| CENTERS FOR MEDICARE & MEDICAID SERVICES |   |  |        |           |  | OM         | IB NO. 0938-039 |
|--|---|--|--------|-----------|--|------------|-----------------|
| STATEMEN                                 | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | JLTIPLE C | ONSTRUCTION  | (X3) DATE  | SURVEY          |
| AND PLAN                                 | OF CORRECTION   | IDENTIFICATION NUMBER  | A. BU  | ILDING    | <u></u>  | COMPLETED  |                 |
|  |   | 155859   | B. W   | NG        |  | 01/26/2023 |                 |
|  | PROVIDER OR SUPPLIE   |  | •      | 501 N     | ADDRESS, CITY, STATE, ZIP COD<br>17TH AVE<br>1 GROVE, IN 46107     |            |                 |
| (X4) ID                                  | SUMMARY   | STATEMENT OF DEFICIENCIE   |        | ID        |  |            | (X5)            |
| PREFIX                                   |   | NCY MUST BE PRECEDED BY FULL   |        | PREFIX    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI | E          | COMPLETION      |
| TAG                                      | •   | R LSC IDENTIFYING INFORMATION  |        | TAG       | CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)                     | RIATE      | DATE            |
| E 0000                                   |   |  |        |           |  |            |                 |
| Bldg                                     |   | paredness Survey was<br>ndiana Department of Health in<br>CFR 483.73.  | E 00   | 000       |  |            |                 |
|  | of Beech Grove wa<br>Emergency Prepare<br>Medicare and Medi<br>and Suppliers, 42 C<br>The facility has 52<br>the survey, the cens<br>Quality Review con | 2000391 15E247 1274990  Preparedness survey, Envive as found not in compliance with edness Requirements for icaid Participating Providers CFR 483.73.  certified beds. At the time of sus was 32.  Impleted on 01/30/23  42 CFR, Subpart 483.73 is NOT |        |           |  |            |                 |
| E 0041<br>SS=F<br>Bldg                   | 482.15(e), 483.73 Hospital CAH and §482.15(e) Condi (e) Emergency ar The hospital must standby power sy emergency plan sthis section and ir             | S(e), 485.625(e) I LTC Emergency Power tion for Participation: and standby power systems. It implement emergency and estems based on the set forth in paragraph (a) of an the policies and set forth in paragraphs (b)(1)                              |        |           |  |            |                 |

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

(e) Emergency and standby power systems.

§483.73(e), §485.625(e)

TITLE (X6) DATE

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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| STATEMEN  | NT OF DEFICIENCIES                      | X1) PROVIDER/SUPPLIER/CLIA                                | A (X2) MULTIPLE CONSTRUCTION (X3) Da |          | (X3) DATE  | SURVEY     |            |
|-----------|---|---|--------------------------------------|----------|--|------------|------------|
| AND PLAN  | OF CORRECTION                           | IDENTIFICATION NUMBER                                     | A. BU                                | JILDING  | <del></del>  | COMPL      |            |
|           |   | 155859  | B. W                                 | ING      |  | 01/26/2023 |            |
| NAME OF I | PROVIDER OR SUPPLIER                    | •   |                                      | STREET A | ADDRESS, CITY, STATE, ZIP COD  | -          |            |
|           |   |   |                                      |          | 7TH AVE  |            |            |
| ENVIVE    | OF BEECH GROVE                          | <u> </u>  |                                      | BEECH    | GROVE, IN 46107  |            |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | TE         | COMPLETION |
| TAG       |   | R LSC IDENTIFYING INFORMATION                             | +                                    | TAG      | DEFICIENCY)  |            | DATE       |
|           | -                                       | and the CAH] must<br>ency and standby power               |                                      |          |  |            |            |
|           |   | n the emergency plan set                                  |                                      |          |  |            |            |
|           | forth in paragraph (a) of this section. |   |                                      |          |  |            |            |
|           | Termini paragrapii                      | (4) 0. 4.10 00040111                                      |                                      |          |  |            |            |
|           | §482.15(e)(1), §4                       | 83.73(e)(1), §485.625(e)(1)                               |                                      |          |  |            |            |
|           | Emergency generator location. The       |   |                                      |          |  |            |            |
|           | •                                       | e located in accordance with                              |                                      |          |  |            |            |
|           |   | rements found in the Health                               |                                      |          |  |            |            |
|           |   | de (NFPA 99 and Tentative<br>ents TIA 12-2, TIA 12-3, TIA |                                      |          |  |            |            |
|           |   | nd TIA 12-6), Life Safety                                 |                                      |          |  |            |            |
|           |   | and Tentative Interim                                     |                                      |          |  |            |            |
|           | ,                                       | 12-1, TIA 12-2, TIA 12-3,                                 |                                      |          |  |            |            |
|           |   | d NFPA 110, when a new                                    |                                      |          |  |            |            |
|           | structure is built o                    | r when an existing  |                                      |          |  |            |            |
|           | structure or building                   | ng is renovated.  |                                      |          |  |            |            |
|           | /82 15(a)(2) 8/8°                       | 3.73(e)(2), §485.625(e)(2)                                |                                      |          |  |            |            |
|           |   | rator inspection and testing.                             |                                      |          |  |            |            |
|           |   | H and LTC facility] must                                  |                                      |          |  |            |            |
|           |   | ergency power system                                      |                                      |          |  |            |            |
|           |   | g, and [maintenance]                                      |                                      |          |  |            |            |
|           | requirements four                       | nd in the Health Care                                     |                                      |          |  |            |            |
|           | Facilities Code, N                      | FPA 110, and Life Safety                                  |                                      |          |  |            |            |
|           | Code.                                   |   |                                      |          |  |            |            |
|           | 482 15(e)(3) 848                        | 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                                 |                                      |          |  |            |            |
|           | power systems op                        | perational during the                                     |                                      |          |  |            |            |
|           | emergency, unles                        | s it evacuates.   |                                      |          |  |            |            |
|           | *[For hospitals at                      | §482.15(h), LTC at  |                                      |          |  |            |            |
|           | l                                       | CAHs §485.625(g):]  |                                      |          |  |            |            |
|           |   | corporated by reference in                                |                                      |          |  |            |            |
|           |   | pproved for incorporation by                              |                                      |          |  |            |            |
|           |   | Director of the Office of the                             |                                      |          |  |            |            |

