STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2023		
		133771	B. W1			09/20/	2023
	ROVIDER OR SUPPLIEF EIN FRANKLIN SE	R NIORLIFE COMM RES & COM CA	RE	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST RE FRANKLIN, IN 46131			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg		paredness Survey was adiana Department of Health in	E 0000		K000 The creation and submission o	of	
	accordance with 42				this Plan of Correction do not		
	Survey Date: 09/26				constitute an admission by this provider of any conclusion set in the statement of deficiencie	s t forth	
	Facility Number: 0	001127			any violation of the regulation.		
	Provider Number:	155771			This provider respectfully requ		
	AIM Number: 200	247220			that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.		
	Otterbein Franklin Care was found in o Preparedness Requi	Preparedness survey, Senior Life Comm Res & Com compliance with Emergency irements for Medicare and ting Providers and Suppliers, 42					
	the survey, the cens						
	Quality Review cor	npleted on 10/02/23					
K 0000							
Bldg. 01							
3	Licensure Survey w Department of Head 483.90(a). Survey Date: 09/26 Facility Number: 0 Provider Number: AIM Number: 200	001127 155771 247220	K 00	000	K000 The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set in the statement of deficiencie any violation of the regulation. This provider respectfully requitat this 2567 Plan of Correctibe considered the Letter of Credible Allegation of Compliant	s t forth es or . uests ion	
	At this Life Safety	Code Survey, Otterbein			and requests a desk review in	IICU	

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

TITLE (X6) DATE

Shannon Logan Administrator 10/13/2023

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/26/2023	
	ROVIDER OR SUPPLIER EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	1070 W	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	found not in complication of the Subpart 483.90(a), 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. Otterbein Frankling Care consists of four buildings constructed Building 01 an NCC story sprinklered but construction with a 1980 is a three story (332) construction with in 1992 is a or Type I (332) construction built in 1992 is a or Type I (332) construction, the fact building. The facility smoke detection in open to the corridor operated detectors or rooms in Health Ce other resident room with hard wired smand Building 04, ha installed in all residual portion of the facility had a census of 150 All areas where resident room services were sprinklered an services were sprinklered services were sprinklered an services were sprinklered services ser	e Comm Res & Com Care was ance with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and Senior Life Comm Res & Com ar separate but connected ed at four different times: C facility built in 1957, is a three adding of Type I (332) basement; Building 02 built in a sprinklered building of Type I with a basement; Building 03 are story sprinklered building of action with a basement; and 2000 is a three story g of Type I (332) construction. Type I (332) construction. Type I (332) construction. Type I (332) construction are of the same type of action with a basement stype of actions and all areas. In Building 02, 47 battery were provided in resident inter 2 and Health Center 3. All is in Building 02 are provided onke detectors. In Building 03 and wired smoke detectors are ent rooms. The healthcare ty has a capacity of 208 and at the time of this survey. Idents have customary access d all areas providing facility dered. In pleted on 10/02/23		of a post-survey review.	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			(X3) DATE SURVEY COMPLETED 09/26/2023		
	PROVIDER OR SUPPLIER EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	\RE	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 0311 SS=E Bldg. 01	openings between construction havin at least 1 hour. An accordance with 8 19.3.1.1 through 1 lf all vertical openi with construction price resistance ratio box. Based on observation failed to maintain processes on the stairwells. LSC 19. shall be enclosed on Section 8.6. LSC 8 separates stories in constructed as a sm see 7.1.3.2.1 for encestates the separation fire resistance rating stories or less. Fire accordance with NF Doors and Other Open Section 4.8.4.1 states bottom of of a door inch. This deficient residents, staff and 17 in Building 02 of Findings include: Based on observation Manager and the Manager and the Manager and the facility accordance of the facility accordance of the facility at the state of the facility of the facility of the facility accordance of the facility accordance with Manager and the Manager and the facility of the faci	or shafts, light and chutes, and other vertical a floors are enclosed with a floors are enclosed with a fine resistance rating of a atrium may be used in 3.6. 