	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155607	B. WI			05/04/	
NAME OF P	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg	A F D	1 0	E 00				
		paredness Survey was ndiana Department of Health in	E 00)00	By submitting the enclosed material we are not admitting	tho	
	accordance with 42	-			truth or accuracy of any speci		
	accordance with 12	2 CTR 103.73.			findings or allegations. We res		
	Survey Dates: 05/03/23 and 05/04/23				the right to contest the finding allegations as part of any		
	Facility Number: (000436			proceedings and submit these)	
	Provider Number:	155607			responses pursuant to our		
	AIM Number: 100275120 At this Emergency Preparedness survey, Bethel Manor was found not in compliance with				regulatory obligations. The factive requests that the plan of	cility	
					correction be considered our		
					allegation of compliance effec	tive	
	Emergency Prepare	edness Requirements for			June 2, 2023 to the annual		
	Medicare and Med	icaid Participating Providers			licensure survey conducted M	ay	
	and Suppliers, 42 (CFR 483.73.			4, 2023. We respectfully requipaper compliance/desk review		
	The facility has 75 the survey, the cen	certified beds. At the time of sus was 61.					
	Quality Review co	mpleted on 05/11/23					
	The requirement at MET as evidenced	t 42 CFR, Subpart 483.73 is NOT by:					
E 0004 SS=C Bldg	441.184(a), 482.1 484.102(a), 485.6 485.727(a), 485.6 491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §483 §485.68(a), §485	54(a), 418.113(a), 15(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a), 2(a) , Review and Update 6.54(a), §418.113(a), 0.84(a), §482.15(a), .475(a), §484.102(a), .625(a), §485.727(a), 6.360(a), §491.12(a),					

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

TITLE (X6) DATE

Morgan Branning Administrator 05/25/2023

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction =-	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF F	PROVIDER OR SUPPLIEI	₹	6015 K	ADDRESS, CITY, STATE, ZIP COD (RATZVILLE RD SVILLE, IN 47710	_
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	Federal, State and preparedness required must develop estate comprehensive elegand must incomprehensive elegand must incomprehensive elegand must incomprehensive elegand updated at legand updated at legand elegand	an. The [facility] must stain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable ind local emergency juirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must stain an emergency in that must be reviewed,			

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Event ID:

U5FW21 Facility ID: 000436

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607		JILDING	ONSTRUCTION	(X3) DATE COMPL 05/04 /	ETED
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710		RATZVILLE RD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on record refailed to develop ar preparedness plant at least annually in 483.73(a). This deresidents in the factoristic findings include: Based on review of Program on 05/04/2 p.m. with the Adm. Coordinator present emergency prepared twelve months. The provided was Augusthe time of review, Emergency Prepared reviewed and update months. This finding was refailed to develop and update months.	view and interview, the facility and maintain an emergency that was reviewed and updated accordance with 42 CFR ficient practice could affect all ility. The Emergency Preparedness 23 between 9:30 a.m. and 2:45 inistrator and Maintenance t, the facility did provide an dness manual, however, it has and updated during the past are most recent date of review ast 2020. Based on interview at the Administrator said the edness Program has not been ted within the past twelve	E 00		The corrective action taken is those residents found to be affected by the deficient practiculus: No specific residents were identified to be affected by the cited deficient practice. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none widentified. The measures or systematic changes that have been put place to ensure that the deficient practice does not rinclude: The IDT met and completed the update of the Emergency Preparedness Plan. Monthly meetings were planned with Maintenance Coordinator and Administrator to ensure the Emergency Preparedness Plathe most up to date. The corrective action taken is monitor performance to assist compliance through quality assurance is: A Quality Assurance Tool has been developed to track meet to update the Emergency Preparedness Plan as an IDT This tool will be completed by Administrator or designee, monthly for 3 months, then quarterly for three quarters. A ideas identified through this at will be immediately corrected.	for ctice ctice class to ere cinto ecur ne ings the ings	06/02/2023

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Event ID:

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PRINTED: 06/02/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	E SURVEY PLETED 4/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C	COD	
BETHEL	MANOR			SVILLE, IN 47710		
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE / DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and pridevelop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies and pridevelop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),		outcome of this tool wi reviewed the quarterly Assessment and Assu meeting to determine i additional interventions needed. An additional kept in the Emergency Preparedness Plan Bir developed to capture t necessary changes to Emergency Preparedn when changes occur of the annual review. The track the annual review ensure compliance.	Quality rance f any s are tool will be nder was he the ness Plan outside of is log will	

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Event ID:

U5FW21 Facility ID: 000436

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PRINTED: 06/02/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	, ,	UILDING	NSTRUCTION	COM	E SURVEY PLETED 4/2023
	OF PROVIDER OR SUPPLIE	R	-	6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
	*[For LTC facilities and procedures.develop and implipreparedness polon the emergency (a) of this section paragraph (a)(1) communication psection. The polibe reviewed and *Additional Requipment of the ESRD Facilities: *[For PACE at §4 procedures. The develop and implipment of this section paragraph (a)(1) communication psection. The policies and reviewed and upon the emergency (a) of this section paragraph (a)(1) communication psection. The policies and reviewed and upon the preparedness polon the partition of this section paragraph (a)(1).	es at §483.73(b):] Policies The LTC facility must ement emergency licies and procedures, based by plan set forth in paragraph control, risk assessment at estate and procedures must of this section, and the lan at paragraph (c) of this cies and procedures must updated at least annually. Interements for PACE and 160.84(b):] Policies and PACE organization must ement emergency licies and procedures, based by plan set forth in paragraph control, risk assessment at estate and procedures must ement of medical and estate and procedures must ement of medical and estate and procedures; and natural estate the health or estate and procedures must entered emergencies; and natural estate the health or estate at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must ement emergency licies and procedures, based by plan set forth in paragraph control, risk assessment at estate and procedures, based by plan set forth in paragraph control, risk assessment at estate and procedures, based by plan set forth in paragraph control, risk assessment at estate and procedures, based by plan set forth in paragraph control this section, and the elan at paragraph (c) of this					

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Event ID:

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PRINTED: 06/02/2023 FORM APPROVED OMB NO. 0938-039

	AN OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING		onstruction	COMPLETED 05/04/2023	
	DF PROVIDER OR SUPPLIEI EL MANOR	R	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(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
	be reviewed and years. These ement not limited to, fire, failures, care-rela supply interruption likely to occur in the area. Based on record residied to develop and preparedness policipolicies and procedupdated at least and CFR 483.73(b). The all residents in the second program on 05/04/2 p.m. with the Admic Coordinator present the plan for facility however the policies been reviewed by the recent twelve mont of review provided interview at the times aid the Emergency policies and procedured and updated within	The Emergency Preparedness 23 between 9:30 a.m. and 2:45 mistrator and Maintenance t, there was documentation in policies and procedures, and procedures have not the facility within the most the period. The most recent date I was August 2020. Based on the of review, the Administrator of Preparedness Program's the past twelve months.	E 0	013	The corrective action taken in those residents found to be affected by the deficient practiculude: No specific residents were identified to be affected by the cited deficient practice. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none we identified. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The IDT met and completed the update of the Emergency Preparedness Policies and Procedures. Monthly meetings were planned with Maintenance. Coordinator and Administrator ensure the Emergency Preparedness Plan is the most to date. The corrective action taken to monitor performance to assist compliance through quality assurance is: A Quality Assurance Tool has	e e e e e e e e e e e e e e e e e e e	06/02/2023

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING		COMPL	
		155607	B. W			05/04/	
				CERTIFIED :	ADDRESS OF THE STREET	I	
NAME OF P	ROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP COD		
BETHEL	MANOR		6015 KRATZVILLE RD EVANSVILLE, IN 47710				
DETHEL	IVIANUN		ī	EVANS			
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					been developed to capture the	Э	
					necessary changes to the		
					Emergency Preparedness Pla		
					when changes occur outside of		
					the annual review. This log w track the annual review updat		
					ensure compliance. This tool		
					be completed by the Administ		
				or designee, monthly for three			
				months, then quarterly for three			
					quarters. Any areas identified		
					through this audit will be		
					immediately corrected. The		
					outcome of this tool will be		
					reviewed at the quarterly Qua	lity	
					Assessment and Assurance		
					meeting to determine if any		
					additional interventions are		
					needed.		
L 0020	400.740() 440.5	(4/-) 440 440/-)					
E 0029 SS=C	403.748(c), 416.5						
SS=C Bldg	441.184(c), 482.1 484.102(c), 485.6	5(c), 483.475(c), 483.73(c),					
ычу. 	, ,	20(c), 486.360(c),					
	491.12(c), 494.62						
	, ,	Communication Plan					
	•	6.54(c), §418.113(c),					
	` ' ' '	0.84(c), §482.15(c),					
	` ' ' -	475(c), §484.102(c),					
	§485.68(c), §485.	625(c), §485.727(c),					
	§485.920(c), §486	6.360(c), §491.12(c),					
	§494.62(c).						
	. , .	ust develop and maintain					
		eparedness communication					
		s with Federal, State and					
		ist be reviewed and updated					
		ears [annually for LTC					
	facilities].	view and interview the facility	F 0	020	The commention action to be a	fo.,	06/02/2022
	based on record rev	view and interview, the facility	E 00	029	The corrective action taken	ror	06/02/2023

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Event ID:

 $U5FW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000436$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLETED
		155607	B. W	/ING		05/04/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
					RATZVILLE RD	
BETHEL	MANOR			EVANS	SVILLE, IN 47710	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
	_	d maintain an emergency			those residents found to be	
	1	unication plan that complies			affected by the deficient pra	ctice
		and local laws was reviewed			include:	
	_	annually in accordance with			No specific residents were	
		This deficient practice could			identified to be affected by the)
	affect all occupants.				cited deficient practice.	
	Findings in ded.	Findings include:			Other residents that have the	
	Based on review of the Emergency Preparedness				potential to be affected have	
					been identified by: All residents have the potentia	nl to
	Program on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Administrator and Maintenance				be affected, however, none w	
					identified.	cie
	Coordinator present, the facility's emergency				The measures or systematic	
	preparedness plan provided did include a plan to				changes that have been put	
	develop and maintain an emergency preparedness				place to ensure that the	into
	_	n that complies with Federal,			deficient practice does not r	ecur
	_	s, however the communication			include:	ccui
		eviewed by the facility within			The IDT met and updated	
	1 ~	lve month period. The most			Communication Plan. Monthly	,
		ew provided was August 2020.			meetings were planned with	
		at the time of review, the			Maintenance Coordinator and	
		the Emergency Preparedness			Administrator to ensure the	
		ication has not been reviewed			Emergency Preparedness Pla	ın is
		the past twelve months.			the most up to date.	
	_				The corrective action taken	to
	This finding was re	viewed with the Administrator			monitor performance to ass	ure
		oordinator during the exit			compliance through quality	
	conference on 05/04	4/23.			assurance is:	
					A Quality Assurance Tool has	
					been developed to capture the	e
					necessary changes to the	
					Emergency Preparedness Pla	
					when changes occur outside	III
					the annual review. This log w	
					track the annual review updat	
					ensure compliance. This tool	
					be completed by the Administ	
					or designee, monthly for three	
					months, then quarterly for three	ee
					quarters. Any areas identified	1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP C	OD	
BETHEL	MANOR		EVANS			
(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 COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
				through this audit will b immediately corrected. outcome of this tool wil reviewed at the quarter Assessment and Assur meeting to determine if additional interventions needed.	The Il be rly Quality rance f any	
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §483. §485.68(d), §485.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)				
	Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testir develop and main preparedness train that is based on the in paragraph (a) of assessment at pa section, policies at (b) of this section, plan at paragraph training and testin	3403.748, ASCs at §416.54, 13, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at HC/FHQs at §491.12:] (d) ng. The [facility] must tain an emergency ning and testing program ne emergency plan set forth f this section, risk ragraph (a)(1) of this nd procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years.				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u></u>	COM	TE SURVEY IPLETED 14/2023		
NAME OF I	PROVIDER OR SUPPLIEF	X	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	and testing. The and maintain an estraining and testing the emergency plate of this section, risk (a)(1) of this section at paragraph (b) of communication plate section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plans and testing progratemergency plans this section, risk at (a)(1) of this section. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facility Training, testing, a dialysis facility mule mergency prepaland patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the communication plate of the procedures at parand the communication plate of the section, paragraph (a)(1) of procedures at parand the communication plate of the section, paragraph (a)(1) of this section, paragraph (b) of this section, paragraph (c) of this section, paragr	s at §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least [483.475(d):] Training and D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every (IID must meet the evacuation drills and training eties at §494.62(d):] and orientation. The lest develop and maintain an redness training, testing ation program that is based or plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) ne training, testing and						