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|                   | OF CORRECTION                             | IDENTIFICATION NUMBER  155859                            | A. BUILDING B. WING |  | COM       | E SURVEY<br>PLETED<br>6/2023 |
|-------------------|---|--|---------------------|--|-----------|------------------------------|
| NAME OF F         | PROVIDER OR SUPPLIER                      |  |                     | ADDRESS, CITY, STATE, ZIP C<br>17TH AVE  | COD       |                              |
| ENVIVE            | OF BEECH GROVE                            | <u> </u>   |                     | H GROVE, IN 46107  |           |                              |
| (X4) ID<br>PREFIX |   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX        | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A | SHOULD BE | (X5)<br>COMPLETION           |
| TAG               |   | LSC IDENTIFYING INFORMATION                              | TAG                 | DEFICIENCY)  |           | DATE                         |
|                   |   | n accordance with 5 U.S.C.<br>part 51. You may obtain    |                     |  |           |                              |
|                   | , ,                                       | he sources listed below.                                 |                     |  |           |                              |
|                   | You may inspect a                         |  |                     |  |           |                              |
|                   |   | rce Center, 7500 Security                                |                     |  |           |                              |
|                   | Boulevard, Baltimo                        | ore, MD or at the National                               |                     |  |           |                              |
|                   | Archives and Reco                         | ords Administration                                      |                     |  |           |                              |
|                   | (NARA). For inforr                        | nation on the availability of                            |                     |  |           |                              |
|                   |   | RA, call 202-741-6030, or                                |                     |  |           |                              |
|                   | go to:                                    |  |                     |  |           |                              |
|                   |   | es.gov/federal_register/code                             |                     |  |           |                              |
|                   | 1   | ations/ibr_locations.html.                               |                     |  |           |                              |
|                   | , ,                                       | this edition of the Code are ference, CMS will publish a |                     |  |           |                              |
|                   | document in the F                         |  |                     |  |           |                              |
|                   | announce the cha                          | · ·  |                     |  |           |                              |
|                   |   | rotection Association, 1                                 |                     |  |           |                              |
|                   | Batterymarch Park                         |  |                     |  |           |                              |
|                   | Quincy, MA 02169                          |  |                     |  |           |                              |
|                   | 1.617.770.3000.                           | ,                  |                     |  |           |                              |
|                   | (i) NFPA 99, Healt                        | h Care Facilities Code,                                  |                     |  |           |                              |
|                   | 2012 edition, issue                       | ed August 11, 2011.                                      |                     |  |           |                              |
|                   | (ii) Technical interi                     | m amendment (TIA) 12-2 to                                |                     |  |           |                              |
|                   | NFPA 99, issued A                         | August 11, 2011.   |                     |  |           |                              |
|                   | (iii) TIA 12-3 to NF<br>2012.             | PA 99, issued August 9,                                  |                     |  |           |                              |
|                   | (iv) TIA 12-4 to NF<br>2013.              | FPA 99, issued March 7,                                  |                     |  |           |                              |
|                   |   | PA 99, issued August 1,                                  |                     |  |           |                              |
|                   |   | FPA 99, issued March 3,                                  |                     |  |           |                              |
|                   | _ ·                                       | e Safety Code, 2012                                      |                     |  |           |                              |
|                   | edition, issued Aug                       |  |                     |  |           |                              |
|                   |   | FPA 101, issued August                                   |                     |  |           |                              |
|                   | 11, 2011.                                 | - , <del></del>  |                     |  |           |                              |
|                   | (ix) TIA 12-2 to NFPA 101, issued October |  |                     |  |           |                              |
|                   | 30, 2012.                                 |  |                     |  |           |                              |
|                   | (x) TIA 12-3 to NF                        | PA 101, issued October                                   |                     |  |           |                              |
|                   | 22, 2013.                                 |  |                     |  |           |                              |