19.3.1.6 angs are properly enclosed providing at least a 2-hour ang, also check this on and interview, the facility protection of 1 of 4 interior 3.1 requires vertical openings are protected in accordance with 3.6.1 requires every floor that a building shall be oke barrier. LSC 8.6.5 states closures of exits. LSC 7.1.3.2.1 a shall have a minimum 1-hr g where the exit connects three doors assemblies are in FPA 80, Standard for Fire pening Protectives. NFPA 80, as the clearance under to shall be a maximum of 3/4ths a practice could affect over 20 visitors in the vicinity of Stair	K 03	311	K311 – Vertical Openings - Enclosure What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified at being affected by this alleged deficient practice. How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potent be affected by the alleged definity practice. The two holes noted in the stairwell were repaired on 10/11/2023 by removing the for fixing the hole with drywall and filling fire stop in the openings (attachment #1, #2, #3, and #4)	the e e ial to cient	10/13/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	MULTIPLE CO BUILDING VING	onstruction 01	(X3) DATE COMPI 09/26	
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION the suspended ceiling above		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) Audit completed on all emer	E RIATE	(X5) COMPLETION DATE
	the stairwell door as Building 02 on the stairwell door was affixed wirating label and late Based on interview observations, the M the stairwell is iden aforementioned hol maintain the fire reswall. These findings were	cross from the Beauty Shop in second floor. The stairwell th a 90-minute fire resistance hed into the door frame. at the time of the aintenance Manager stated tified as Stair 17 and agreed the in the stairwell wall did not sistance rating of the stairwell e reviewed with the ger and the Building Services			stairwells and vertical opening 10/11/2023. (attachment #5 #6) What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur? An audit of the stairwells will completed every two weeks months or until 100% complis met. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quassurance program will be into place? Any identified deficiencies we corrected upon discovery ar reviewed by the QAPI commends.	be for 3 ance	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr	n - Testing and m is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance			for further recommendation. By what date the systemic changes for each deficient will be completed? 10/13/2023		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/26/2023 155771 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1070 W JEFFERSON ST OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE FRANKLIN, IN 46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility K 0345 K345 - Fire Alarm System -10/13/2023 failed to ensure 1 of 1 fire alarm systems was Testing and Maintenance maintained in accordance with LSC 9.6.1.3. LSC What corrective action(s) will 9.6.1.3 requires a fire alarm system to be installed, be accomplished for those tested, and maintained in accordance with NFPA residents found to have been 70, National Electrical Code and NFPA 72, affected by the deficient National Fire Alarm Code. NFPA 72, Section practice? 14.2.1.2.2 requires that system defects and No residents were identified as malfunctions shall be corrected. This deficient being affected by this alleged practice could affect all residents, staff and deficient practice. visitors. How other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on observations with the Maintenance action(s) will be taken? Manager and the Maintenance Technician during No other residents have been a tour of the facility from 12:40 p.m. to 3:40 p.m. on identified as having the potential to 09/26/23, the remote fire alarm control panel at the be affected by the alleged deficient Building 02 second floor nurse's station was in the practice. trouble mode. The display for the remote fire The fire alarm control panel alarm control panel read "Open circuit General vendor. AADCO corrected the NAC" as the cause of fire alarm system trouble. issue on 10/11/2023. (attachment Based on interview at the time of the #7 and #8) observations, the Maintenance Manager stated What measures will be put into the main fire alarm control panel was replaced place and what systemic recently, the fire alarm system will activate if need changes will be made to be but the fire alarm system control panel keeps ensure that the deficient going back into the trouble mode following practice does not recur? repeated contractor visits for repair. A maintenance check of the fire panel is completed daily. These findings were reviewed with the An audit of the fire panel will be Maintenance Manager and the Building Services completed, by the Maintenance Coordinator during the exit conference. Manager and/or his designee, once a week until the end of 3.1-19(b) phase one construction to ensure that the control panel does not reflect any trouble alarms. How will the corrective