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Event ID:

 $U5FW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000436$

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	MENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155607			onstruction 	COMPLETED 05/04/2023	
	OF PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) IE PREFE 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
TAG	orientation progra updated at every Based on record rer failed to develop ar preparedness training was reviewed and use accordance with 42 practice could affect Findings include: Based on review of Program on 05/04/2 p.m. with the Admit Coordinator present available to show the preparedness training however the training been reviewed by the recent twelve mont of review provided interview at the time said the Emergency training and testing reviewed and update months. This finding was re-	m must be evaluated and 2 years. View and interview, the facility and maintain an emergency and and testing program that updated at least annually in CFR 483.73(d). This deficient et all occupants. The Emergency Preparedness 23 between 9:30 a.m. and 2:45 inistrator and Maintenance t, there was documentation and facility had an emergency and testing program, and testing program has not the facility within the most h period. The most recent date I was August 2020. Based on the of review, the Administrator of Preparedness Program's a program has not been teed within the past twelve	E 0		The corrective action taken in those residents found to be affected by the deficient practiculude: No specific residents were identified in the survey finding: Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none we identified. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The IDT met and updated Emergency Preparedness Tra and Testing Plan. Monthly meetings were planned with Maintenance Coordinator, Hur Resources, and Administrator ensure the Emergency Preparedness Plan is the most to date. The corrective action taken to monitor performance to assist compliance through quality assurance is: A Quality Assurance Tool has been developed to capture the necessary changes to the Emergency Preparedness Pla when changes occur outside of the annual review. This log wit track the annual review update ensure compliance. This tool with the survey of the ensure compliance. This tool with the survey of the	for ctice s. e sl to ere into ecur ining man to t up to ure	06/02/2023

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 1/2023
NAME OF P	ROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZI RATZVILLE RD SVILLE, IN 47710	P COD	
(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 ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	N SHOULD BE HE APPROPRIATE)	(X5) COMPLETION DATE
E 0041 SS=F Bldg	482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency an The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this solid systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location required Care Facilities Colliterim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA	(e), 485.625(e) 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. and the CAH] must ency and standby power the emergency plan set (a) of this section.		be completed by the or designee, monthly months, then quarter quarters. Any areas through this audit wi immediately corrected outcome of this tool reviewed at the quarters and Assessment and Assessment intervention	y for three rrly for three identified II be ed. The will be rterly Quality surance e if any	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DA'	(X3) DATE SURVEY COMPLETED 05/04/2023		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		(X5) COMPLETION	
TAG	structure is built of structure or buildid 482.15(e)(2), §48 Emergency general The [hospital, CA implement the eminspection, testing requirements four Facilities Code, National Code. 482.15(e)(3), §48 Emergency general LTC facilities source to power endergency general LTC facilities source to power endergency, unless that is section are all reference by the Federal Register 552(a) and 1 CFF the material from You may inspect	r when an existing ng is renovated. 3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] nd in the Health Care IFPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the sit evacuates. §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. a part 51. You may obtain the sources listed below. a copy at the CMS	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE	
	Boulevard, Baltim Archives and Red (NARA). For infor this material at Na go to:	urce Center, 7500 Security fore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code					
	_of_federal_regul	ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a					

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document in the Federal Register to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILDING B. WING	onstruction 	COMPLETED 05/04/2023	
NAME OF F	PROVIDER OR SUPPLIER		6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710	
(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
	announce the cha (1) National Fire F Batterymarch Parl Quincy, MA 02168 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issue (ii) Technical interi 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. (xiii) NFPA 110, S Standby Power Sy including TIAs to C 2009.	rotection Association, 1 A, B, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued March 3, FPA 99, issued March 3, FPA 101, issued August FPA 101, issued August FPA 101, issued October FPA 101, issued October FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,			
	failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2).	riew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 review and interview, the	E 0041	The corrective action taken in those residents found to be affected by the deficient prainclude: No specific residents were identified in the survey finding Other residents that have the potential to be affected have been identified by:	ctice S. e

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STREET ADDRESS, CITY, STATE, JP COD		OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING		COMPLETED 05/04/2023
Description	NAME OF P	ROVIDER OR SUPPLIER				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO THE PROPERTIES OF THE APPROPRIATE OF THE APPROP	BETHEL	MANOR				
facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9.30 a.m. and 2.45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.					PROVIDER'S PLAN OF CORRECTION	
facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9.30 a.m. and 2.45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.		*			CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION
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the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 30 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 2.45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30'9's during the past 12 month period.		_	•		1	
generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 30 continuous hour for a total test duration of not less than 1.5 continuous hour. This deficient practice could affect all occupants in the facility. Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.		•				
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one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSs (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice does not recur include: The Maintenance Coordinator contacted generator company and a load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test will have to be completed annually due to the inability to meet the 30% threshold. A timeframe for the cool down period was added to the monthly maintenance check list. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.		_			changes that have been put	into
(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 30 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator contacted generator company and a load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample was sent out. The load bank test was completed on 5/17/2023 and a fuel sample will have to be completed annually due to the inability to the cold dwn pring for 1 continuous four for a to c		· ·	_		place to ensure that the	
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Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.			-		•	
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EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. the cool down period was added to the monthly maintenance check list. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance check list. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance compliance to ensure compliance. With contracted companies to ensure compliance.			•		•	
shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. the monthly maintenance check list. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. with contracted companies to ensure compliance.						
loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Iist. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.					-	
of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. The corrective action taken to monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.						
minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. monitor performance to assure compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance to ensure compliance compliance. No further monitoring was deemed necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.		· ·	· -			to
nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. compliance through quality assurance is: No further monitoring was deemed necessary, the monthly maintenance compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.		_	_			
total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. Findings include: Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Assurance is: No further monitoring was deemed necessary, the monthly necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.						
occupants in the facility. necessary, the monthly maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance. Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.		total test duration of	f not less than 1.5 continuous			
Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. maintenance checks will ensure compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.		hours. This deficien	t practice could affect all		No further monitoring was de-	emed
Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. compliance. A reminder program is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.		occupants in the fac	ility.			
Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. is in the process of being integrated to ensure compliance with contracted companies to ensure compliance.						
Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. integrated to ensure compliance with contracted companies to ensure compliance.		Findings include:				am
a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. with contracted companies to ensure compliance.						
9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.						ice
Coordinator present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period.		•	•		•	
for the diesel powered generator was documented less than 30% during the past 12 month period.					ensure compliance.	
less than 30% during the past 12 month period.		•				
		-	_			
Dasses on microrow at the time of record review,						
the Maintenance Coordinator acknowledged the						
generator ran under load on a monthly basis but						
does not achieve 30% of the name plate rating.						
Additionally, the Maintenance Coordinator						
acknowledged a load bank test for the generator		-				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		l ,	ILDING	NSTRUCTION	COMPL 05/04/	ETED	
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP COD		
BETHEL	MANOR			EVANS	VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		ithin the past 12 months. The generator load bank test was					
	This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23.						
	facility failed to may of monthly generated generator during the 6.4.4.1.1.4(a) of 20 testing of the generated lectrical system to 110, the Standard for Powers Systems, Clay NFPA 99 requires a performance, exercing generator to be regular for inspection by the jurisdiction. NFPA Engine Shutdown redelay of 5 minutes or running of the Emeror to shutdown, engine cool down.	review and interview, the intain a complete written record or load testing for 1 of 1 e past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the alarly maintained and available e authority having 110, 6.4.2.1.5.9 Time Delay on equires that a minimum time shall be provided for unloaded regency Power Supply (EPS) This delay provides additional This time delay shall not be 15 kW or less) air-cooled prime					
	residents, staff and Findings include: Based on record rev a.m. and 3:30 p.m., 9:30 a.m. and 2:45 g Coordinator present the generator month down period after th	view on 05/03/23 between 9:30 and again on 05/04/23 between p.m. with the Maintenance t, there was documentation on ally load test log for a cool me load test, however, it was or "yes" only. A time frame					

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				DING	NSTRUCTION	(X3) DATE : COMPL 05/04/	ETED
NAME OF F	PROVIDER OR SUPPLIER			6015 KR	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD /ILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	of record review, th Coordinator said the generator was at lea check mark or yes v	Based on interview at the time e facility Maintenance e cool down time for the last 5 minutes, but agreed the was not adequate.					
		oordinator during the exit					
	facility failed to ensign was performed for a generators. NFPA 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power System NFPA 110, Section shall be performed approved by ASTM	review and interview, the sure an annual fuel quality test of 1 diesel powered 99, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES I System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states are performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient t all residents, as well as staff					
	a.m. and 3:30 p.m. a 9:30 a.m. and 2:45 j Coordinator present an annual generator however, there was annual fuel quality available for review	view on 05/03/23 between 9:30 and again on 05/04/23 between p.m. with the Maintenance it, there was documentation of inspection dated 01/09/23, no documentation of an test for the diesel generator v. Based on interview at the					
		w, the Maintenance the facility does have a diesel having spoken with the					

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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. BU	JILDING		COMPL	ETED
		155607	B. W	ING		05/04/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹		1	RATZVILLE RD		
BETHEL	MANOR			EVANS	VILLE, IN 47710		
(X4) ID		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 APPROPRIA'	ГЕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		inspection vendor it was					
		uel sample has not been taken					
	within the past 12 month period. The most recent						
	fuel sample test was performed on 04/20/22.						
	This finding was re	viewed with the Administrator					
	_	oordinator during the exit					
	conference on 05/04	C					
		review and interview, the					
		ovide complete documentation					
		of 1 Emergency Power Standby					
	-	ce with NFPA 110, Standard					
		Standby Power Systems,					
		quired by NFPA 99 Health Care					
		etion 6.4.1.1.6.1. NFPA 110					
		that all Level 1 Emergency ll be tested at least once within					
	•	Where the assigned class is					
		s, it shall be permitted to					
	-	fter 4 hours. NFPA 99 Section					
		at Type 1 and Type 2 essential					
		ower sources shall be classified					
		Level 1 generator sets. This					
		ould affect all building					
	occupants.	oute union and outening					
	1						
	Findings include:						
	Based on record rev	view on 05/03/23 between 9:30					
		and again on 05/04/23 between					
	•	p.m. with the Maintenance					
		t, the facility could only					
	-	tion of an invoice of the four					
	-	ergency generator conducted					
	on 09/02/22. The in	nformation and results of the					
	four hour test were	not available for review. This					
	was confirmed by the	he Maintenance Coordinator at					
	the time of record re	eview.					