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| STATEMEN  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA       | (X2) M | ULTIPLE CO | ONSTRUCTION   | (X3) DATE SURVEY |
|-----------|--|----------------------------------|--------|------------|---|------------------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER            | A. BU  | JILDING    | <del></del>   | COMPLETED        |
|           |  | 155859                           | B. WI  | ING        |   | 01/26/2023       |
| NAME OF I | DDOVIDED OD CLIDDI IEI   |                                  |        | STREET A   | ADDRESS, CITY, STATE, ZIP COD   |                  |
|           | PROVIDER OR SUPPLIEF   |                                  |        |            | 17TH AVE  |                  |
| ENVIVE    | OF BEECH GROVE   |                                  |        | BEECH      | I GROVE, IN 46107   |                  |
| (X4) ID   |  | STATEMENT OF DEFICIENCIE         |        | ID         | PROVIDER'S PLAN OF CORRECTION   | (X5)             |
| PREFIX    |  | ICY MUST BE PRECEDED BY FULL     |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | COMPLETION       |
| TAG       |  | R LSC IDENTIFYING INFORMATION    |        | TAG        | DEFICIENC!)   | DATE             |
|           | (XI) TIA 12-4 to NI<br>22, 2013.   | FPA 101, issued October          |        |            |   |                  |
|           |  | tandard for Emergency and        |        |            |   |                  |
|           | (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, |                                  |        |            |   |                  |
|           |  |                                  |        |            |   |                  |
|           | 2009   |                                  |        |            |   |                  |
|           |  | view and interview, the facility | E 00   | 041        | What corrective action will be  | 02/26/2023       |
|           | failed to implement  | the emergency power system       |        |            | accomplished for those reside   |                  |
|           |  | and maintenance requirements     |        |            | found to have been affected b   | y the            |
|           |  | Care Facilities Code, NFPA       |        |            | alleged deficient practice;   |                  |
|           |  | y Code in accordance with 42     |        |            |   |                  |
|           |  | This deficient practice could    |        |            | A.The appropriate vendor was  | 5                |
|           | affect all residents,  | staff and visitors.              |        |            | scheduled to complete the   |                  |
| T. P      |  |                                  |        |            | appropriate fuel analysis on e  |                  |
|           | Findings include:  |                                  |        |            | generator to be in compliance this standard.  | with             |
|           | a Based on record:   | review with the Administrator    |        |            | tilis standard.   |                  |
|           |  | ee Supervisor during from 9:10   |        |            | B.The appropriate vendor was  |                  |
|           |  | on 01/26/23, documentation of    |        |            | called and scheduled to comp  |                  |
|           | _  | ity test for the facility's two  |        |            | the required annual load test t   |                  |
|           | _  | ergency generators was not       |        |            | each generator to be in   |                  |
|           | available for review   | 7. Based on interview at the     |        |            | compliance with this standard   |                  |
|           |  | ew, the Administrator stated the |        |            |   |                  |
|           |  | sel fuel fired emergency         |        |            | c. The appropriate vendor was   |                  |
|           | 1 -  | ed documentation of an           |        |            | called and scheduled to comp  |                  |
|           |  | test for each of the two diesel  |        |            | the required supplemental loa   |                  |
|           |  | y generators was not available   |        |            | testing for four hours that is to   |                  |
|           | for review at the time   | ne of the survey.                |        |            | occur within the most recent the  | nree             |
|           | h Rased on review  | of "Emergency Generator -        |        |            | years.  |                  |
|           |  | documentation for the most       |        |            |   |                  |
|           |  | h period with the Administrator  |        |            | How other residents having th   | e                |
|           |  | w from 9:10 a.m. to 12:00 p.m.   |        |            | potential to be affected by the   |                  |
|           |  | cility has two diesel fuel fired |        |            | same alleged deficient practic  |                  |
|           |  | ors. One emergency generator     |        |            | will be identified and what   |                  |
|           | has a name plate ra  | ting of 350 kW and monthly       |        |            | corrective action will be taken   | ;                |
|           | load testing docume  | entation indicated monthly       |        |            |   |                  |
|           | _  | es 40 kW to 45 kW during load    |        |            | All residents residing at this  |                  |
|           |  | not meet or exceed 30% of the    |        |            | facility have the potential to be   | e                |
|           | name plate rating.   | The second emergency             | 1      |            | affected by the alleged deficie   | ent I            |

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|                          | OF CORRECTION   | IDENTIFICATION NUMBER  155859  | A. BUILDIN<br>B. WING | G   | COMPLETED 01/26/2023   |
|--------------------------|---|--|-----------------------|---|--|
|                          | PROVIDER OR SUPPLIER  |  | 501                   | eet address, city, state, zip co<br>I N 17TH AVE<br>ECH GROVE, IN 46107   | DD   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFI<br>TAC    | CROSS-REFERENCED TO THE AP  | ECTION (X5)  DULD BE COMPLETION PROPRIATE DATE   |
|                          | generator has a name monthly load testing monthly load testing testing. Based on it review, the Administ two diesel fuel fired 220 kW load value emergency generators agreed documentation of the two generators within the period was not available the survey.  c. Based on record rand the Maintenance review from 9:10 a. thirty-six month per testing documentation for the facility's two generators was not a interview at the time Administrator states fuel fired emergency documentation of sur four hours within the period was not available the survey.  These findings were | g documentation indicated g achieves 220 kW during load atterview at the time of record strator stated the facility has a emergency generators, the documented for the 60 kW or value was in error and on of an annual load bank test diesel fuel fired emergency e most recent twelve month lable for review at the time of every with the Administrator e Supervisor during record m. to 12:00 p.m. on 01/26/23, riod emergency generator on for four continuous hours of diesel fuel fired emergency available for review. Based on the of record review, the diesel fuel fired the facility has two diesels of generators and agreed applemental load testing for the most recent three year lable for review at the time of |                       | A.The appropriate vend called out to complete the appropriate fuel analysist generator to be in complete the standard.  B.The appropriate vend called and scheduled to the required annual load each generator to be in compliance with this standard.  C. The appropriate vend called and scheduled to the required supplement testing for four hours the occur within the most relevance.  What measures will be place and what systems changes will be made to that the alleged deficient does not recur;  The Maintenance staff vinserviced on required granes of completion of times.  Scheduled logs/calendarded added for documentation scheduling to ensure the deficient practice does in reoccur. | or was ne s on each diance with  or was complete d test to  indard.  dor was complete tal load at is to icent three  out into atic o ensure it practice  were generator d time load  ars were in and e alleged |