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action(s) be monitored to

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G <u>01</u>	(X3) DATE SURVEY COMPLETED 09/26/2023	
NAME OF F	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP COD OW JEFFERSON ST	•	
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C				
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	N (X5) BE COMPLETION DATE	
				ensure the deficient practivill not recur, i.e., what quassurance program will be into place? Any identified deficiencies a corrected upon discovery a reviewed by the QAPI comfor further recommendation. By what date the systemic changes for each deficien will be completed?	vill be nd mittee	
K 0353 SS=F Bldg. 01	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 Provide in REMAR coverage for any is automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on observa failed to ensure 1 of gauges were replace	supply source RKS information on non-required or partial er system. and NFPA 25 ation and interview, the facility of over 3 sprinkler system ed every 5 years or	K 0353	K353 – Sprinkler System – Maintenance and Testing What corrective action(s)	10/13/2023	
	documented as teste comparison with a			be accomplished for those residents found to have be affected by the deficient	9	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u>01</u>	COMPLETED	
		155771	B. W	ING		09/26/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
OTTEDD	DEIN EDANIZI IN CE	NUODI IEE COMMA DEC 9 COM C	^ DE		/ JEFFERSON ST		
OTTERE	BEIN FRANKLIN SE	NIORLIFE COMM RES & COM C	AKE	FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	Maintenance of Wa	ater-Based Fire Protection			practice?		
	Systems, 2011 Edit	ion, Section 5.3.2.1 states			No residents were identified a	s	
	gauges shall be rep	laced every 5 years or tested			being affected by this alleged		
	every 5 years by comparison with a calibrated				deficient practice.		
	gauge. Gauges not accurate to within 3 percent of				How other residents having	the	
	the full scale shall be recalibrated or replaced.				potential to be affected by th		
	This deficient pract	rice could affect all residents,			same deficient practice will l		
	staff, and visitors in	n the facility.			identified and what corrective		
					action(s) will be taken?		
	Findings include:				No other residents have been		
					identified as having the potent		
	Based on observations with the Maintenance				be affected by the alleged def		
	Manager and the Maintenance Technician during				practice.		
	a tour of the facility from 12:40 p.m. to 3:40 p.m. on				Audit completed on all riser		
	09/26/23, the facilit	ty has supervised wet sprinkler			gauges and all electrical room	is to	
	systems. The manu	afacture date of 2017 was listed			look for any misplaced ceiling		
	on the face of the s	prinkler system gauge located			on 10/11/2023. Please see be		
	at the sprinkler syst	tem riser for Building 01 in the			and after pictures (attachment	(9#	
		nical Room. No recalibration			Koorsen Fire & Security repla		
	date information wa	as affixed to the sprinkler			sprinkler gauge on system 9 ii		
	system gauge. Bas	ed on interview at the time of			building 4 (attachment #10, #1		
	the observations, th	ne Maintenance Manager			and #13)		
	stated he did not be	lieve the sprinkler system			What measures will be put in	ıto	
	gauge had been rec	alibrated within the most			place and what systemic		
	recent five year per	riod and agreed the sprinkler			changes will be made to		
	system gauge was r	nore than five years old.			ensure that the deficient		
					practice does not recur?		
	These findings wer	e reviewed with the			A routine audit has been adde	d to	
	Maintenance Mana	ger and the Building Services			WorxHub for a monthly check	for	
	Coordinator during	the exit conference.			any misplaced ceiling tiles. A		
					check for riser gauge dates ha	ave	
	3.1-19(b)				been added to WorxHub annu	ıally.	
					How will the corrective		
	2. Based on observa	ation and interview, the facility			action(s) be monitored to		
	failed to maintain the	he ceiling construction in 1 of 1			ensure the deficient practice	!	
	Murphy's Special C	Care wings in Building 03.			will not recur, i.e., what qual	ity	
	NFPA 13, 2010 edi	tion, Section 3.3.5.4 defines a			assurance program will be p	-	
	smooth ceiling as a	continuous ceiling free from			into place?		
	significant irregular	rities, lumps, or indentations.			Any identified deficiencies will	be	
		ot air and gases around the			corrected upon discovery and		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2023		
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	ARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 30 residents, staff, and visitors in the Murphy's Special Care wing in Building 03. Findings include:				reviewed by the QAPI committee for further recommendation. By what date the systemic changes for each deficiency will be completed? 10/13/2023		
Findings include: Based on observations with the Maintenance							
	Manager and the M a tour of the facility 09/26/23, a ten inch of suspended ceiling Murphy's Special C Building 03. Based observations, the M the triangular shape	ons with the Maintenance faintenance Technician during from 12:40 p.m. to 3:40 p.m. on a long triangular shaped section g tile was missing in the tare wing Electrical Room in a lon interview at the time of the faintenance Manager agreed and hole in the ceiling tile would the sprinkler located in the					
	1	e reviewed with the ger and the Building Services the exit conference.					
	3.1-19(b)						
K 0363 SS=E Bldg. 01	than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material ing fire for at least 20 fully sprinklered smoke e only required to resist the					

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	ROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary such flammable or complying to a covering is not exact doors complying the door closed with a complete the door closed with a public the door closed with a permitted. There is closing of the door release when the permitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lad other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating the application.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of the permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,						
	failed to ensure 1 of second floor in Buil closing and latching would resist the pas practice could affec	on and interview, the facility over 20 corridor doors on the ding 02 had no impediment to g into the door frame and sage of smoke. This deficient t over 20 residents, staff and ty of the second floor Nurse's 12.	K 03	363	K363 – Corridor – Doors What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? No residents were identified as being affected by this alleged	1	10/13/2023	

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	OF CORRECTION	IDENTIFICATION NUMBER 155771	A. BUILDING B. WING	<u>01</u>	COMPLETED 09/26/2023
	ROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM CA	1070	ET ADDRESS, CITY, STATE, ZIP COD W JEFFERSON ST NKLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	Findings include: Based on observation Manager and the Manager and the facility 09/26/23, the corridon the second floor the fully open position the floor under the of the time of the observation of the door frame and of smoke and removation. These findings were	ons with the Maintenance aintenance Technician during from 12:40 p.m. to 3:40 p.m. on or door to the Nurse's Office in Building 02 was propped in on with a wedge placed on loor. Based on interview at rvations, the Maintenance aforementioned corridor door to closing and latching into would not resist the passage red the wedge from under the ereviewed with the ger and the Building Services	TAG	deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what correctivaction(s) will be taken? No other residents have been identified as having the potential be affected by the alleged depractice. The wedge that was propping supervisor's door open was immediately removed by the Maintenance Manager on 9/26/2023 during the tour with life safety surveyor. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? An audit will be completed by unit manager and/or her desidaily for one week, three times week for two weeks, and twice week for one week to ensure no doors are inappropriately propped open. (attachment flow will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quates assurance program will be printo place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI commit for further recommendation. By what date the systemic changes for each deficiency	the he be ve on attial to ficient at the mto of the gnee es a see a that that that that the model of the litty but the model of the mod