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(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2023
STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710	•
ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) DE PRIATE COMPLETION DATE
	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710 ID PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		UILDING	NSTRUCTION	(X3) DATE : COMPL 05/04/	ETED	
NAME OF P	PROVIDER OR SUPPLIER		6015 KF	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	Based on interview the Maintenance Cogenerator ran under does not achieve 30 Additionally, the Macknowledged a loahad not occurred with most recent diesel good dated 03/31/22. This finding was reand Maintenance Coonference on 05/04 2. Based on record facility failed to man of monthly generate generator during the 6.4.4.1.1.4(a) of 20 testing of the generate electrical system to 110, the Standard for Powers Systems, Clayers Sy	at the time of record review, bordinator acknowledged the load on a monthly basis but % of the name plate rating. aintenance Coordinator d bank test for the generator thin the past 12 months. The generator load bank test was viewed with the Administrator coordinator during the exit 4/23. Treview and interview, the intain a complete written record or load testing for 1 of 1 to past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby mapter 8. Chapter 6.4.4.2 of a written record of inspection, using period, and repairs for the charly maintained and available to authority having 110, 6.4.2.1.5.9 Time Delay on equires that a minimum time shall be provided for unloaded regency Power Supply (EPS) This delay provides additional This time delay shall not be 1.5 kW or less) air-cooled prime lent practice could affect all				
	Based on record rev	riew on 05/03/23 between 9:30				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTII A. BUILDI B. WING		ISTRUCTION	(X3) DATE : COMPL 05/04/	ETED
NAME OF I	PROVIDER OR SUPPLIEF		60	15 KR	DDRESS, CITY, STATE, ZIP COD ATZVILLE RD /ILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	a.m. and 3:30 p.m., 9:30 a.m. and 2:45 Coordinator present the generator month down period after the with a check mark of was not included. If of record review, the Coordinator said the generator was at least check mark or yes with the conference on 05/0-3. Based on record facility failed to ensure was performed for generators. NFPA 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA 110, Section shall be performed approved by ASTM practice could affect and visitors. Findings include: Based on record review. Findings include:	and again on 05/04/23 between p.m. with the Maintenance t, there was documentation on ally load test log for a cool me load test, however, it was per "yes" only. A time frame Based on interview at the time re facility Maintenance e cool down time for the last 5 minutes, but agreed the was not adequate.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607		ILDING	NSTRUCTION	(X3) DATE : COMPL 05/04/	ETED
	PROVIDER OR SUPPLIER		•	6015 KF	ODDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	annual fuel quality available for review time of record review time of record review Coordinator stated to generator but after I facility's generator determined that a fit within the past 12 m fuel sample test was: This finding was re and Maintenance Coonference on 05/04 4. Based on record facility failed to profor the testing of 1 of System in accordant for Emergency and Section 8.4.9, as rec Facilities Code, Sec Section 8.4.9 states Power Systems shale every three years. The greater than 4 hours terminate the test afford. 1.1.6.1 states the electrical system post Type 10, Class X deficient practice of occupants. Findings include: Based on record review. Based on record review. Based on record review. Growth and 3:30 p.m. and	no documentation of an test for the diesel generator. Based on interview at the ew, the Maintenance the facility does have a diesel naving spoken with the inspection vendor it was nel sample has not been taken nonth period. The most recent is performed on 03/31/22. viewed with the Administrator coordinator during the exit 4/23. review and interview, the ovide complete documentation of 1 Emergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care the exition 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency ll be tested at least once within Where the assigned class is so, it shall be permitted to the 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified in Level 1 generator sets. This build affect all building					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		r í	JILDING	NSTRUCTION	(X3) DATE COMPL 05/04 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER MANOR			6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	on 09/02/22. The ir four hour test were rwas confirmed by the time of record real. This finding was rev	viewed with the Administrator oordinator during the exit					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Dates: 05/0 Facility Number: 0 Provider Number: AIM Number: 1002 At this Life Safety 0 was found not in co for Participation in 1 Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	00436 155607 275120 Code survey, Bethel Manor mpliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and	K 0	000	By submitting the enclosed material we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect June 2, 2023 to the annual licensure survey conducted M 4, 2023. We respectfully request paper compliance/desk review	ric serve s or sility tive ay est a	
	was determined to be construction and was facility has a fire ala smoke detectors in the the corridors, and in	ity with a walkout lower level be of Type II (111) as fully sprinklered. The arm system with hard wired the corridors, spaces open to a all resident sleeping rooms. apacity of 63 and had a census					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155607	B. WING 05/04/20			2023	
NAME OF P	ROVIDER OR SUPPLIER		•	6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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)	TE	(X5) COMPLETION DATE
K 0271 SS=E Bldg. 01	at the time of this surfaces where resimplified and services were sprinklered and services where conditions and services and services are serviced as a services and services and services and services and services are services and ser	idents have customary access d all areas providing facility clered, except three detached r facility storage. Impleted on 05/11/23	K 0.	271	The corrective action taken in those residents found to be affected by the deficient practiculude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none we identified. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The Ivy Unit Courtyard sidewards.	the e e e e e e e e e e e e e e e e e e	06/02/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG <u>01</u>	COMPLETED	
		155607	B. WING	B. WING 05/04/2023		
NAME OF F	ROVIDER OR SUPPLIER		60	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY)	BE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)	DATE	
		g from this area in the event of		was corrected and leveled.		
		ed on interview at the time of		The corrective action take		
	observation, the Maintenance Coordinator			monitor performance to a		
	-	racks and level changes along		compliance through quali	ty	
	exit.	public way from this courtyard		assurance is:	and by	
	exit.			A walk-through was perforr Administrator and Maintena	-	
	This finding was re	viewed with the Administrator		Coordinator and no further	ince	
		oordinator during the exit		monitoring was deemed		
	conference on 05/04	C		necessary due to this being	ı an	
	conference on our	25.		isolated instance.	, an	
	3.1-19(b)			losiaca motanos.		
K 0293	NFPA 101					
SS=E	Exit Signage					
Bldg. 01	Exit Signage					
	2012 EXISTING					
	Exit and directiona	al signs are displayed in				
	accordance with 7	'.10 with continuous				
	illumination also s	erved by the emergency				
	lighting system.					
	19.2.10.1					
	(Indicate N/A in or					
	•	less than 30 occupants				
		exit travel is obvious.)				
		on and interview, the facility	K 0293	The corrective action take	00,02,202	
		f 1 courtyard gate was		those residents found to		
		it sign. This deficient practice		affected by the deficient p	ractice	
		12 residents, as well as staff		include:	J : 41	
	and visitors.			No residents were identified	in the	
	Findings include:			survey findings. Other residents that have	tho	
	i manigs include:					
	Based on observation	ons on 05/04/23 between 11:45		potential to be affected had been identified by:	IAC	
		during a tour of the facility with		All residents have the poter	ntial to	
	*	oordinator, there was no exit		be affected, however, none	•	
		m the courtyard from the lower		identified. All exit doors have		
		exit. Based on interview at		checked to ensure exit sign		
		tion, the Maintenance		on all the doors.	5 415	
		d out that there once was an		The measures or systema	ntic	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF E	PROVIDER OR SUPPLIEF	2	6015 K	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710	
BETHEL (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF exit sign on the gate some time. This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the but had been removed at viewed with the Administrator oordinator during the exit 4/23.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) changes that have been put place to ensure that the deficient practice does not r include: The Maintenance Coordinator added an exit sign on the gate from the courtyard near the ly Unit exit. All exit doors have b checked to ensure exit signs a on all the doors. The corrective action taken monitor performance to ass compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure tha above corrective actions and changes are being followed. T tool will be completed by the Maintenance Coordinator or designee, weekly for four wee	into ecur ey een are to ure tthe
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire			then monthly for three months and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Qua Assessment and Assurance meeting to determine if any additional interventions are needed.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155607	B. WING 05/04/2023			2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
DETTILL	IVIANOIX			LVANO	VILLE, IN 477 10		
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with 8	3.7.1 or 19.3.5.9. When the					
	approved automat	tic fire extinguishing system					
	option is used, the	e areas shall be separated					
	· ·	s by smoke resisting					
	l •	ors in accordance with 8.4.					
	Doors shall be sel						
	_	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
	hazardous areas that are deficient in						
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	b. Laundries (large c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square for g. Laboratories (if Hazard - see K32). Based on observation failed to ensure the hazardous area door was provided with a closing device. This affect at least 12 results visitors in the Ivy U. Findings include:	er than 100 square feet) nance, and Paint Shops coms (exceeding 64 In Rooms Illons) orage Rooms/Spaces eet) classified as Severe 2) on and interview, the facility corridor door to 1 of over 10 rs, such as storage room door, a properly operating self is deficient practice could sidents, as well as staff and Unit.	K 0	321	The corrective action taken for those residents found to be affected by the deficient practinclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: No residents were identified as	the	06/02/2023
		ons on 05/04/23 between 11:45 during a tour of the facility with			being negatively affected by the cited deficient practice.	ie	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF F	PROVIDER OR SUPPLIER		6015 k	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Services Storage Ro Records Office was was full of combust boxes, totes, plus pa door to this storage closing device, how door completely wh door frame on the la damaged and would fully automatically, from the Medical R with a self closing of the time of observar Coordinator agreed Environmental Services to the time of the time This finding was re	pordinator, the Environmental pom within the Medical over 50 square feet in size and ible items such as cardboard aper and plastic items. The room was provided with a self ever, it would not close the ten tested several times. The atching side of the door was a not allow the door to close. Furthermore, the corridor door ecords Office was not provided device. Based on interview at tion, the Maintenance the damaged door frame to the rices Storage Room was som closing fully automatically. Wiewed with the Administrator pordinator during the exit 4/23.		The measures or systematic changes that have been purplace to ensure that the deficient practice does not include: The Maintenance Coordinate adjusted the Environmental Services Storage Room door including moving the striker plack and refastening the door to the wall to ensure the door would self-close. The corrective action taken monitor performance to ass compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure the above corrective actions and changes are being followed. tool will be completed by the Maintenance Coordinator or designee, weekly for four weethen monthly for three month and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quarterly Quarterly to determine if any additional interventions are needed.	tinto recur recur relate plate or jam to sure sat the This eks, s,
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PI	AN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED	
		155607	B. WING		05/04/2023
	OF PROVIDER OR SUPPLIER	3	601	EET ADDRESS, CITY, STATE, ZIP COD 5 KRATZVILLE RD ANSVILLE, IN 47710	•
(X4) IE PREFIX TAG	K (EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION INFERA 25. Standard for the	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	(X5) SE COMPLETION DATE
	Inspection, Testin Water-based Fire Records of syster inspection and test secure location are a) Date sprinkler. b) Who provided b) Who provided c) Water system. Provide in REMAI coverage for any automatic sprinklet 9.7.5, 9.7.7, 9.7.8 1. Based on record facility failed to enspiping systems was accordance with NI the Inspection, Test Water-Based Fire Fedition, Section 14 piping and branch I conducted every 5 connection at the eremoving a sprinkled line for the purpose of foreign organic at Alternative nondest shall be permitted. required to be inspectively and maintenant components and shauthority having justices.	supply source RKS information on non-required or partial er system.	K 0353	The corrective action taken those residents found to be affected by the deficient princlude: No residents were identified survey findings. Other residents that have a potential to be affected has been identified by: All residents have the potential be affected, however, none identified. The measures or systematic changes that have been purplace to ensure that the deficient practice does not include: Maintenance Coordinator in the company that conducts pipe inspection that it needs be completed and it was completed on 5/4/2023. On 5/4/2023, the contracted con was made aware of the loos	the the ve tial to were tic ut into trecur sotified the ed to