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|                          | OF CORRECTION  | IDENTIFICATION NUMBER  155859  | A. BUILDING B. WING   |   | COMPLETED 01/26/2023 |  |  |
|--------------------------|--|--|---|---|----------------------|--|--|
|                          | ROVIDER OR SUPPLIER<br>OF BEECH GROVE  |  | STREET ADDRESS, CITY, STATE, ZIP COD 501 N 17TH AVE BEECH GROVE, IN 46107 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | (X5) COMPLETION DATE |  |  |
| K 0000<br>Bldg. 01       | Licensure Survey w Department of Health 483.90(a).  Survey Date: 01/26/ Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety C Grove was found no Requirements for Pa CFR Subpart 483.90 the 2012 Edition of Association (NFPA) Chapter 19, Existing 410 IAC 16.2.  This facility was sur buildings due to the of different portions | 00391<br>15E247  | K 0000  | How will the corrective action monitored or QA will be put in place to ensure the alleged deficient practice will not recommonthly by the maintenance Director and/or designee and report findings to be provided the QA committee that will also monitor compliance. | ur;                  |  |  |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155859 |  | <br>JILDING   | 01                  | COMPL<br>01/26/   | ETED |                            |
|--|--|---|---------------------|---|------|----------------------------|
| NAME OF P  | PROVIDER OR SUPPLIER   |   |                     | ADDRESS, CITY, STATE, ZIP COD<br>7TH AVE  |      |                            |
| ENVIVE   | OF BEECH GROVE   |   |                     | GROVE, IN 46107   |      |                            |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE   | (X5)<br>COMPLETION<br>DATE |
| K 0346   | in 1997, was determ construction and ful had hard wired smo smoke barriers and Building 0202, cons fully sprinklered thr basement adjacent t separated by a two l be of Type I (332) c and the basement of was constructed in customary access to building. Building smoke detection systevel facility consist addition with each of ground level was deconstruction and ful Wing addition was fire alarm system w located near smoke capacity of 52 and hof this visit.  All areas where resi were sprinklered. T | lined to be of Type II (000)  ly sprinklered. Building 0102  ke detectors located near in all resident sleeping rooms.  sisting of the first floor of the ree story building with a to the health care center, and roomstruction. The first floor onstruction. The first floor onstruction. The first floor the adjacent building which 1959 was surveyed due to the chapel and Salon in the 1920 had a complete corridor of the Wilding 0302 is a split of the two floors exiting at termined to be of Type V (111)  ly sprinklered. The Therapy constructed in 2015 and has a ith hard wired smoke detection barriers. The facility has a had a census of 32 at the time  dents have customary access the facility has one detached cility storage services which |                     |   |      |                            |
| SS=F<br>Bldg. 01                                     | Fire Alarm System<br>Fire Alarm - Out o<br>Where required fir<br>services for more<br>period, the authori<br>be notified, and the<br>evacuated or an a   | f Service<br>e alarm system is out of<br>than 4 hours in a 24-hour<br>ty having jurisdiction shall  |                     |   |      |                            |

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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                          | 01  | COMPL |            |
|  |  | 155859   | B. W     | ING                              |   | 01/26 | /2023      |
|  |  | <u> </u>   | <u> </u> | STREET A                         | ADDRESS, CITY, STATE, ZIP COD   |       |            |
| NAME OF F  | PROVIDER OR SUPPLIER   | 8  |          |                                  | 17TH AVE  |       |            |
| ENVIVE   | OF BEECH GROVE   | <u> </u>   |          |                                  | I GROVE, IN 46107   |       |            |
| (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<br>CROSS-REFERENCE TO THE APPROPRIATE |       | COMPLETION |
| TAG  |  | R LSC IDENTIFYING INFORMATION                                |          | TAG                              | DEFICIENCY)   |       | DATE       |
|  |  | e fire alarm system has                                      |          |                                  |   |       |            |
|  | been returned to s   | service.   |          |                                  |   |       |            |
|  | 9.6.1.6  |  | 17.0     | 246                              | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\                                  |       | 02/26/2022 |
|  |  | view and interview, the facility                             | KU       | 346                              | What corrective action will be  | 4     | 02/26/2023 |
|  | _  | complete written policy for the nts indicating procedures to |          |                                  | accomplished for those reside   |       |            |
|  | 1 ~  |  |          |                                  | found to have been affected b   | y ine |            |
|  | be followed in the event the fire alarm system has   |  |          |                                  | alleged deficient practice;   |       |            |
|  | to be placed out-of-service for four hours or more in a twenty four hour period in accordance with |  |          |                                  | This Provider developed a   |       |            |
|  | I -  | 6. This deficient practice                                   |          |                                  | complete written policy indica  | tina  |            |
|  | affects all residents,   | -  |          |                                  | procedures to be followed in the  | •     |            |
|  | unces un residents,  | , stall and visitois.  |          |                                  | event of the fire alarm system  |       |            |
| Findings include:                                    |  |  |          | when out of service for more t   |   |       |            |
|  |  |  |          | 4 hours in a 24 hour period;     | IIIII   |       |            |
|  | Based on review of   | "Emergency Disaster  |          |                                  | procedure for fire watch and p  | roner |            |
|  |  | gency Procedure - Fire                                       |          | authorities to be notified       |   | порог |            |
|  | _  | tion dated 01/06/23 with the                                 |          | consistent with the requirements |   | nts   |            |
|  |  | he Maintenance Supervisor                                    |          |                                  | of LSC, Section 9.6.1.6.  |       |            |
|  |  | w from 9:10 a.m. to 12:00 p.m.                               |          |                                  |   |       |            |
|  | _  | e watch plan for fire alarm                                  |          |                                  | How other residents having th   | е     |            |
|  |  | was incomplete. The plan did                                 |          |                                  | potential to be affected by the   |       |            |
|  |  | when a fire watch for fire alarm                             |          |                                  | same alleged deficient practic  |       |            |
|  |  | itiated. The plan did not state                              |          |                                  | will be identified and what   |       |            |
|  | when the required f  | -  |          |                                  | corrective action will be taken   |       |            |
|  | out-of-service for m   | nore than 4 hours in a 24-hour                               |          |                                  |   |       |            |
|  | period, the authority  | y having jurisdiction shall be                               |          |                                  | All residents residing at this  |       |            |
|  | notified, and the but  | ilding shall be evacuated or an                              |          |                                  | facility have the potential to be                                       | •     |            |
|  | approved fire watch  | shall be provided for all                                    |          |                                  | affected by the same alleged  |       |            |
|  | 1 ^ ^  | eted by the shutdown until the                               |          |                                  | practice.   |       |            |
|  | · ·  | as been returned to service.                                 |          |                                  |   |       |            |
|  | 1 ^  | to contact the Indiana                                       |          |                                  | This Provider reviewed curren   | ıt    |            |
|  |  | th via the IDOH Gateway link                                 |          |                                  | systems and developed a   |       |            |
|  |  | sdh.in.gov as the primary                                    |          |                                  | complete written policy indicat   | _     |            |
|  | I -  | condary method when the                                      |          |                                  | procedures to be followed in the  |       |            |
|  |  | nonoperational by completing                                 |          |                                  | event of the fire alarm system  |       |            |
|  |  | ing form and e-mailing it to                                 |          |                                  | when out of service for more t  | han   |            |
|  | incidents@isdh.in.gov. Based on interview at the time of record review, the Administrator agreed   |  |          |                                  | 4 hours in a 24 hour period;  |       |            |
|  |  |  |          |                                  | procedure for fire watch and p  | roper |            |
|  |  | mentation for fire alarm system                              |          |                                  | authorities to be notified  |       |            |
|  | impairment was inc   | omplete.   |          |                                  | consistent with the requiremen  | nts   |            |