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2023		
	ROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM C	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0372	NEDA 101				will be completed? 10/13/2023		
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers where an is installed for smoth to the smoke barrier systems where an is installed for smoth to the smoke barrier system in REMAR Based on observation failed to ensure 1 of protected to maintain the smoke barriers to be with LSC Section 8 hour fire resistive recould affect over 40 on the second floor Findings include: Based on observation Manager and the Most at our of the facility 09/26/23, foam was holes which were not above the corridor of Building 02 from B	pall be constructed to a sance rating per 8.5. Smoke ermitted to terminate at an ele dampers are not required as in fully ducted HVAC approved sprinkler system obtained by the compartments adjacent er.) hanical smoke control etcs. (KS.) In and interview, the facility of 10 smoke barrier walls were in the fire resistance rating of LSC Section 19.3.7.5 requires the constructed in accordance and shall have a minimum 1/2 atting. This deficient practice of residents, staff and visitors	K 0	372	K372 – Subdivision of Building Spaces – Smoke Barrier What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having the potential to be affected by this ame deficient practice will be identified and what corrective action(s) will be taken? No other residents have been identified as having the potential be affected by the alleged defipractice. The hole in the stairwell will be	the e e e ial to	10/13/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155771	B W	/ING	<u></u>	09/26	
		100771	D. 1			03/20/	72020
NAME OF I	DOWNER OF CHIRD IEL			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C.		1070 W	/ JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE	FRANK	LIN, IN 46131		
	ı		1		<u> </u>		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a 90-minute fire res	istance rating label and latched			fixed by cutting out foam and		
	into the door frame.	. Based on interview at the			replacing it with proper fire sto	р	
	time of the observar	tions, the Maintenance		material on 10/11/2023.			
		was not aware of the fire			(attachment #15 and #16)		
	_	the foam used to firestop the			What measures will be put		
		noles in the smoke barrier wall.			into place and what systemic		
	notes in the smoke	oles in the smoke barrier wan.			changes will be made to	•	
	These findings were	ese findings were reviewed with the			ensure that the deficient		
	_	ger and the Building Services					
		the exit conference.			practice does not recur? An audit of the stairwells will b	_	
	Coordinator during	the exit conference.					
	3.1-19(b)				completed every two weeks fo	r	
					three months or until 100%		
					compliance is met.		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	ty	
					assurance program will be p	_	
					into place?		
					Audits will be reviewed by the	ΟΔ	
					committee. Once initial audits		
					have been completed, and 10		
					compliance has been met, the		
					committee may decide to		
					discontinue audits.		
					By what date the systemic		
					changes for each deficiency		
					will be completed?		
					10/13/2023		
K 0521	NFPA 101						
SS=F	HVAC						
Bldg. 01	HVAC						
g. v .		n, and air conditioning shall					
	_	nd shall be installed in					
	accordance with t						
		ne manufacturer s					
	specifications.						
	18.5.2.1, 19.5.2.1						
	Based on record rev	view, observation and	Κ()521	K521 – HVAC		10/20/2023

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interview; the facility failed to ensure all fire

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What corrective action(s) will

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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 09/26/2023 155771 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1070 W JEFFERSON ST OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE FRANKLIN, IN 46131 (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 dampers in the facility were inspected and be accomplished for those provided necessary maintenance within the most residents found to have been recent four year period in accordance with NFPA affected by the deficient 90A. LSC 9.2.1 requires heating, ventilating and practice? air conditioning (HVAC) ductwork and related No residents were identified as equipment shall be in accordance with NFPA 90A, being affected by this alleged Standard for the Installation of Air-Conditioning deficient practice. and Ventilating Systems. NFPA 90A, 2012 How other residents having the Edition, Section 5.4.8.1 states fire dampers shall be potential to be affected by the maintained in accordance with NFPA 80, Standard same deficient practice will be for Fire Doors and Other Opening Protectives. identified and what corrective NFPA 80, 2010 Edition, Section 19.4.1 states each action(s) will be taken? damper shall be tested and inspected 1 year after No other residents have been installation. The test and inspection frequency identified as having the potential to shall be every 4 years. If the damper is equipped be affected by the alleged deficient with a fusible link, the link shall be removed for practice. testing to ensure full closure and lock-in-place if SafeCare is scheduled to inspect so equipped. The damper shall not be blocked identified fire dampers on from closure in any way. All inspections and 10/16/2023. testing shall be documented, indicating the A WorxHub ticket has been location of the fire damper, date of inspection, created so that fire dampers are name of inspector and deficiencies discovered. inspected annually. The documentation shall have a space to indicate when and how the deficiencies were corrected. What measures will be put into Section 19.4.3 states full unobstructed access to place and what systemic the fire damper shall be verified and corrected as changes will be made to required. This deficient practice could affect all ensure that the deficient residents, staff and visitors. practice does not recur? Audits of the fire dampers will be Findings include: conducted by the Maintenance Manager and/or his designee Based on review of the fire alarm system weekly for four weeks and then inspection contractor's "Inspection and Testing monthly for three months. Form" documentation dated 07/20/23 with the How will the corrective Maintenance Manager and the Building Services action(s) be monitored to Coordinator during record review from 9:10 a.m. to ensure the deficient practice 12:15 p.m. on 09/26/23, fire damper inspection and will not recur, i.e., what quality

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maintenance documentation was not available for

review. Based on interview at the time of record

review, the Building Services Coordinator stated

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into place?