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STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR 6015 KRATZVILLE RD EVANSVILLE, IN 47710	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	(X5) COMPLETION DATE
Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, documentation of an internal inspection of the wet sprinkler system performed within the most recent five year period was not available for review. The most recent internal pipe inspection provided was dated 03/12/18. Based on interview at the time of record review on 05/04/23, the Maintenance Coordinator said the five year internal pipe inspection was performed this morning (05/04/23), but there was no documentation with results of the inspection provided by the sprinkler vendor at the time of exit. This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference on 05/04/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		r í	UILDING	nstruction 01	(X3) DATE (COMPL 05/04/	ETED	
NAME OF P	ROVIDER OR SUPPLIER			6015 KF	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION acility.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Findings include: Based on record revalue. Based on record revalue. Coordinator present sprinkler system condocumentation for the Based on interview the Maintenance Coof sprinkler system valves during the particle of the Maintenance of sprinkler system valves during the particle of the Maintenance of Systems of the Sprinkler cabinate of Systems, 2011 Edit supply of spare sprinkler shall be maintained sprinklers that have any way can be prospected of the sprinklers shall be keeper the sprinkler when should be used in the sprin	with the Maintenance to the was no monthly introl valves inspection the past 12 month period. The past 12 month period to the time of record review, coordinator confirmed the lack inspections on the control that 12 months. The wiewed with the Administrator coordinator during the exit the fact of 1 sprinkler systems the sure 1 of 1 sprinkler systems to the Inspection, Testing, the Water-Based Fire Protection tion, Section 5.4.1.4 states a thklers (never fewer than six) to on the premises so that any the been operated or damaged in the property. The test in a cabinet located where the types and temperature therefore the property. The test in a cabinet located where the types and the property. A special the provided and kept in the the removal and installation deficient practice could affect					
		•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155607		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 05/04	LETED	
	PROVIDER OR SUPPLIER	3	6015 K	ADDRESS, CITY, STATE, ZIP COI RATZVILLE RD SVILLE, IN 47710)	
(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 CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	a.m. and 1:45 p.m. the Maintenance Cocabinet in the sprint sprinkler heads that slots, which could depend on the color of	viewed with the Administrator foordinator during the exit 4/23. vation and interview, the sure sprinkler heads in 1 of 5 ats covered with paint were 5, 2011 edition, at 5.2.1.1.1 show signs of leakage; shall a, foreign materials, paint, and and shall be installed in the (e.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be age (2) Corrosion (3) Physical f fluid in the glass bulb heat (5) Loading (6) Painting are sprinkler manufacturer.				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING <u>01</u> COMPLET B. WING 05/04/20				
		155607	B. W	ING		05/04/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BETHEL	MANOR			EVANSVILLE, IN 47710			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
K 0355 SS=E Bldg. 01	a.m. and 1:45 p.m. of the Maintenance Cosprinkler heads ceiling were covered with be interview at the time Maintenance Coord heads in the ceiling were covered with be replaced. This finding was regard Maintenance Coconference on 05/04/23.1-19(b) NFPA 101 Portable Fire Extire Portable Fire Extire Portable Fire Extire installed, inspected accordance with Neortable Fire Extire 18.3.5.12, 19.3.5.13. Based on observation failed to ensure 2 of extinguishers had domaintenance in accordance with Neortable Fire Extire 18.3.5.1.1.1 states portable Fire Exting 7.3.1.1.1 states fire to maintenance at in year, at the time of 1 specifically indicated electronic notification of the specifically indicated electronic notification.	nguishers nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility f over 10 portable fire	K 0	355	The corrective action taken to those residents found to be affected by the deficient practiculude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. All fire extinguished have been checked to ensure others require inspection and maintenance.	the the late	06/02/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G <u>01</u>	(X3) DATE SURVEY COMPLETED 05/04/2023		
NAME OF F	PROVIDER OR SUPPLIER		601	EET ADDRESS, CITY, STATE, ZIP COD 5 KRATZVILLE RD NSVILLE, IN 47710		
BETHEL (X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR attached that indicat maintenance was per performing the work the agency performing practice could affect visitors. Findings include: Based on observation a.m. and 1:45 p.m. of the Maintenance Co portable fire extings Office and the Beau maintenance tag dor recent annual maint February of 2021. A the facility had affine documenting the da maintenance was per Based on interview observation, the Ma acknowledged the tr fire extinguishers di annual maintenance month period. This finding was received.	wo aforementioned portable and not have documented within the most recent twelve viewed with the Administrator pordinator during the exit	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	ERIATE COM I	(X5) IPLETION DATE
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Corridors - Areas Spaces (other tha			additional interventions are needed.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155607		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF F	PROVIDER OR SUPPLIEF	₹	6015 k	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	treatment rooms a waiting areas, nur and cooking facilitin accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1. Based on observation failed to ensure 1 of were separated from capable of resisting required in a sprink exception per 19.3. That spaces other that treatment rooms, are open to the corridor provided: (a) The space opens onto in are protected by an automatic smoke dowith 19.3.4, and (b) automatic sprinkler to obstruct access to practice could affect as well as staff and rindings include: Based on observation and 1:45 p.m. the Maintenance Cocopier room was op direct supervision for Nurses' Station). For mot met because the not protected by an	and hazardous areas), rse's stations, gift shops, ties, open to the corridor are the the criteria under 18.3.6.1 on and interview, the facility of 4 areas open to the corridor on the corridor on the corridor of the passage of smoke as elered building, or met an	K 0361	The corrective action taken those residents found to be affected by the deficient prainclude: No residents were identified is survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none widentified. The measures or systematic changes that have been put place to ensure that the deficient practice does not include: The Maintenance Coordinato notified our fire system compato install a smoke detector in copy room. The corrective action taken monitor performance to assocompliance through quality assurance is: A audit of all smoke detectors conducted by Administrator a Maintenance Coordinator. Affithe audit was completed, sho no further concerns, it was	for 06/02/2023 actice In the lee
	Maintenance Coord not provided with a	te of observation, the dinator agreed this area was an electrically supervised etector or a door to the egress		deemed that no further monit was necessary.	oring

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED B. WING 05/04/2023			
		155607	B. W.	ING		05/04/	2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDENCE N. AN 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 APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	corridor and was no hour station (i.e., No	ot directly supervised by a 24 urses' Station).					
	This finding was reviewed with the Administrator and Maintenance Coordinator during the exit conference.						
	3.1-19(b)						
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke						
	failed to ensure 1 of protected to maintai smoke barrier. LSC smoke barriers to be with LSC Section 8 hour fire resistive ra could affect at least and visitors in the left. Findings include: Based on observation	on and interview, the facility f 5 smoke barrier walls was in the smoke resistance of the C Section 19.3.7.5 requires e constructed in accordance .5 and shall have a minimum ½ ating. This deficient practice 12 residents, as well as staff ower level Ivy Unit. ons on 05/04/23 between 11:45 during a tour of the facility with	K 0	372	The corrective action taken to those residents found to be affected by the deficient practinclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none we identified. All visible expandable foam was audited to ensure compliance.	the the lito	06/02/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/04/2023		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION POOR PROPERTY OF THE STATE O	PR	(X5) COMPLETION DATE			
	wall above the smol had six penetrations through the smoke I stopped. There was had been covered we conduits and water smoke barrier wall? Based on interview Maintenance Coord documentation avait expandable foam us fire stop material.	see barrier doors in the Ivy Unit of conduits and water lines parrier wall not proper fire expandable spray foam that ith black paint around the lines that penetrated the above the smoke barrier doors. at the time of observation, the inator said there was no lable to show that the ed was a proper and approved wiewed with the Administrator pordinator during the exit			The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The Maintenance Coordinator removed all the improper expandable foam and replace that was removed with an approved fire rating caulking. The corrective action taken a monitor performance to assic compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure that above corrective actions and changes are being followed. Tool will be completed by the Maintenance Coordinator or designee, weekly for four weethen monthly for three months and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Qual Assessment and Assurance meeting to determine if any additional interventions are needed.	into ecur d all to ure t the his ks,	
K 0511 SS=F Bldg. 01	complies with NFF Code, electrical w						