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| STATEMEN  | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION |          | (X3) DATE SURVEY  |       |            |
|-----------|----------------------|-------------------------------|----------------------------|----------|---|-------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BU                      | JILDING  | 01  | COMPL | ETED       |
|           |                      | 155859                        | B. W                       | ING      |   | 01/26 | /2023      |
|           |                      |                               |                            | STREET A | ADDRESS, CITY, STATE, ZIP COD   |       |            |
| NAME OF P | ROVIDER OR SUPPLIER  |                               |                            |          | 7TH AVE   |       |            |
| FNVIVE (  | OF BEECH GROVE       | =                             | BEECH GROVE, IN 46107      |          |   |       |            |
|           |                      |                               |                            |          |   |       | ı          |
| (X4) ID   | SUMMARY S            | STATEMENT OF DEFICIENCIE      |                            | ID       | PROVIDER'S PLAN OF CORRECTION   |       | (X5)       |
| PREFIX    | *                    | CY MUST BE PRECEDED BY FULL   | PREFIX                     |          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |       | COMPLETION |
| TAG       | REGULATORY OR        | LSC IDENTIFYING INFORMATION   |                            | TAG      | DEFICIENCY  |       | DATE       |
|           |                      |                               |                            |          | of LSC, Section 9.6.1.6.  |       |            |
|           |                      | viewed with the Administrator |                            |          |   |       |            |
|           | during the exit conf | erence.                       |                            |          | What measures will be put into  | )     |            |
|           | 3.1-19(b)            |                               |                            |          | place and what systematic   |       |            |
|           |                      |                               |                            |          | changes will be made to ensu  |       |            |
|           |                      |                               |                            |          | that the alleged deficient pract  | ice   |            |
|           |                      |                               |                            |          | does not recur;   |       |            |
|           |                      |                               |                            |          |   |       |            |
|           |                      |                               |                            |          | The Maintenance staff were  |       |            |
|           |                      |                               |                            |          | inserviced on the Fire Watch  |       |            |
|           |                      |                               |                            |          | policy, notifications and time  |       |            |
|           |                      |                               |                            |          | frames consisted with the   |       |            |
|           |                      |                               |                            |          | requirements of LSC, Section  |       |            |
|           |                      |                               |                            |          | 9.6.1.6.  |       |            |
|           |                      |                               |                            |          |   |       |            |
|           |                      |                               |                            |          | This Provider developed a   |       |            |
|           |                      |                               |                            |          | complete written policy indicat   | _     |            |
|           |                      |                               |                            |          | procedures to be followed in the  | ne    |            |
|           |                      |                               |                            |          | event of the fire alarm system  |       |            |
|           |                      |                               |                            |          | when out of service for more the  | nan   |            |
|           |                      |                               |                            |          | 4 hours in a 24 hour period;  |       |            |
|           |                      |                               |                            |          | procedure for fire watch and p  | roper |            |
|           |                      |                               |                            |          | authorities to be notified  |       |            |
|           |                      |                               |                            |          | consistent with the requiremen  | าเร   |            |
|           |                      |                               |                            |          | of LSC, Section 9.6.1.6.  |       |            |
|           |                      |                               |                            |          | How will the corrective actions   |       |            |
|           |                      |                               |                            |          | monitored or QA will be put int   | .0    |            |
|           |                      |                               |                            |          | place to ensure the alleged   |       |            |
|           |                      |                               |                            |          | deficient practice will not recu  | Γ;    |            |
|           |                      |                               |                            |          | The new and undeted neglective  | /ill  |            |
|           |                      |                               |                            |          | The new and updated policy w  | /111  |            |
|           |                      |                               |                            |          | be added to the facility  | awad  |            |
|           |                      |                               |                            |          | Emergency Plan which is revie   |       |            |
|           |                      |                               |                            |          | and updated annually. This pl   |       |            |
|           |                      |                               |                            |          | will be reviewed by the monthl  | у     |            |
|           |                      |                               |                            |          | QA committee to ensure it is  |       |            |
|           |                      |                               |                            |          | consistent with the LSC stands  | ards  |            |
|           |                      |                               |                            |          | and updated as needed.  |       |            |
|           |                      |                               | I                          |          | l   |       | I          |

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|                            | T OF DEFICIENCIES<br>OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155859                          | (X2) MULTIPLE C A. BUILDING B. WING | construction 01   | (X3) DATE SURVEY COMPLETED 01/26/2023 |  |
|----------------------------|--|--|-------------------------------------|---|---------------------------------------|--|
|                            | ROVIDER OR SUPPLIER<br>OF BEECH GROVE  |  | 501 N                               | ADDRESS, CITY, STATE, ZIP COD<br>17TH AVE<br>H GROVE, IN 46107  |                                       |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE                  |  |
| K 0353<br>SS=F<br>Bldg. 01 | Sprinkler System - Automatic sprinkler are inspected, test accordance with Nonspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAF coverage for any reautomatic sprinkler 9.7.5, 9.7.7, 9.7.8, Based on record revinterview; the facility system inspections in NFPA 25, Standard and Maintenance of Systems, 2011 Editing gauges on wet pipe inspected monthly the condition and that me is being maintained and fire department inspected, tested, and with Chapter 13. Section 4.3.1 all inspections, tests system and its comparison of the system and its compari | supply source  RKS information on non-required or partial or system.             | K 0353                              | What corrective action will be accomplished for those reside found to have been affected be alleged deficient practice;  This Provider developed logsensure monthly sprinkler systems gauge and valve inspection is documented and checked earnough to ensure systems are properly working.  How other residents having the potential to be affected by the same alleged deficient practic will be identified and what corrective action will be taken.  All residents residing in the face | ents by the  to em ch ch              |  |