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assurance program will be put

Audit will be reviewed by the QA

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771			JILDING	01	COMPL 09/26/	ETED	
	PROVIDER OR SUPPLIER		DE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST		
OTTERB	EIN FRANKLIN SEI	NIORLIFE COMM RES & COM CA	KE.	FRANKI	-IN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	damper inspections damper inspection a documentation was system inspection rewith the Maintenance Technifacility from 12:40 pfire damper was inst HVAC ductwork in sleeping Room 381 floor in Building 02 manufacture date of damper in Room 38 had an affixed sticke 2007. Neither fire documentation indicrecent inspection and These findings were	not included on fire alarm eport. Based on observations be Manager and the ician during a tour of the p.m. to 3:40 p.m. on 09/26/23, a talled in the wall mounted the bathroom for resident and Room 386 on the third. A sticker with the 2008 was affixed to the fire 1. The fire damper in Room 386 er with the manufacture date of damper had any affixed bating the date of the most dinecessary maintenance.			committee. Once initial audit is completed and 100% compliar is met, the committee may choose to discontinue the audi By what date the systemic changes for each deficiency will be completed? 10/20/2023	ice	
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dri and unexpected tir conditions, at least The staff is familia aware that drills ar routine. Where dri 9:00 PM and 6:00	t quarterly on each shift. r with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155771	B. WI	NG		09/26/	2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIE	R			/ JEFFERSON ST			
OTTERB	EIN FRANKLIN SE	ENIORLIFE COMM RES & COM CA	RE					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		view and interview, the facility	K 0'	712	K712 – Fire Drills		10/13/2023	
	•	ocumentation of a fire drill			What corrective action(s) wi	"		
	conducted on the second shift for 1 of 4 quarters.				be accomplished for those			
	-	tice affects all residents, staff			residents found to have bee	n		
	and visitors.				affected by the deficient			
	Findings in the fact				practice?	_		
	Findings include:				No residents were identified a	เร		
	Based on review of	f "Overall Review of Quarterly			being affected by this alleged			
		ntation and "Record of Alarm			deficient practice. How other residents having	the		
		ire" documentation with the			potential to be affected by the			
	•	ger and the Building Services			same deficient practice will			
		grecord review from 9:10 a.m. to			identified and what corrective			
	_	6/23, documentation of a fire drill			action(s) will be taken?			
	-	econd shift in the second			No other residents have been	1		
		y, June) 2023 was not available			identified as having the poten			
		on interview at the time of			be affected by the alleged det			
	record review, the	Maintenance Manager stated			practice.			
	the facility operates	s three shifts per day, one of			Fire Drills were scheduled in			
	the two fire drills c	onducted on 05/08/23 and on			WorxHub by the previous			
	06/16/23 was inten	ded to be a second shift fire			Maintenance Director. After			
	drill but was docum	nented as a third shift fire drill			auditing the dates and times	of all		
	and agreed docume	entation of a fire drill conducted			fire drills over the last year, it	was		
		in the second quarter 2023			discovered that the fire drill th	at		
	was not available f	or review.			should have occurred during	the		
					second quarter on second shi	ift		
	_	re reviewed with the			was actually completed 15			
		ager and the Building Services			mintues after second shift end			
	Coordinator during	the exit conference.			which then made the drill effe			
	2 1 10/1-> 1 2 1 2	71(-)			for third shift. The Maintenan			
	3.1-19(b) and 3.1-5	51(c)			Manager has reconfigured the			
					dates and times of each fire d			
					occur early in the shifts to ens that a timing mishap does not			
					reoccur.	•		
					What measures will be put in	nto		
					place and what systemic			
					changes will be made to			
					ensure that the deficient			
					practice does not recur?			
			1					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CE

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ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED
	155771	B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST

OTTERE	BEIN FRANKLIN SENIORLIFE COMM RES & COM CA		RANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of		The Maintenance Manager has reconfigured the dates and times of each fire drill to occur early in the shifts to ensure that a timing mishap does not reoccur. (attachment #17) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Any identified deficiencies will be corrected upon discovery and reviewed by the QAPI committee for further recommendation. By what date the systemic changes for each deficiency will be completed? 10/13/2023			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPL	
		155771	B. W	ING		09/26	/2023
NAME OF F	PROVIDER OR SUPPLIER	-		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	KOVIDEK OK SUITEIEN			1070 V	V JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM (CARE	FRANK	KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	or spread is not present.					
	19.7.5.6	1		.=.2	1,7750 0 1 111 5 11		10/12/2022
		on and interview, the facility	K ()753	K753 – Combustible Decoration		10/13/2023
		f 2 smoke compartments on the			What corrective action(s) will	l l	
		Iding 02 was maintained in .7.5.6. 19.7.5.6 states			be accomplished for those residents found to have been	_	
		tions shall be prohibited in				1	
		upancy, unless one of the			affected by the deficient practice?		
	following criteria is				No residents were identified a	9	
	_	retardant or are treated with			being affected by this alleged	3	
	` '	lant coating that is listed and			deficient practice.		
		ion to the material to which it is			How other residents having	the	
	applied.				potential to be affected by th		
		meet the requirements of			same deficient practice will be		
		d Methods of Fire Tests for			identified and what correctiv		
	Flame Propagation	of Textiles and Films.			action(s) will be taken?		
	(3) The decorations	exhibit a heat release rate not			No other residents have been		
	exceeding 100 kW	when tested in accordance with			identified as having the potent	tial to	
	NFPA 289, Standar	d Method of Fire Test for			be affected by the alleged def	icient	
	Individual Fuel Pac	kages, using the 20 kW			practice.		
	ignition source.				All coloring pages have been		
		s, such as photographs,			removed from the door on		
		art, are attached directly to			9/26/2023. (attachment #18)		
		nd non-fire-rated doors in			What measures will be put in	nto	
	accordance with the	_			place and what systemic		
	` '	non-fire-rated doors do not			changes will be made to		
		peration or any required			ensure that the deficient		
	limitations of 19.7.5	and do not exceed the area			practice does not recur? All staff on HC2 were inservice	od by	
		not exceed 20 percent of the				ed by	
	` '	oor areas inside any room or			the Unit Manager and/or his designee on 10/10/2023 to inf	orm	
	_	ompartment that is not			staff of the Combustible	OHH	
	_	at by an approved automatic			Decoration rule. (attachment	#1 9)	
		accordance with Section 9.7.			An Audit will be completed by	,	
		not exceed 30 percent of the			HC2 Unit Manager and/or his	u IC	
		oor areas inside any room or			designee once weekly for four		
	_	ompartment that is protected			weeks to ensure there are no		
	*	oproved supervised automatic			further coloring pages hanging	no c	
		accordance with Section 9.7.			the doorways. (attachment #2		