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155607	B. W	ING		05/04	/2023
NAME OF P	PROVIDER OR SUPPLIEF		_		ADDRESS, CITY, STATE, ZIP COD	_	
BETHEL	MANOR		6015 KRATZVILLE RD EVANSVILLE, IN 47710				
DEINEL	IVIAINUR			EVAINS	OVILLE, IIN 4// IU		
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL					COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	tallations can continue in					
	service provided r						
	18.5.1.1, 19.5.1.1	ation and interview, the	17.0	<i>E</i> 1 1	The corrective action taken for		06/02/2022
			KU	511			06/02/2023
	facility failed to ensure 4 of 4 electrical panels observed in the facility corridors were secured from non-authorized personnel. NFPA 70, 2011				those residents found to be affected by the deficient practice include:		
		2 Energized parts of service			No residents were identified in	n the	
	equipment shall be enclosed as specified in				survey findings.	i uic	
		ed as specified in 230.62(B).			Other residents that have the	e	
	(A) Enclosed. Energized parts shall be enclosed				potential to be affected have		
		t be exposed to accidental			been identified by:		
	contact or shall be guarded as in 230.62(B).				All residents have the potentia	al to	
	(B) Guarded. Energized parts that are not enclosed				be affected, however, none w		
	shall be installed on a switchboard, panelboard, or				identified. All electrical panels		
	control board and g	uarded in accordance with			were checked to ensure they		
	110.18 and 110.27.	Where energized parts are			locked.		
	guarded as provided	d in 110.27(A)(1) and (A)(2), a			The measures or systematic	:	
	means for locking of	or sealing doors providing			changes that have been put	into	
	access to energized	parts shall be provided. This			place to ensure that the		
	_	ould affect all residents, staff			deficient practice does not r	ecur	
	and visitors in the fa	acility.			include:		
					All electrical panels are locked		
	Findings include:				and the Maintenance Coordin		
		05/04/00			has the key. A GFCI was add		
		ations on 05/04/23 between			the outlet identified in the staff	İ	
		p.m. during a tour of the facility			break room.	4-	
		ce Coordinator, all four			The corrective action taken		
	_	served in the facility corridors			monitor performance to ass	ure	
		n tested. The panels included y of items in the facility. Based			compliance through quality		
	· ·	time of each observation, the			A Quality Assurance Tool has		
		linator agreed all electrical			A Quality Assurance Tool has been developed to ensure that		
		_			above corrective actions and	ı. uı c	
	panels in the facility corridors need to be locked.				changes are being followed.	hie -	
	This finding was re	viewed with the Administrator			tool will be completed by the	1113	
	_	oordinator during the exit			Maintenance Coordinator or		
	conference on 05/04	_			designee, weekly for four wee	ks	
	0110010	-			then monthly for three months		
	3.1-19(b)				and then quarterly for three	• •	
1	· · · · · · · · · · · · · · · · · · ·						•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/04/2023			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
BETHEL	MANOR		EVANSVILLE, IN 47710				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
	`			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
	SUMMARY (EACH DEFICIEN REGULATORY OR 2. Based on observ facility failed to enswere provided with (GFCI) protection a 70, NEC 2011 Editi Circuit-Interrupter I states, ground-fault personnel shall be p 210.8(A) through (Circuit-interrupter stacessible location. Informational Note: circuit interrupter p feeders. (B) Other Than Dw single-phase, 15- ar installed in the locathrough (8) shall hacircuit-interrupter p (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessible branch circuit dediction, or pipeline shall be permitted to with 426.28 or 427. Exception No. 2 to only, where the consupervision ensure fare involved, an asset.	ation and interview, the sure 1 of over 10 wet locations, ground fault circuit interrupter gainst electric shock. NFPA on at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault hall be installed in a readily at See 215.9 for ground-fault rotection for personnel on elling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault rotection for personnel.		· .	COMPLETION DATE		
	shall be permitted for only those receptacle						
		ly equipment that would ard if power is interrupted or					
	1	ard if power is interrupted or t is not compatible with GFCI					
	protection.	1 52 52					
	ī		1		1		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BUILDING B. WING	G <u>01</u>	COMP	COMPLETED 05/04/2023		
	F PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD				
BETHE	L MANOR		EVA	ANSVILLE, IN 47710			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETION DATE	
	(5) Sinks - where re 1.8 m (6 ft.) of the Exception No. 1 to receptacles used to removal of power whazard shall be per GFCI protection. Exception No. 2 to patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet loca (7) Locker rooms what is a service electrical diagnostic equipment NFPA 70, 517-20 where the wet location to interrupter (GFCI) reduce the contact of electrical insulation. This deficient practive while in the Staff Electrical in the St	eceptacles are installed within outside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without (5): For receptacles located in as of general care or critical a care facilities other than those protection shall not be required. tions with associated showering the bays, and similar areas where ent, electrical hand tools. Wet Locations, requires alled equipment within the area of have ground-fault circuit protection. Note: Moisture can resistance of the body, and is more subject to failure. tice could affect mostly staff Break Room. Ons on 05/04/23 between 11:45 during a tour of the facility with coordinator, the electric ve feet of the sink in the Staff ot provided with a GFCI tested with a GFCI tested with a GFCI tested with a GFCI tested interview at the time of aintenance Coordinator agreed the Staff Break Room was not					

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DEPARTMEN' CENTERS FOI	FORM APPROVED OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF	PROVIDER OR SUPPLIEI	3		ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD		
BETHEL	MANOR		EVANS	SVILLE, IN 47710		
(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)		
K 0531 SS=F		eviewed with the Administrator doordinator during the exit 4/23.				
Bldg. 01	Elevators 2012 EXISTING Elevators comply Elevators are insp specified in ASME Elevators and Esc Service is operate record. Existing elevators A17.3, Safety Coc and Escalators. A a travel distance of below the level th emergency perso purposes, conforr Requirements of a (Includes firefighter recall and smoke firefighter's servic key operation, ma detectors, and ele detectors.) 19.5.3, 9.4.2, 9.4.	with the provision of 9.4. Dected and tested as E A17.1, Safety Code for Calators. Firefighter's End monthly with a written It conform to ASME/ANSI Dected for Existing Elevators Ill existing elevators, having Of 25 feet or more above or at best serves the needs of Innel for firefighting In with Firefighter's Service IN ASME/ANSI A17.3. In the service Phase I key In the detector automatic recall, In the Phase II emergency in-car In the provision of 9.4. In the service of the servic	V 0521	The corrective action taken t	for	06/02/2022
	interview; the facility of 1 elevators fire with 9.4.6, Elevators	ity failed to maintain testing of efighter recall in accordance r Testing. LSC 9.4.6.2 states ith fire fighters' emergency	K 0531	those residents found to be affected by the deficient pracinclude: No residents were identified in	ctice	06/02/2023

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operations in accordance with 9.4.3 shall be

subject to a monthly operation with a written

record of the findings made and kept on the

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survey findings.

Other residents that have the

potential to be affected have

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMPLETED 05/04/2023
NAME OF P	PROVIDER OR SUPPLIEF		6015 k	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION D by ASME A 17 1/CSA B44	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
	Safety Code for Eledeficient practice of and visitors in the first and visitors in the first and visitors in the first and 3:30 p.m. 9:30 a.m. and 2:45 Coordinator present available for the most available for the passinterview at the time Maintenance Coordinator and the first fighter recall for observation on 05/01:45 p.m. during a first maintenance Coordinator present and the maintenance Coordinator present available for the passinterview at the time Maintenance Coordinator present and present a monthly first fighter recall for observation on 05/01:45 p.m. during a first first main floor level Maintenance Coordinator present and pre	view on 05/03/23 between 9:30 and again on 05/04/23 between p.m. with the Maintenance t, there was no documentation onthly firefighter recall for the t twelve months. Based on e of record review, the linator said he does not y inspection and testing of the the elevator. Based on 14/23 between 11:45 a.m. and four of the facility with the linator, the elevator was efighter recall key operation at this was confirmed by the linator at the time of		been identified by: No residents were identified being negatively affected by cited deficient practice. The measures or systematic changes that have been purplace to ensure that the deficient practice does not include: The Maintenance Coordinate checked the firefighter recall the elevator and added this to his monthly elevator chece. The corrective action taken monitor performance to as compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure the above corrective actions and changes are being followed. tool will be completed by the Maintenance Coordinator or designee, monthly for three months, then quarterly for the quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quantity additional interventions are needed.	ic ic it into irecur or for check ks. in to sure y as nat the d This ree d
K 0712 SS=F Bldg. 01		the transmission of a fire simulation of emergency fire			

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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 01 B. WING 05/04/2023 155607 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6015 KRATZVILLE RD **BETHEL MANOR EVANSVILLE, IN 47710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the K 0712 The corrective action taken for 06/02/2023 facility failed to ensure 12 of 12 fire drill reports those residents found to be included complete documentation of the affected by the deficient practice transmission of a fire alarm signal to the monitoring company/fire department during the No residents were identified in the past twelve months. LSC 19.7.1.4 requires fire survey findings. drills in health care occupancies shall include the Other residents that have the potential to be affected have transmission of the fire alarm signal and simulation of emergency conditions. This been identified by: deficient practice could affect all residents. All residents have the potential to be affected, however, none were Findings include: identified. The measures or systematic Based on review of the facility's fire drill reports changes that have been put into on 05/04/23 between 9:30 a.m. and 3:30 p.m. with place to ensure that the the Maintenance Coordinator present, all 12 fire deficient practice does not recur drill reports performed during the past 12 month include: period did not include documentation for the Maintenance Coordinator and transmission of the alarm to the monitoring Administrator created a quarterly company. Based on interview at the time of plan for timings of fire drills. record review, the Maintenance Coordinator Documentation of the fire alarm's acknowledged there was no information on all 12 signal transmission was received fire drill reports to verify that transmission of the for the fire drills that occurred in alarm was received by the monitoring company. the past year. The corrective action taken to This finding was reviewed with the Administrator monitor performance to assure and Maintenance Coordinator during the exit compliance through quality conference. assurance is: A Quality Assurance Tool has 3-1.19(b) been developed to ensure that the

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023			
NAME OF F	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	facility failed to ensity varied times for 1 of 4 quarters. This decresidents in the facility of the facility	The facility's fire drill reports on 9:30 a.m. and 11:45 a.m. with coordinator present, four of evening) fire drills were 3:00 p.m. and 4:05 p.m. Based time of record review, the linator acknowledged the times of drills were performed and ere not varied enough.		above corrective actions and changes are being followed. The tool will be completed by the Maintenance Coordinator or designee, monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	e		
K 0761 SS=C Bldg. 01	\						
-	interview; the facili inspection and testinassemblies was con 19.1.1.4.1.1. Communities barriers require permitted only in compartment of the province of the province of the province of the province of the facility of the province of the facility of the	on, record review, and ty failed to ensure an annual ng of 2 of 2 stairwell fire door npleted in accordance with LSC nunicating openings in dividing d by 19.1.1.4.1 shall be peridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, semblies and fire window	K 0761	The corrective action taken for those residents found to be affected by the deficient practinclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none we identified	tice the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023				
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE			
	assemblies and thei including all frames and sills in accorda NFPA 80, Standard Opening Protective specified in this Co door assemblies shall less than annually, inspection shall be by the AHJ. NFPA assemblies shall be sides to assess the cassembly. NFPA 80, 5.2.4.2 s following items shall low items	r accompanying hardware, s, closing devices, anchorage, nee with the requirements of a for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both overall condition of door dates as a minimum, the all be verified: or breaks exist in surfaces of same. Signed and glazing beads ely fastened in place, if so so, hinges, hardware, and deshold are secured, aligned, the with no visible signs of signed or broken. Signed on the exceed clearances is 3.1.7. Signed evice is operational; that is, appletely closes when operated doosition. The is installed, the inactive leaf are operates and secures the		The measures or systemate changes that have been purplace to ensure that the deficient practice does not include: The Maintenance Coordinate inspected the fire doors, the added the stairwell fire doors the quarterly fire door inspective action taken monitor performance to as compliance through quality assurance is: An audit was performed by the Administrator and the Maintenance Coordinator of fire doors on the fire door inspection log and no further monitoring outside of the qualifier door inspection was deen necessary.	ic It into It recur or In Is to Sto Stion. In to Sure If It all the It arterly			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 05/04/	ETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	(11) Gasketing and inspected to verify to This deficient practical as well as staff, and Findings include: Based on record revial. Based on record revial. Based on and 3:30 p.m. and 2:45 p. Coordinator present provide documentate of the two stairwell past 12 month period time of record reviee. Coordinator said the	edge seals, where required, are heir presence and integrity. ce could affect all residents, visitors. iew on 05/03/23 between 9:30 and again on 05/04/23 between o.m. with the Maintenance, the facility was unable to ion for an annual inspection fire door assemblies during the d. Based on interview at the		TAG	DEFICIENCY		DATE
	of the facility with t on 05/04/23 betwee were two stairwell f the facility.	on observations during a tour the Maintenance Coordinator in 11:45 a.m. and 1:45 p.m., there fire door assemblies noted in viewed with the Administrator pordinator during the exit 1/23.					
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro annually confirm the	a - Essential Electric Syste b - Essential Electric cance and Testing other alternate power ated equipment is capable be within 10 seconds. If the can is not met during the can be provided to capability for the life branches. Maintenance					

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DEPARTMENT	Γ OF HEALTH AND HU	MAN SERVICES				FO	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
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	COMPI	LETED
		155607	B. W	ING		05/04	/2023
				CTREET	ADDRESS SITU STATE ZIR SOD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DETHEL	MANOD				RATZVILLE RD		
BETHEL	WANOR			EVAINS	SVILLE, IN 47710		
(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	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	and testing of the	generator and transfer					
	switches are perfe	ormed in accordance with					
	NFPA 110.						
	Generator sets ar	e inspected weekly,					
	Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours.						
	Scheduled test ur	nder load conditions include					
	a complete simula	ated cold start and					
	automatic or man	ual transfer of all EES					
	loads, and are co	nducted by competent					
	personnel. Mainte	enance and testing of stored					
	energy power sou	ırces (Type 3 EES) are in					
	accordance with I	NFPA 111. Main and feeder					
	circuit breakers a	re inspected annually, and a					
	program for perio	dically exercising the					
	components is es	tablished according to					
	manufacturer req	uirements. Written records					
	of maintenance a	nd testing are maintained					
	and readily availa	ble. EES electrical panels					
	and circuits are m	narked, readily identifiable,					
		n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency power	r source is a design					
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1						
		I review and interview, the	K 0	918	The corrective action taken in	for	06/02/2023
		ercise the generator annually to			those residents found to be		
	_	ents of NFPA 110, 2010 Edition,			affected by the deficient pra	ctice	
		nergency and Standby Powers			include:		
		3.4.2. Section 8.4.2 states diesel			No residents were identified in	the	
	-	rvice shall be exercised at least			survey findings.		
	· ·	a minimum of 30 minutes, using			Other residents that have the		
	one of the followin	_			potential to be affected have	!	
	(1) Loading that ma	aintains the minimum exhaust			been identified by:		

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manufacturer

gas temperatures as recommended by the

(2) Under operating temperature conditions and at

not less than 30 percent of the EPS (Emergency

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cited deficient practice.