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| STATEMEN  | NT OF DEFICIENCIES              | X1) PROVIDER/SUPPLIER/CLIA         | (X2) MULTIPLE CONSTRUCTION (X  |                                  |   | (X3) DATE SURVEY |            |
|---|---------------------------------|------------------------------------|--------------------------------|----------------------------------|---|------------------|------------|
| AND PLAN  | OF CORRECTION                   | IDENTIFICATION NUMBER              | A. BU                          | JILDING                          | 01  | COMPL            | ETED       |
|   |                                 | 155859                             | B. W                           | ING                              |   | 01/26/           | 2023       |
|   |                                 |                                    |                                | CTREET                           | ADDRESS CITY STATE ZID COD  |                  |            |
| NAME OF I                                       | PROVIDER OR SUPPLIEF            | 2                                  |                                |                                  | ADDRESS, CITY, STATE, ZIP COD   |                  |            |
|   | OF BEECH GROVE                  | _                                  |                                |                                  | TOPOVE IN 46407   |                  |            |
| EINVIVE   | OF BEECH GROVE                  | =                                  |                                | BEECH                            | I GROVE, IN 46107   |                  |            |
| (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 | TF               | COMPLETION |
| TAG   | REGULATORY OF                   | R LSC IDENTIFYING INFORMATION      |                                | TAG                              | DEFICIENCY)   |                  | DATE       |
|   | request. This defici            | ient practice could affect all     |                                |                                  | have the potential to be affecte  | ed               |            |
|   | residents, staff, and visitors. |                                    |                                |                                  | by the alleged deficient practic  | e.               |            |
|   |                                 |                                    |                                |                                  |   |                  |            |
|   |                                 |                                    |                                |                                  | This Provider developed logs  | to               |            |
|   |                                 |                                    | ensure monthly sprinkler syste | em                               |   |                  |            |
|   | Based on record rev             | view with the Administrator        |                                |                                  | gauge and valve inspection is   |                  |            |
|   | and the Maintenanc              | ee Supervisor from 9:10 a.m. to    |                                |                                  | documented and checked eac  | h                |            |
|   | 12:00 p.m. on 01/20             | 6/23, monthly sprinkler system     |                                |                                  | month to ensure systems are   |                  |            |
|   | _                               | spection documentation for         |                                |                                  | properly working.   |                  |            |
|   |                                 | most recent twelve month           |                                |                                  |   |                  |            |
| period was not available for review. Review of  |                                 |                                    |                                |                                  | What measures will be put into  | )                |            |
| "Sprinkler Inspection Report" documentation     |                                 |                                    |                                |                                  | place and what systematic   |                  |            |
| dated 03/15/22, 08/19/22 and 11/23/22 indicated |                                 |                                    |                                |                                  | changes will be made to ensu  | re               |            |
| the sprinkler system inspection contractor      |                                 |                                    |                                | that the alleged deficient pract |   |                  |            |
|   |                                 | r system gauge and valve           |                                |                                  | does not recur;   |                  |            |
|   |                                 | e months of the most recent        |                                |                                  | ,   |                  |            |
|   | _                               | d but additional sprinkler         |                                |                                  | The maintenance staff were  |                  |            |
|   | system gauge and v              |                                    |                                |                                  | inserviced on the documentati   | on               |            |
|   |                                 | the most recent twelve month       |                                |                                  | logs and requirements of mon  |                  |            |
|   |                                 | lable for review. Based on         |                                |                                  | gauge and valve inspections.  |                  |            |
|   | _                               | he Administrator and the           |                                |                                  | gaage and valve inspections.  |                  |            |
|   |                                 | visor during a tour of the         |                                |                                  | This Provider developed logs  | 'n               |            |
|   | _                               | p.m. to 1:00 p.m. on 01/26/23, the |                                |                                  | ensure monthly sprinkler syste  |                  |            |
|   | -                               | sed wet sprinkler systems.         | gauge and valve inspection is  |                                  |   | ,,,,             |            |
|   |                                 | at 1:10 p.m. on 01/26/23, the      |                                |                                  | documented and checked each   | h                |            |
|   |                                 | visor stated "no sir, I do not"    |                                |                                  | month to ensure systems are   |                  |            |
|   | _                               | g asked if the facility performs   |                                |                                  | properly working.   |                  |            |
|   |                                 | gauge and valve inspections in     |                                |                                  | Property working.   |                  |            |
|   | addition to the cont            |                                    |                                |                                  | How will the corrective actions   | he               |            |
|   | addition to the cont            | пастот півросноїв.                 |                                |                                  | monitored or QA will be put int   |                  |            |
|   | This finding was re             | viewed with the Administrator      |                                |                                  | place to ensure the alleged   | .0               |            |
|   | during the exit conf            |                                    |                                |                                  | deficient practice will not recu  | r.               |            |
|   | daring the exit coll            | erence.                            |                                |                                  | denoterit practice will not recu  | ١,               |            |
|   | 3.1-19(b)                       |                                    |                                |                                  | The sprinkler system gauge a  | nd               |            |
|   | 3.1-17(0)                       |                                    |                                |                                  | valve inspection logs will be   | ıu               |            |
|   |                                 |                                    |                                |                                  | reviewed monthly for the  |                  |            |
|   |                                 |                                    |                                |                                  | completion by the Maintenanc  | •                |            |
|   |                                 |                                    |                                |                                  | Director and or designee. The   |                  |            |
|   |                                 |                                    |                                |                                  | _   |                  |            |
|   |                                 |                                    |                                |                                  | logs will be provided to the QA committee to monitor and che                                      |                  |            |
|   |                                 |                                    |                                |                                  | Committee to monitor and che  | JK.              |            |