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(d) Decorations do not exceed 50 percent of the

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How will the corrective

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155771	B. WI	NG		09/26/		
				_	_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					JEFFERSON ST			
OTTERB	EIN FRANKLIN SEI	NIORLIFE COMM RES & COM CA	RE	FRANK	LIN, IN 46131			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWIDER'S BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE	
	wall, ceiling, and do	oor areas inside patient			action(s) be monitored to			
	sleeping rooms having a capacity not exceeding				ensure the deficient practice			
	four persons, in a sr	noke compartment that is			will not recur, i.e., what quali			
	protected throughout by an approved, supervised				assurance program will be p			
	automatic sprinkler system in accordance with				into place?			
	Section 9.7.				Any identified deficiencies will	be		
		ations, such as photographs			corrected upon discovery and			
		ch limited quantities that a			reviewed by the QAPI commit	tee		
	hazard of fire develo	opment or spread is not			for further recommendation.			
	present.				By what date the systemic			
	-	ice could affect over 20			changes for each deficiency			
		visitors in the vicinity of the			will be completed?			
	Building 02 Server	Room on the second floor.			10/13/2023			
	T' 1' ' 1 1							
	Findings include:							
	Based on observation	ons with the Maintenance						
		aintenance Technician during						
	-	from 12:40 p.m. to 3:40 p.m. on						
		entire face of the corridor door						
	-	Server Room in Building 02						
		idividual 8 inch by 10 inch						
		affixed to the corridor side of						
		et of paper did not have affixed						
	documentation indic	cating the material was fire						
	retardant or fire reta	rdant treated. Based on						
	interview at the time	e of the observations, the						
	Maintenance Techn	ician stated he was not aware						
	if the affixed paper	art had been treated with fire						
	retardant material an	nd agreed fire resistance rating						
		he paper art was not available						
	for review.							
	These findings were	a reviewed with the						
		ger and the Building Services						
	Coordinator during							
	Coordinator during	the east conference.						
	3.1-19(b)							
	2.1 17(0)							

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CENTERS FOR		OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155771		r í	UILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2023		
	ROVIDER OR SUPPLIEF	NIORLIFE COMM RES & COM (CARE	1070 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	CEDED BY FULL PREFIX (EACH CORRECTED IN CROSS-REFERENCE CROSS-		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE	
SS=E Bldg. 01	Soiled Linen and Soiled Linen and Soiled Linen and Soiled linen or trashall not exceed average density or room or space shigallons/square feed capacity of 32 gal within any 64 squalinen or trash colled capacities greater located in a room area when not attacted in	Trash Containers sh collection receptacles 32 gallons in capacity. The f container capacity in a all not exceed 0.5 at. A total container lons shall not be exceeded are feet area. Mobile soiled action receptacles with a than 32 gallons shall be protected as a hazardous ended. solely for recycling are accluded from the above are each container is less a gallons unless attended, ar combustibles are labeled ting FM Approval Standard at.	K	0754	K754 – Soiled Linen and Tras Containers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were identified as being affected by this alleged deficient practice. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective.	I s the e oe	10/13/2023

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09/26/23, one unattended partially filled trash cart

and one unattended partially filled trash can were

stored next to one another in the Building 02

second floor Server Room by the dining room.

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action(s) will be taken?