No residents were identified as

being negatively affected by the

The measures or systematic

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023		
NAME OF I	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE		
	installations that do 8.4.2 shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not nameplate kW ratin total test duration of hours. This deficier occupants in the fact Findings include: Based on record revalum, and 3:30 p.m. 9:30 a.m. and 2:45 Coordinator present for the diesel power less than 30% durin Based on interview the Maintenance Congenerator ran under does not achieve 30 Additionally, the Macknowledged a load had not occurred with most recent diesel goated 04/08/22. This finding was reand Maintenance Conference on 05/00 3.1-19(b) 2. Based on record	es diesel-powered EPS not meet the requirements of ised monthly with the available Power Supply System) load and nnually with supplemental Cest) at not less than 50 percent ate kW rating for 30 continuous less than 75 percent of the EPS ag for 1 continuous hour for a f not less than 1.5 continuous at practice could affect all bility. View on 05/03/23 between 9:30 and again on 05/04/23 between p.m. with the Maintenance t, the monthly load percentage red generator was documented ag the past 12 month period. at the time of record review, coordinator acknowledged the reload on a monthly basis but 10% of the name plate rating. Italintenance Coordinator ad bank test for the generator ithin the past 12 months. The generator load bank test was		changes that have been place to ensure that the deficient practice does include: The Maintenance Coord contacted generator devices and a fuel was sent out. The load be will have to be completed due to the inability to me 30% threshold. A timefrathe cool down period was the monthly maintenance through quassurance is: No further monitoring was necessary, the monthly maintenance checks will compliance. A reminder is in the process of being integrated to ensure companiensure compliance.	inator Inpany and Impleted Isample Isa		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BU	A. BUILDING 01 B. WING		COMPLETED 05/04/2023		
NAME OF F	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
	SUMMARY (EACH DEFICIENT REGULATORY OF Of monthly generate generator during the 6.4.4.1.1.4(a) of 20 testing of the generelectrical system to 110, the Standard for Powers Systems, C. NFPA 99 requires a performance, exercing generator to be regular for inspection by the jurisdiction. NFPA Engine Shutdown redelay of 5 minutes arunning of the Emeror to shutdown. engine cool down. required on small (1 movers. This deficing residents, staff and Findings include: Based on record revalum. and 3:30 p.m., 9:30 a.m. and 2:45 Coordinator presenthe generator month down period after the with a check mark of was not included. It	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION or load testing for 1 of 1 e past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the alarly maintained and available e authority having 110, 6.4.2.1.5.9 Time Delay on equires that a minimum time shall be provided for unloaded regency Power Supply (EPS) This delay provides additional This time delay shall not be 15 kW or less) air-cooled prime ient practice could affect all		6015 KF	RATZVILLE RD	TE .	(X5) COMPLETION DATE
	Coordinator said th generator was at lea check mark or yes we This finding was re	e cool down time for the ast 5 minutes, but agreed the was not adequate. viewed with the Administrator oordinator during the exit					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	 JILDING	nstruction <u>01</u>	(X3) DATE : COMPL 05/04/	ETED
NAME OF I	PROVIDER OR SUPPLIER		6015 KF	NDDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	3. Based on record facility failed to enswas performed for generators. NFPA 2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect and visitors. Findings include: Based on record revalum, and 3:30 p.m. and 3:30 p.m. and 2:45 p. Coordinator present an annual generator however, there was annual fuel quality available for review time of record review time of record review to facility's generator in determined that a further was annual fuel sample test was This finding was record to the sample test was This finding	the facility does have a diesel having spoken with the inspection vendor it was let sample has not been taken nonth period. The most recent is performed on 04/20/22.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	ľ	UILDING	nstruction 01	(X3) DATE COMPL 05/04/	ETED
NAME OF E	PROVIDER OR SUPPLIER	2		6015 KF	DDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	3.1-19(b)						
	facility failed to profor the testing of 1 system in accordant for Emergency and Section 8.4.9, as refacilities Code, Sec Section 8.4.9 states Power Systems shadevery three years. It is greater than 4 hours terminate the test at 6.4.1.1.6.1 states the electrical system poat Type 10, Class X	review and interview, the ovide complete documentation of 1 Emergency Power Standby are with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care extion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 11 be tested at least once within Where the assigned class is as, it shall be permitted to fter 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified at Level 1 generator sets. This bould affect all building					
	a.m. and 3:30 p.m. 9:30 a.m. and 2:45 Coordinator presen provide documenta hour test of the emon 09/02/22. The infour hour test were was confirmed by the time of record r	viewed with the Administrator coordinator during the exit					

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STATEMENT OF I		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	r í	JILDING	nstruction 01	(X3) DATE (COMPL 05/04/	ETED
NAME OF PROVII	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710				
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
Bldg. 01 Extra Elect Extra Povuse pati (PC ass the the nonexc do remed for record wiring term corresponding to the corresponding term corresponding	ens ctrical Equipme ension Cords ver strips in a p d for componer ent-care-relate (REE) assemble embled by qua conditions of 1 patient care videred (e.g., ept in long-term of use PCREE in the late of vicinity) endined of vicinity, entire the care related and with general distance are related and meet 2.3.6 (NFPA 99 PA 70), 590.3 (ed on observation of the patient for fixed with general distance and the late (LSC 9.1.2 requires LSC 9.1.2 requires LSC 9.1.2 required in the cords and captions are considered to complete the late (LSC 9.1.2). The late (LSC 9.1.3) are quired to complete the late (LSC 9.1.4) are quired to complete (LSC 9.1.5) are quired to complete (LSC 9.1.5). The late (LSC 9.1.5) are quired to complete (LSC 9.1.5) are quired to complete (LSC 9.1.5) are quired to complete (LSC 9.1.5). The late (LSC 9.1.5) are quired to complete (LSC 9.1.5) are quired to complete (LSC 9.1.5) and captions and captions are quired to complete (LSC 9.1.5) are quired to complete (LSC 9.1.5). The late (LSC 9.1.5) are quired to complete (LSC 9.1.5) are quired to co	ent - Power Cords and ent - Power Strips in continuous ent ent ent have been lified personnel and meet 0.2.3.6. Power strips in continuous ent	K 0	920	The corrective action taken of those residents found to be affected by the deficient practinclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. All areas that wou potentially require the use of a	the lto	06/02/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2023
NAME OF P	PROVIDER OR SUPPLIEF		6015 k	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	IN (X5) BE COMPLETION DATE
	Based on observation a.m. and 1:45 p.m. the Maintenance Cocurling irons and or plugged into a power Shop/Salon. Based observation, the Macknowledged the unbeauty Shop.	ons on 05/04/23 between 11:45 during a tour of the facility with coordinator, there were two he hand held hair dryer er strip in the Beauty on interview at the time of hintenance Coordinator hase of the power strip in the viewed with the Administrator coordinator during the exit		power cord were checked of compliance. The measures or systemal changes that have been populate to ensure that the deficient practice does not include: The power strip was remove the beauty shop and educated was provided to staff about power strip. The corrective action taken monitor performance to accompliance through qualities assurance is: A Quality Assurance Tool held been developed to ensure the above corrective actions and changes are being followed tool will be completed by the Maintenance Coordinator of designee, weekly for three withen monthly for three monithen quarterly for three quality and will be immediately corrected. The outcome of tool will be reviewed at the quarterly Quality Assessment Assurance meeting to determine and ditional interventions needed.	ed from tion using en to ssure ty eas that the ed I. This e r weeks, ths, rters. h this this ent and rmine if
K 0000					
Bldg. 02	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0000	By submitting the enclosed material we are not admittir truth or accuracy of any spe findings or allegations. We	ecific

