on observation failed to ensure 1 or power strips were not fixed wiring. LSC comply with Section electrical wiring and NFPA 70, National NFPA 70, National NFPA 70, Article 4 specifically permitted shall not be used as a structure. LSC Secretice equipment of safety shall be design in accordance with This deficient pract residents, staff and second floor Building 2223. Findings include: Based on observation Maintenance Management of the process of the practice of th	personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms of meet UL 1363. In cooms, power strips meet ls. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was to the conditions of 10.2.4. Poly, 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 con and interview, the facility of 1 extension cords including to to used as a substitute for 19.5.1 requires utilities to m 9.1. LSC 9.1.2 requires d equipment to comply with Electrical Code, 2011 Edition. 100.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of the extension cords and approved all applicable NFPA standards. The interview of the median and proved all applicable NFPA standards. The interview of the median account of the facility of the median account of the facility 1:20 a.m. on 11/23/22, a hair	KO	920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potential be affected by the alleged defipractice. Beautician was educated 11/24/2022 by Maintenance Manager on power and extens cords. (attachment #24) What measures will be put in place and what systemic changes will be made to	the e e e ial to icient	12/16/2022

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/23/2022	
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CAF			\RE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)			(X5) COMPLETION DATE
	dryer was plugged in the second floor room 2223. Based observations, the M Manager agreed a p	into a power strip on the floor Building 2 Beauty Shop near on interview at the time of the fain Building Maintenance power strip was being used as and wiring at the aforementioned			ensure that the deficient practice does not recur? Audit to be conducted weekly four weeks and then random audits once a month for three months for extension cord use (attachment #25) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI committed for further recommendation. By what date the systemic changes for each deficiency will be completed? 12/16/2022	ty ut be	

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