No other residents have been

identified as having the potential to

be affected by the alleged deficient

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	MULTIPLE CO BUILDING VING	ONSTRUCTION 01	COMI	E SURVEY PLETED 6/2023
	PROVIDER OR SUPPLIER	NIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF The trash cart had s was 32 gallon capacity. Th trash cart and the tr The Building 02 Se dining room which Based on interview observations, the M the aforementioned being stored in a ro- area when unattend	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ignage on the cart indicating it city and the trash can was 20 e combined capacity of the ash can exceeded 32 gallons. rver Room was open to the was open to the corridor. at the time of the aintenance Technician agreed trash receptacles were not om protected as a hazardous ed. e reviewed with the ger and the Building Services	CARE	ID PREFIX TAG	providers plan of corrective action(s) be monitored to ensure the deficient will not recur; a week for one weethen twice weekly for two (attachment #21) How will the corrective action(s) be monitored to ensure the deficient practice does not recur? Audits to ensure trash car appropriate storage area completed by the back of house supervisor and/or it designee daily for one weethen twice weekly for two (attachment #21) How will the corrective action(s) be monitored to ensure the deficient practice into place? Any identified deficiencies corrected upon discovery reviewed by the QAPI corfor further recommendation.	ediately storage ut into as are I in an will be the her ek, three k, and weeks. ctice quality be put as will be and nmittee on.	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	Extens Electrical Equipmonents Extension Cords	ent - Power Cords and ent - Power Cords and patient care vicinity are only nts of movable			By what date the system changes for each deficie will be completed? 10/13/2023		

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	C OF HEALTH AND HU MEDICARE & MEDIC					FO	TTED: 10/19/2023 RM APPROVED IB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	, ,	UILDING	ONSTRUCTION 01	(X3) DATE COMPI 09/26	LETED
	ROVIDER OR SUPPLIE	R ENIORLIFE COMM RES & COM (CARE	1070 W	ADDRESS, CITY, STATE, ZIP COD JEFFERSON ST LIN, IN 46131		
(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 BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(PCREE) assembled by question the conditions of the patient care in non-PCREE (e.g. except in long-termeet UL 1363A of for non-PCREE in (outside of vicinity non-patient care other UL standar used with general cords are not used wiring of a structure.	ted electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in vicinity may not be used for, personal electronics), rm care resident rooms that EE. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are all precautions. Extension ed as a substitute for fixed the proved immediately upon					

completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 10/13/2023 K920 - Electrical Equipment failed to ensure 1 of 1 extension cords including Power Cords and Extension Cords power strips were not used as a substitute for What corrective action(s) will fixed wiring. LSC 19.5.1 requires utilities to be accomplished for those comply with Section 9.1. LSC 9.1.2 requires residents found to have been electrical wiring and equipment to comply with affected by the deficient NFPA 70, National Electrical Code, 2011 Edition. practice? NFPA 70, Article 400.8 requires that, unless No residents were identified as specifically permitted, flexible cords and cables being affected by this alleged shall not be used as a substitute for fixed wiring of deficient practice. a structure. LSC Section 4.5.7 states any building How other residents having the service equipment or safeguard provided for life potential to be affected by the safety shall be designed, installed and approved same deficient practice will be in accordance with all applicable NFPA standards. identified and what corrective NFPA 99, Standard for Health Care Facilities, 2012 action(s) will be taken? edition, defines patient care areas as any portion No other residents have been of a health care facility wherein patients are identified as having the potential to intended to be examined or treated. Patient care be affected by the alleged deficient vicinity is defined as a space, within a location practice.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2023	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST		_
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM C	ARE		(LIN, IN 46131		
(X4) ID	SUMMARY	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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		imination and treatment of			An in-service was given to H0		
		6 ft (1.8 m) beyond the normal			staff regarding the use of pov		
	device that supports	chair, table, treadmill, or other			strips on 10/10/2023 by the U		
		-			Manager and/or her designed). 	
	examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the				(attachment #22) Social Services contacted far	oilv	
		ection 10.4.2.3 states household			on 10/13/2023 to request a lo		
		not commonly equipped with			charging cord for resident's ta	-	
		ors in their power cords shall			What measures will be put i		
		ed they are not located within			place and what systemic		
		nity. This deficient practice			changes will be made to		
		ident in Room 285 in Building			ensure that the deficient		
	02 on the second flo				practice does not recur?		
					An audit will be conducted by	the	
	Findings include:				Maintenance Manager or his		
					designee weekly for four wee	ks	
	Based on observation	ons with the Maintenance			and then random audits once	а	
	_	aintenance Technician during			month for three months for		
	-	from 12:40 p.m. to 3:40 p.m. on			extension cord use.		
	_	er tablet was plugged into a			How will the corrective		
		vas laying on the resident bed			action(s) be monitored to		
		ilding 02 on the second floor.			ensure the deficient practice		
	I -	ne power strip could not be			will not recur, i.e., what qua	-	
		on interview at the time of the			assurance program will be p	out	
		aintenance Manager agreed a			into place?		
	used in the patient of	unknown UL listing was being			Any identified deficiencies wil		
	aforementioned loca	•			corrected upon discovery and		
	aforementioned foc	ation.			reviewed by the QAPI commi for further recommendation.	uee	
	These findings were	e reviewed with the			ioi iuitiiei recommenuation.		
		ger and the Building Services			By what date the systemic		
		the exit conference.			changes for each deficiency	,	
					will be completed?		
	3.1-19(b)				10/13/2023		
K 0923	NFPA 101						
SS=D		Cylinder and Container					
Bldg. 01	Storag	-					
		Cylinder and Container					
	Storage						