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		UILDING	02	COMPL 05/04/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	Survey Dates: 05/0 Facility Number: 0 Provider Number: 100. At this Life Safety 0 health facility at Be compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (L Care Occupancies a This one story facility Type V (111) consts sprinklered. The fa with hard wired sme spaces open to the c sleeping rooms. Th certified beds and h this survey. The tot was 75 and had a ce survey. All areas where resi	3/23 and 05/04/23 00436 155607 275120 Code survey, the small house thel Manor was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 18, New Health and 410 IAC 16.2. The street of the corridors, corridors, and all resident efacility has a fire alarm system obke detectors in the corridors, corridors, and all resident efacility has a capacity of 12 and a census of 6 at the time of that capacity of both buildings ensus of 61 at the time of this dents have customary access d all areas providing facility clered.		the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect June 2, 2023 to the annual licensure survey conducted May 2023. We respectfully request paper compliance/desk reviews	ility ive ay sst a	
K 0291 SS=C Bldg. 02	NFPA 101 Emergency Lightir Emergency Lightir Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2 hour ed automatically in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/04/2023		
NAME OF F	PROVIDER OR SUPPLIER			6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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
	Based on record review; the facility complete document battery backup light 30 seconds during the annually for 90 min to ensure the light of the periods of power or emergency lighting accordance with Serequires functional monthly, with a min maximum of 5 week than 30 seconds, (3) conducted annually if the emergency lighting powered and (5) Winspections and test for inspection by the jurisdiction. This directions are recorded as a second of the power of the	riew, observation, and ty failed to ensure there was ation for the testing of 3 of 3 is that were tested monthly for the past 12 months, and utes during the past 12 months would provide lighting during ttages. LSC 18.2.9.1 requires shall be provided in ction 7.9. Section 7.9.3.1.1 (1) testing shall be conducted himum of 3 weeks and a ks between tests, for not less of Functional testing shall be for a minimum of 1 1/2 hours whiting system is battery ritten records of visual s shall be kept by the owner	K 0	291	The corrective action taken those residents found to be affected by the deficient prainclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected, however, none widentified. The measures or systematic changes that have been put place to ensure that the deficient practice does not include: The Maintenance Coordinato added all the emergency light onto a testing schedule. He a edited his testing schedule to include the time frame. All emergency lights were added the 30 minute monthly scheduland the 90 minute annual schedule. The corrective action taken monitor performance to assocompliance through quality assurance is: An audit of all emergency light testing was conducted, and necessary outside the monthly and annual checks.	ctice in the ine ine ine ine ine ine ine ine ine in	06/02/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155607	B. W	NG		05/04/	/2023
NAME OF P	ROVIDER OR SUPPLIER			6015 KF	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD		
BETHEL	MANOR			EVANS	VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		90 minute annual test has not					
	-	the three battery lights sets. ons on 05/03/23 between 12:45					
		during a tour of the facility with					
		pordinator, there were 3 battery					
		lights in the facility, two in					
		in the fire alarm control panel					
	room.	in the fire diamir control panel					
	This finding was rev	viewed with the Administrator					
	and Maintenance Co	oordinator during the exit					
	conference on 05/04	1/23.					
	3.1-19(b)						
K 0334	NEDA 404						
K 0324 SS=F	NFPA 101						
Bldg. 02	Cooking Facilities Cooking Facilities						
Diag. 02	Cooking racilities Cooking equipmer	nt is protected in					
		IFPA 96, Standard for					
		I and Fire Protection of					
		ing Operations, unless:					
		king equipment (i.e., small					
		s microwaves, hot plates,					
		for food warming or limited					
	cooking in accorda	ance with 18.3.2.5.2,					
	19.3.2.5.2.						
		s open to the corridor in					
	-	ents with 30 or fewer					
		ith the conditions under					
	18.3.2.5.3, 19.3.2.						
	_	s in smoke compartments					
	•	atients comply with					
		8.3.2.5.4, 19.3.2.5.4.					
		orotected according to					
	-	B are not required to be					
	enclosed as hazardous areas, but shall not be open to the corridor.						
	•	18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 05/04/2023	
	PROVIDER OR SUPPLIER MANOR	6015 K	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710		
(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	
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/03/23 between 9:30 a.m. and 3:30 p.m. and again on 05/04/23 between 9:30 a.m. and 2:45 p.m. with the Maintenance Coordinator present, there was no inspection	K 0324	The corrective action taken in those residents found to be affected by the deficient prainclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. The exhaust systemas immediately serviced. The measures or systematic changes that have been put place to ensure that the deficient practice does not reinclude: The Maintenance Coordinator contacted the company that services the exhaust system at ensure the Rehab Cottage is semi-annual routine cleaning schedule. The corrective action taken is monitor performance to assis compliance through quality assurance is: The exhaust hood system was serviced at the Rehab Cottage placed on a semi-annual clear schedule, reports of the clean will be kept by the Maintenance Coordinator. No outside monit was deemed necessary.	ctice In the In the In	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF F	ROVIDER OR SUPPLIER	1	60	TREET ADDRESS, CITY, STATE, ZIP COD 015 KRATZVILLE RD VANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION lable during the past twelve	IID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
K 0345 SS=F Bldg. 02	months for the rang Based on interview the Maintenance Conot in place for the inspection for the Conot in place for the Conot in p	e hood exhaust system. at the time of record review, pordinator said a contract was range hood exhaust system lottage House. viewed with the Administrator loordinator during the exit 4/23. In - Testing and In - Testing and In an approved program In requirements of NFPA 70, Code, and NFPA 72, In and Signaling Code. In acceptance, maintenance adily available.	K 0345	The corrective action taken those residents found to be affected by the deficient princlude: No residents were identified survey findings. Other residents that have a potential to be affected had been identified by: No residents were identified being negatively affected by cited deficient practice. The measures or systematic changes that have been potential to be affected.	ractice I in the the ve I as the the	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SU COMPLE 05/04/2	TED
NAME OF F	PROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP CO (RATZVILLE RD SVILLE, IN 47710	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE
	trends of these alarn zones or areas when increase over the property shall be performed. It is a performed to the control of t	quipment arranged for the diffire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be rated, or replaced. vity cannot be tested or respray device that administers centration of aerosol into the cient practice could affect all visitors in the facility. Ariew on 05/03/23 between 9:30 and 05/04/23 between 9:30 a.m. the Maintenance Coordinator was unable to produce a sitivity report for all 23 smoke set 24 month period or prior. at the time of record review, pordinator confirmed there was sensitivity testing		place to ensure that the deficient practice does include: At the Rehab Cottage, s detector sensitivity testir completed due to the sy being an intelligent syste being on 24/7 monitoring. The Maintenance Coord contacted the contracted company to perform senvisual inspections. The corrective action to monitor performance to compliance through quassurance is: No further monitoring was necessary. The necessary and be found on the comportal system when needs smoke detector sensitivities constant and community with the fire panel to senver error codes if there are in	moke ng is not stem em and g. linator d ni-annual aken to o assure uality as deemed ary reports npanies ded. The ty testing nicates nd any	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 02	(X3) DATE : COMPL 05/04/	ETED
NAME OF E	PROVIDER OR SUPPLIER		ε	015 KR	DDRESS, CITY, STATE, ZIP COD ATZVILLE RD /ILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		viewed with the Administrator coordinator during the exit 4/23.					
	3.1-19(b)						
	facility failed to ma accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual insper accordance with the more often if requir jurisdiction. Table must be visually ins a. Control unit troul b. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification appl e. Magnetic hold-op	tors (e.g. duct detectors, manual at detectors, smoke detectors,					
	Findings include:	riaw on 05/02/23 hatwaan 0:30					
	a.m. and 3:30 p.m. and 2:34 p.m. with present, there was dregarding an annual dated 06/09/22 by the inspection vendor, I semi-annual visual provided within six inspection by either maintenance staff.	riew on 05/03/23 between 9:30 and 05/04/23 between 9:30 a.m. the Maintenance Coordinator ocumentation provided fire alarm system inspection he facility's fire alarm nowever, there was no inspection documentation months after the annual the vendor or in-house Based on interview at the time e Maintenance Coordinator visual inspection of the fire					

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 $U5FW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000436$

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF F	PROVIDER OR SUPPLIER	t	6015 k	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	alarm system's devi	ices has not been performed e alarm inspection on 06/09/22.	TAG	DEFICIENCY	DATE	
	_	eviewed with the Administrator doordinator during the exit 4/23.				
	3.1-19(b)					
K 0353 SS=F Bldg. 02	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system	supply source				
	1. Based on record interview; the facili system inspections for 1 of 1 sprinkler the Inspection, Test Water-Based Fire P Edition, Section 5.1 department connect tested, and maintain	review, observation, and ity failed to document sprinkler in accordance with NFPA 25 system. NFPA 25, Standard for ting, and Maintenance of Protection Systems, 2011 1.2 states valves and fire tions shall be inspected, ned in accordance with Chapter 2 states Table 13.1.1.2 shall be	K 0353	The corrective action taken at those residents found to be affected by the deficient prainclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential	ctice the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 The summary of the provider of the provider of the propoper o
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 B. WING OFFICIENCY OFFICIENCY OFFICE ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710 (EACH OFFICIENCY) OFFICIENCY
BETHEL MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) COMPLETION DATE (X6) DEFICIENCY OF LSC IDENTIFYING INFORMATION (X7) DEFICIENCY OF LSC IDENTIFYING INFORMATION (X8) DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X7) COMPLETION DATE (X8) DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X8) DPROVIDER'S PLAN OF CORRECTION (COMPLETION DATE) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION DATE) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICE DEFIC
BETHEL MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X5) COMPLETION DATE (X6) DEFICIENCY OF LSC IDENTIFYING INFORMATION (X7) DEFICIENCY OF LSC IDENTIFYING INFORMATION (X8) DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X7) COMPLETION DATE (X8) DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X8) DPROVIDER'S PLAN OF CORRECTION (COMPLETION DATE) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION DATE) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICE DEFIC
BETHEL MANOR (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 EVANSVILLE, IN 47710 (ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE be affected, however, none were identified.
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 (X5) PREFIX PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE be affected, however, none were identified.
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 PREFIX PREFIX CEACH CORRECTION OF CORRECTION CEACH CORRECTION OF CORRECTION CEACH CORRECTION DATE COMPLETION DATE be affected, however, none were identified.
TAG REGULATORY OR LSC IDENTIFYING INFORMATION utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 CROSS-REFERENCED TO THE APPROPRIATE DATE DATE be affected, however, none were identified.
utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 be affected, however, none were identified.
valves, valve components and trim. Section 4.3.1 identified.
I was a constant of the first of the constant
states records shall be made for all inspections, The measures or systematic
tests, and maintenance of the system and its changes that have been put into
components and shall be made available to the place to ensure that the
authority having jurisdiction upon request. This deficient practice does not recur
deficient practice could affect all residents, staff, include:
and visitors in the facility. Maintenance Coordinator notified
the company that conducts the
Findings include: pipe inspection that it needed to
be completed and it was
Based on record review on 05/03/23 between 9:30 completed on 5/4/2023. On
a.m. and 3:30 p.m. with the Maintenance 5/4/2023, the contracted company
Coordinator present, there was no monthly was made aware of the loose and
sprinkler system control valves inspection painted sprinkler heads and
documentation for the past 12 month period. replaced fixtures. The company
Based on interview at the time of record review, was notified and replaced the
the Maintenance Coordinator confirmed the lack sprinkler cabinet box.
of sprinkler system inspections on the control The corrective action taken to
valves during the past 12 months. monitor performance to assure
This finding was reviewed with the Administrator
This finding was reviewed with the Administrator and Maintenance Coordinator during the exit A Quality Assurance Tool has
conference on 05/04/23. been developed to ensure that the above corrective actions and
3.1-19(b) above corrective actions and changes are being followed. This
tool will be completed by the
2. Based on observation and interview, the Maintenance Coordinator or
facility failed to ensure 1 of 1 sprinkler systems designee, weekly for four weeks,
spare sprinkler cabinets were properly maintained. then monthly for three months,
NFPA 25, Standard for the Inspection, Testing, and then quarterly for three
and Maintenance of Water-Based Fire Protection quarters. Any areas identified
Systems, 2011 Edition, Section 5.4.1.4 states a through this audit will be
supply of spare sprinklers (never fewer than six) immediately corrected. The
shall be maintained on the premises so that any outcome of this tool will be
sprinklers that have been operated or damaged in reviewed at the quarterly Quality
any way can be promptly replaced. The sprinklers Assessment and Assurance
shall correspond to the types and temperature meeting to determine if any
ratings of the sprinklers on the property. The additional interventions are
sprinklers shall be kept in a cabinet located where needed.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607		JILDING	nstruction <u>02</u>	(X3) DATE (COMPL 05/04 /	ETED
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 6015 KRATZVILLE RD EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	no time exceed 100 sprinkler wrench sh cabinet to be used it of sprinklers. This all residents and star Findings include: Based on observation p.m. and 1:30 p.m. the Maintenance Cocabinet in the sprinkler heads were slots, which could concead if falling out door. Based on into observation, the Maintenance of the sprinkler heads in the sprinkler heads in the two of the sprinkler heads in the two of the sprinkler heads in the sprinkl	ons on 5/03/23 between 12:45 during a tour of the facility with bordinator, the spare sprinkler kler riser room had only five ds, and two of the spare e laying loosely and not in cause breakage to the sprinkler when opening the cabinet erview at the time of kintenance Coordinator there were only five total spare the spare sprinkler cabinet and takler heads were laying loose their own slots.					
K 0712 SS=C Bldg. 02	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is re part of established					