|                            | EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTURE (X2) MULTIPLE |   |                     | (X3) DATE SURVEY  COMPLETED  01/26/2023   |   |
|----------------------------|--|---|---------------------|---|---|
|                            | ROVIDER OR SUPPLIER<br>OF BEECH GROVE  |   | 501 N               | ADDRESS, CITY, STATE, ZIP COD<br>17TH AVE<br>H GROVE, IN 46107  |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE                    |
| IX 0254                    | NEDA 404   |   |                     | monthly for proper documenta and completion.  | ation                                   |
| K 0354<br>SS=F<br>Bldg. 01 | extent and duration been determined, are inspected and recommendations management or deand the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record revisaled to provide a containing procedur protection of all result automatic sprinkler out-of-service for 10 period in accordance 9.7.5 requires sprinkler comply with NFPA Inspection, Testing Water-Based Fire P Edition, Section 15. that the impairment deficient practice coand visitors.   | or Out of Service er system is impaired, the n of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been | K 0354              | What corrective action will be accomplished for those reside found to have been affected be alleged deficient practice;  This Provider developed a complete written policy indica procedures to be followed in the event of the fire alarm system when out of service for more at 4 hours in a 24 hour period; procedure for fire watch and pauthorities to be notified consistent with the requirement of LSC, Section 9.6.1.6.  How other residents having the potential to be affected by the same alleged deficient practice. | ents by the  ating the than broper ents |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |  |                     | (X3) DATE SURVEY COMPLETED 01/26/2023  |                   |                            |
|--|--|--|--|---------------------|--|-------------------|----------------------------|
|  | PROVIDER OR SUPPLIER<br>OF BEECH GROVE   |  |  | 501 N 1             | ADDRESS, CITY, STATE, ZIP COD<br>I TTH AVE<br>I GROVE, IN 46107  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE                | (X5)<br>COMPLETION<br>DATE |
|  | Preparedness: Eme<br>Watch" documenta  | rgency Procedure - Fire<br>tion dated 01/06/23 with the<br>he Maintenance Supervisor   |  |                     | will be identified and what corrective action will be taken;   |                   |                            |
|  | during record revie<br>on 01/26/23, the fir<br>system impairment<br>not expressly state  | w from 9:10 a.m. to 12:00 p.m. e watch plan for sprinkler was incomplete. The plan did when a fire watch would be did not state when the required  |  |                     | All residents residing at this facility have the potential to be affected by the same alleged practice.  | •                 |                            |
|  | automatic sprinkler hours or more in a 2 having jurisdiction building shall be ev watch shall be prov unprotected by the system has been ret also failed to contact having jurisdiction, contacting the India the IDOH Gateway https://gateway.isdl or by the secondary Gateway is nonope Incident Reporting incidents@isdh.in.g | system is out-of-service for 10 24-hour period, the authority shall be notified, and the racuated or an approved fire ided for all parties left shutdown until the sprinkler urned to service. The plan et IDOH, which is an authority and failed to include una Department of Health via link at n.in.gov as the primary method method when the IDOH rational by completing the form and e-mailing it to gov. The fire watch policy for |  |                     | This Provider reviewed curren systems and developed a complete written policy indicat procedures to be followed in the event of the fire alarm system when out of service for more to 4 hours in a 24 hour period; procedure for fire watch and pauthorities to be notified consistent with the requirement of LSC, Section 9.6.1.6.  What measures will be put into place and what systematic changes will be made to ensure that the alleged deficient practice. | ing han roper hts |                            |
|  | to contact the alarm<br>building owner and<br>required automatic<br>out-of-service for 1<br>period. Based on in<br>review, the Admini<br>plan for sprinkler sy<br>incomplete.  | system impairment also failed<br>a monitoring company, the<br>the insurance company if the<br>sprinkler system is<br>0 hours or more in a 24-hour<br>nterview at the time of record<br>strator agreed the fire watch<br>system impairment was  |  |                     | does not recur;  The Maintenance staff were inserviced on the Fire Watch policy, notifications and time frames consisted with the requirements of LSC, Section 9.6.1.6.  This Provider developed a   |                   |                            |
|  | This finding was re during the exit conf 3.1-19(b)   | viewed with the Administrator erence.  |  |                     | complete written policy indicat<br>procedures to be followed in the<br>event of the fire alarm system<br>when out of service for more the<br>4 hours in a 24 hour period;<br>procedure for fire watch and p  | ne<br>han         |                            |

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PRINTED: 03/23/2023

|                            | T OF HEALTH AND HU<br>R MEDICARE & MEDIO  |  |     |                     |   |  | RM APPROVED<br>IB NO. 0938-039 |
|----------------------------|---|--|-----|---------------------|---|--|--------------------------------|
| STATEME                    | NT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155859  |     | JILDING             | ONSTRUCTION  01   | (X3) DATE SURVEY COMPLETED 01/26/2023  |                                |
|                            | PROVIDER OR SUPPLIE   |  | •   | 501 N               | ADDRESS, CITY, STATE, ZIP COD<br>17TH AVE<br>1 GROVE, IN 46107  |  |                                |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | TE                                     | (X5)<br>COMPLETION<br>DATE     |
|                            |   |  |     |                     | authorities to be notified consistent with the requirement of LSC, Section 9.6.1.6.  How will the corrective actions monitored or QA will be put integrated by the alleged deficient practice will not recurrent to the facility. Emergency Plan which is reviewed updated annually. This play will be reviewed by the monthly QA committee to ensure it is consistent with the LSC standard updated as needed. | s be<br>to<br>r;<br>vill<br>ewed<br>an |                                |
| K 0521<br>SS=F<br>Bldg. 01 | comply with 9.2 a accordance with specifications. 18.5.2.1, 19.5.2.1 Based on record reinterview; the facil dampers in the faci provided necessary recent four year pe 90A. LSC 9.2.1 reair conditioning (H | on, and air conditioning shall and shall be installed in the manufacturer's  1, 9.2  view, observation and ity failed to ensure all fire dity were inspected and maintenance within the most riod in accordance with NFPA equires heating, ventilating and (VAC) ductwork and related in accordance with NFPA 90A, | K 0 | 521                 | What corrective action will be accomplished for those reside found to have been affected b alleged deficient practice;  The appropriate vendor was c and scheduled to inspect and provide any necessary   | y the                                  | 02/26/2023                     |

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Standard for the Installation of Air-Conditioning

Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard

NFPA 80, 2010 Edition, Section 19.4.1 states each

and Ventilating Systems. NFPA 90A, 2012

for Fire Doors and Other Opening Protectives.