NAME OF PROVIDIR OR SUPPLIE OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE REGILATORY OR LSC INDEPLIENTING INFORMATION Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3 -3.00 but 53,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with ofor (or gales outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustible construction having a minimum '12 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, inclividual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet in one ach door or gale of a cylinder storage room, where the sign includes the wording as a minimum 'CAUTON'. OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.' Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from the supplier. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771		JILDING	nstruction 01		(X3) DATE : COMPL 09/26/	ETED
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION Creater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but < 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA				.RE	1070 W	JEFFERSON ST			
Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE CROSS-REFERENCE!	E ACTION SHOULD BE D TO THE APPROPRI	ATE	COMPLETION
Based on observation and interview, the facility K 0923 K923 – Gas Equipment – Cylinder 10/13/2023	IAU	Greater than or ed Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 d Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enconcombustible of minimum 1/2 hr. fit Less than or equally a single smoke cylinders available patient care areas of less than or equiver equired to be stored Cylinders must be as specified in 11. A precautionary si on each door or groom, where the saminimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with interestablished. Empayord confusion. Care protected from 11.3.1, 11.3.2, 11.99)	qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 subic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. I to 300 cubic feet compartment, individual a for immediate use in with an aggregate volume all to 300 cubic feet are not red in an enclosure. handled with precautions 6.2. gn readable from 5 feet is ate of a cylinder storage ign includes the wording as FION: OXIDIZING GAS(ES) NO SMOKING." d so cylinders are used in y are received from the ylinders are segregated When facility employs gral pressure gauge, a e considered empty is ty cylinders are marked to cylinders stored in the open in weather. 3.3, 11.3.4, 11.6.5 (NFPA)	К 0				inder	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPLETED	
		155771	B. WING			09/26/	2023
			1				
NAME OF P	ROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD		
OTTERR		NUODUIEE OOMM DEO A OOM O			JEFFERSON ST		
OTTERB	EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	ARE F	KANKI	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	D	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	failed to ensure 1 of	f 10 cylinders of nonflammable			and Container Storage		
	gases such as oxyge	en in the Building 03			What corrective action(s) will	l	
	Rehabilitation wing	g area were properly secured			be accomplished for those		
	from falling. NFPA	A 99, Health Care Facilities			residents found to have been	1	
	Code, 2012 Edition	, Section 11.3.3 states storage			affected by the deficient		
	for nonflammable g	gases with a total volume equal			practice?		
	to or less than 8.5 c	ubic meters (300 cubic feet)			No residents were identified as	3	
	shall comply with 1	1.3.3.1 and 11.3.3.2. NFPA 99,			being affected by this alleged		
	Section 11.3.3.2 sta	ites precautions in handling			deficient practice.		
	cylinders specified	in 11.3.3.1 shall be in			How other residents having t	he	
	accordance with 11	.6.2. Section 11.6.2.3(11) states			potential to be affected by the	е	
	freestanding cylinde	ers shall be properly chained			same deficient practice will b	e	
	or supported in a pr	oper cylinder stand or cart.			identified and what corrective	е	
	This deficient pract	ice could affect over 10			action(s) will be taken?		
	residents, staff and	visitors in the vicinity of			No other residents have been		
	Building 03 Rehabi	llitation wing oxygen storage			identified as having the potenti	ial to	
	room.				be affected by the alleged defi	cient	
					practice.		
	Findings include:				The "E" type oxygen cylinder v	vas	
					immediately put in the secured	l	
	Based on observation	ons with the Maintenance			area by the Maintenance Mana		
	Manager and the M	laintenance Technician during			on 9/26/2023 during the tour w	/ith	
	a tour of the facility	from 12:40 p.m. to 3:40 p.m. on			the Life Safety inspector.		
	09/26/23, one of ter	n 'E' type oxygen cylinders was			The Rehab staff was inservice	d on	
	freestanding on the	floor of the Building 03			the proper storing of Oxygen		
	Rehabilitation wing	g oxygen storage room and was			containers between 10/11/202	3 –	
	not properly chaine	d or supported in a proper			10/13/2023 by the Unit Manag	er.	
	cylinder stand or ca	rt. Based on interview at the			(attachment #23)		
	time of the observat	tions, the Maintenance			What measures will be put in	to	
	Manager agreed the	e oxygen cylinder was not			place and what systemic		
	properly chained or	supported in a proper cylinder			changes will be made to		
	stand or cart.				ensure that the deficient		
					practice does not recur?		
	These findings were	e reviewed with the			An audit will be conducted by	the	
	Maintenance Manag	ger and the Building Services			Maintenance Manager and/or	his	
	Coordinator during	the exit conference.			designee to ensure oxygen		
					containers are stored		
	3.1-19(b)				appropriately, daily for one we	ek,	
					three times a week for one we		
					and then twice weekly for two	•	
					•		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. Bl	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2023	
	PROVIDER OR SUPPLIEI EIN FRANKLIN SE	NIORLIFE COMM RES & COM CA	STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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	
					weeks. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place? Any identified deficiencies will corrected upon discovery and reviewed by the QAPI commit for further recommendation. By what date the systemic changes for each deficiency will be completed? 10/13/2023	ty ut be tee		

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