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	·		ETED	
		155607	B. WING		05/04/2023			
		<u> </u>	ST	REET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF	PROVIDER OR SUPPLIE	R	60)15 KF	RATZVILLE RD			
BETHEL	MANOR		Ε\	VANS\	VILLE, IN 47710			
(X4) ID	1	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE	
		rills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms.	10.7.1.7						
	18.7.1.4 through		17 0712		The commention action tolers	F	06/02/2022	
		view and interview, the facility e drills were held at varied times	K 0712	,	those residents found to be affected by the deficient practice include:		06/02/2023	
		e shifts during 4 of 4 quarters.						
	1	tice could affect all residents in						
	the facility.	lice could affect all fesidents in						
	the facility.			No residents were identified in the survey findings. Other residents that have the		ıııc		
	Findings include:					2		
	i manigs merade.				potential to be affected have			
	Based on review of the facility's fire drill reports				been identified by:			
		en 9:30 a.m. and 3:30 p.m. with			All residents have the potentia	ıl to		
		oordinator present, four of		be affected, however, none				
		evening) fire drills were			identified.			
	·	3:00 p.m. and 4:00 p.m. Based			The measures or systematic			
	_	time of record review, the			changes that have been put			
	Maintenance Coord	dinator acknowledged the times			place to ensure that the			
	the second shift fire	e drills were performed and			deficient practice does not re	ecur		
	agreed the times we	ere not varied enough.			include:			
					Maintenance Coordinator and			
		eviewed with the Administrator			Administrator created a quarte	erly		
		Coordinator during the exit			plan for timings of fire drills.			
	conference on 05/0	4/23.			Documentation of the fire aları			
	2.1.10(1)				signal transmission was received			
	3.1-19(b)				for the fire drills that occurred	in		
					the past year.			
					The corrective action taken t			
					monitor performance to assu	ure		
					compliance through quality assurance is:			
					A Quality Assurance Tool has			
					been developed to ensure that			
					above corrective actions and			
					changes are being followed. T	his		
					tool will be completed by the			
					Maintenance Coordinator or			
					designee, monthly for three			

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	OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING	02	COMPLETED 05/04/2023
NAME OF P	PROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				months, then quarterly for thre quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quarterly and Assessment and Assurance meeting to determine if any additional interventions are needed.	
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterior monthly test, a pro annually confirm the safety and critical and testing of the si switches are perfo NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mor Scheduled test un a complete simula automatic or manuloads, and are cor personnel. Maintel energy power sour accordance with N circuit breakers are program for period components is est	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer fried in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. der load conditions include			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u>		COMPLETED	
		155607	B. WING 05/04/2023			/2023	
		l .	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			RATZVILLE RD		
BETHEL	MANOR				VILLE, IN 47710		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		1	ID	· 		(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		nd testing are maintained		1710			DATE
		ble. EES electrical panels					
	1 -	arked, readily identifiable,					
		n normal power circuits.					
	1	ssibility of damage of the					
		source is a design					
	consideration for r	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		review and interview, the	K 0	918	The corrective action taken	for	06/02/2023
	1	ercise the generator annually to			those residents found to be		
		nts of NFPA 110, 2010 Edition,			affected by the deficient pra	ctice	
		nergency and Standby Powers			include:		
	1 .	4.2. Section 8.4.2 states diesel			No residents were identified in	n the	
	_	rvice shall be exercised at least			survey findings.		
	1	minimum of 30 minutes, using			Other residents that have the		
	one of the following	intains the minimum exhaust			potential to be affected have been identified by:	•	
		recommended by the			No residents were identified a	c	
	manufacturer	recommended by the			being negatively affected by the		
		temperature conditions and at			cited deficient practice.	10	
		cent of the EPS (Emergency			The measures or systematic	;	
	Power Supply) nam				changes that have been put		
	Section 8.4.2.3 state	es diesel-powered EPS			place to ensure that the		
	installations that do	not meet the requirements of			deficient practice does not r	ecur	
		ised monthly with the available			include:		
		Power Supply System) load and			The Maintenance Coordinator		
		nnually with supplemental			contacted generator company		
	,	est) at not less than 50 percent			a load bank test was complete		
		te kW rating for 30 continuous			on 5/17/2023 and a fuel samp		
		ess than 75 percent of the EPS			was sent out. The load bank t		
	_	g for 1 continuous hour for a f not less than 1.5 continuous			will have to be completed ann	•	
		it practice could affect all			due to the inability to meet the 30% threshold. A timeframe for		
	occupants in the fac	-					
	occupants in the fac	inty.			the cool down period was add the monthly maintenance che		
	Findings include:				list.	OI\	
	1 manigo merade.				The corrective action taken	to	
	Based on record rev	view on 05/03/23 between 9:30			monitor performance to ass		
		and again on 05/04/23 between			compliance through quality		
	i *	~	1		,		1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE C A. BUILDING B. WING	O2		ESURVEY LETED 1/2023
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR		6015 k	ADDRESS, CITY, STATE, ZIP KRATZVILLE RD SVILLE, IN 47710	COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	Coordinator present for the diesel power less than 30% during Based on interview the Maintenance Congenerator ran under does not achieve 30 acknowledged a lost had not occurred with most recent diesel goated 03/31/22. This finding was reand Maintenance Coonference on 05/0 and Maintenance of Maintenance of Maintenance of Maintenance of Maintenance of Maintenance on 05/0 and Maintenance of Maintenance of Maintenance on 05/0 and Maintenance of Maintenance on 05/0 and Maintenance of Maintenance of Maintenance on 05/0 and Maintenance of Maintenance o	review and interview, the sintain a complete written record for load testing for 1 of 1 e past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA for Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the ularly maintained and available		assurance is: No further monitoring necessary, the month maintenance checks compliance. A remind is in the process of be integrated to ensure could with contracted complensure compliance.	nly will ensure der program eing compliance	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF P	PROVIDER OR SUPPLIER	2	6015 K	ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD SVILLE, IN 47710		
(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)	(XS COMPLE DAT	ETION
	movers. This defici residents, staff and	ient practice could affect all visitors.				
	a.m. and 3:30 p.m., 9:30 a.m. and 2:45 p. Coordinator present the generator month down period after the with a check mark of was not included. For record review, the Coordinator said the generator was at least check mark or yes with the generator was at least check which	viewed with the Administrator oordinator during the exit				
	facility failed to ensign was performed for a generators. NFPA 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power System NFPA 110, Section shall be performed approved by ASTM	review and interview, the sure an annual fuel quality test 1 of 1 diesel powered 99, Health Care Facilities Code, on 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 be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient at all residents, as well as staff				

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	OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING	02	COMPI 05/04	
NAME OF I	PROVIDER OR SUPPLIER		6015 KI	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD VILLE, IN 47710		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Findings include:					
	a.m. and 3:30 p.m. a 9:30 a.m. and 2:45 p Coordinator present an annual generator however, there was annual fuel quality available for review time of record reviee Coordinator stated t generator but after h facility's generator i determined that a fu within the past 12 n fuel sample test was This finding was re and Maintenance Coonference on 05/04 3.1-19(b) 4. Based on record facility failed to pro for the testing of 1 o System in accordan for Emergency and Section 8.4.9, as rec Facilities Code, Sec Section 8.4.9 states Power Systems shale every three years. V greater than 4 hours terminate the test af 6.4.1.1.6.1 states the electrical system po	the facility does have a diesel having spoken with the inspection vendor it was let sample has not been taken nonth period. The most recent is performed on 03/31/22.				

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	OF CORRECTION	IDENTIFICATION NUMBER 155607	A. BUILDING B. WING	02		LETED 1/2023
NAME OF P	PROVIDER OR SUPPLIER		6015 K	ADDRESS, CITY, STATE, ZIP COD RATZVILLE RD SVILLE, IN 47710		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY)	BE	(X5) COMPLETION DATE
	deficient practice co occupants. Findings include:	uld affect all building				
K 0920	a.m. and 3:30 p.m. a 9:30 a.m. and 2:45 p. Coordinator present provide documentat hour test of the eme on 09/02/22. The in four hour test were a was confirmed by the time of record results finding was revand Maintenance Coconference on 05/04 3.1-19(b) NFPA 101	viewed with the Administrator pordinator during the exit 1/23.				
SS=D Bldg. 02	Extens Electrical Equipment Extension Cords Power strips in a pused for component patient-care-relate (PCREE) assembled by quanthe conditions of 1 patient care vicinity non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in	d electrical equipment				

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 $U5FW21 \hspace{0.5cm} {\rm Facility} \hspace{0.1cm} {\rm ID:} \hspace{0.5cm} 000436$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155607		(X2) MULTIPLE (A. BUILDING B. WING	construction 02	(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF PROVIDER OR SUPPLIER BETHEL MANOR		6015	r ADDRESS, CITY, STATE, ZIP COD KRATZVILLE RD ISVILLE, IN 47710		
(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)	(X5) COMPLETION DATE
TAG	non-patient care rother UL standard with general precaare not used as a a structure. Exten temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on observation failed to ensure a possibility of the substitute for fixed LSC 18.5.1 requires 9.1. LSC 9.1.2 requequipment to comp Electrical Code, 20 400.8 requires that, flexible cords and consubstitute for fixed deficient practice constitute for fixed deficient practice	ooms, power strips meet ds. All power strips are used autions. Extension cords substitute for fixed wiring of sion cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility ower strip was not used as a wiring in 1 of 1 Beauty Shop. so utilities to comply with Section wires electrical wiring and ly with NFPA 70, National 11 Edition. NFPA 70, Article unless specifically permitted, sables shall not be used as a wiring of a structure. This could affect one resident and one on 05/03/23 between 12:45 during a tour of the facility with cordinator, there were two he hand held hair dryer er strip in the Beauty on interview at the time of anintenance Coordinator use of the power strip in the wiewed with the Administrator coordinator during the exit	K 0920	The corrective action taken those residents found to be affected by the deficient prainclude: No residents were identified in survey findings. Other residents that have the potential to be affected have been identified by: All residents have the potential be affected. All areas that wo potentially require the use of a power cord were checked enscompliance. The measures or systematic changes that have been put place to ensure that the deficient practice does not ninclude: The power strip was removed the beauty shop and education was provided to staff about us power strip. The corrective action taken monitor performance to associate compliance through quality assurance is: A Quality Assurance Tool has been developed to ensure that	for 06/02/2023 ctice In the e e e into recur from on sing to ure
	3.1-19(b)			above corrective actions and	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155607	(X2) MULTIPL A. BUILDING B. WING	e construction G 02	(X3) DATE COMPI 05/04	LETED
NAME OF P	ROVIDER OR SUPPLIEF	2	601	EET ADDRESS, CITY, STATE, ZIP COD 5 KRATZVILLE RD ANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	E	(X5) COMPLETION DATE
				changes are being followed tool will be completed by the Maintenance Coordinator or designee, weekly for three withen monthly for three quark Any areas identified through audit will be immediately corrected. The outcome of tool will be reviewed at the quarterly Quality Assessme Assurance meeting to deter any additional interventions needed.	veeks, hs, ters. this his his nt and mine if	

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