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standard.

If continuation sheet

maintenance as required by this

How other residents having the

potential to be affected by the

same alleged deficient practice

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |                     | (X3) DATE SURVEY  COMPLETED  01/26/2023  |                      |
|--|--|--|---------------------|--|----------------------|
|  | ROVIDER OR SUPPLIER  |  | 501 1               | ET ADDRESS, CITY, STATE, ZIP COD<br>N 17TH AVE<br>CH GROVE, IN 46107   |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  | (X5) COMPLETION DATE |
|  | damper shall be test<br>installation. The tes  | ted and inspected 1 year after st and inspection frequency ars. If the damper is equipped  |                     | will be identified and what corrective action will be take   |                      |
|  | with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the   |  |                     | All residents residing in the healthcare center has the po to be affected by the alleged deficient practice.   |                      |
|  | location of the fire on name of inspector a The documentation  | umented, indicating the damper, date of inspection, and deficiencies discovered. shall have a space to indicate deficiencies were corrected.   |                     | The appropriate vendor was and scheduled to inspect and provide any necessary maintenance as required by   | d                    |
|  | the fire damper shall  | s full unobstructed access to  ll be verified and corrected as cient practice could affect all   |                     | standard.  What measures will be put in  | nto                  |
|  | Findings include:  | VISITOIS.  |                     | place and what systematic<br>changes will be made to ens<br>that the alleged deficient pra<br>does not recur;  |                      |
|  | and the Maintenanc<br>12:00 p.m. on 01/26<br>damper inspections<br>recent four year per<br>review. Based on o<br>Administrator and t   | view with the Administrator ee Supervisor from 9:10 a.m. to 5/23, documentation of fire conducted within the most riod was not available for observations with the he Maintenance Supervisor       |                     | The Maintenance staff were inserviced on the requirementh this standard to ensure ongoinspection and maintenance occurs within the required tinframe for all fire dampers. | ing                  |
|  | p.m. on 01/26/23, a<br>HVAC ductwork w<br>fire resistance rated<br>suspended ceiling a<br>Room 130 in the A  | facility from 12:00 p.m. to 1:00 fire damper was noted in hich penetrated the two hour smoke barrier wall above the bove the corridor door set by Wing and above the bove the corridor door set by |                     | The appropriate vendor was and scheduled to inspect and provide any necessary maintenance as required by standard.   | d                    |
|  | Room 144 in the B to the fire dampers most recent inspects maintenance. A she corridor wall above of the two fire dampers and the two fire dampers are the same than the s | Wing. Documentation affixed did not provide the date of the ion and necessary eet of paper was affixed to the the suspended ceiling at each per locations indicating the                           |                     | How will the corrective action monitored or QA will be put it place to ensure the alleged deficient practice will not reconstruction.                                      | nto<br>cur;<br>et up |
| i  | most recent fire dan   | nper inspection and necessary  | 1                   | with the vendor and calenda  | r                    |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |   | (X3) DATE SURVEY COMPLETED 01/26/2023 |                            |
|--|--|---|--|---------------------|---|---------------------------------------|----------------------------|
|  | ROVIDER OR SUPPLIER<br>OF BEECH GROVE  |   |  | 501 N 1             | ADDRESS, CITY, STATE, ZIP COD<br>7TH AVE<br>GROVE, IN 46107   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION             |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | ΓE                                    | (X5)<br>COMPLETION<br>DATE |
|  | interview at the time<br>observations, the M<br>additional fire damp<br>documentation was<br>agreed documentatic<br>conducted within the<br>was not available for  | viewed with the Administrator   |  |                     | developed by provider to moni compliance of fire dampers. T monitoring will occur by the Maintenance Director and/or designee. The QA committee review and monitor monthly ar annually to ensure completion ongoing compliance. | his<br>will<br>nd                     |                            |
|  | 3.1-19(b)  | erence.   |  |                     |   |                                       |                            |
| K 0712<br>SS=F<br>Bldg. 01   | alarm signal and seconditions. Fire drand unexpected ticonditions, at leas The staff is familia aware that drills at routine. Where draware that drills at 19.70 PM and 6:00 announcement manualible alarms.  19.7.1.4 through 1 Based on record reversal failed to document of the staff and the staff and the staff at the staff and the staff at the staff and the staff at the st | ay be used instead of   | K 0  | 712                 | What corrective action will be accomplished for those resider found to have been affected by  |                                       | 02/26/2023                 |
|  | the second and third<br>deficient practice af<br>visitors.<br>Findings include:<br>Based on review of  | d shift for 2 of 4 quarters. This fects all residents, staff and "Fire/Disaster Drill", "Fire Drill |  |                     | An annual fire drill schedule was developed by Envive Healthca upon taking over operations or Oct 1, 2022. This schedule is being followed to ensure a fire   | as<br>re<br>1                         |                            |
|  | Report" and "Recor   |   |  |                     | is conducted on each shift for  |                                       |                            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |       | (X3) DATE SURVEY  COMPLETED  01/26/2023  |   |
|--|--|---|-------|--|---|
|  | PROVIDER OR SUPPLIER   |   | 501 N | ET ADDRESS, CITY, STATE, ZIP COD<br>N 17TH AVE<br>CH GROVE, IN 46107   |   |
|  | SUMMARY:  (EACH DEFICIEN  REGULATORY OR  documentation with  Maintenance Super from 9:10 a.m. to 12 documentation of a fire drill or staff trai procedures in the se June) 2022 and thire September) 2022 w  Based on interview the Administrator so shifts per day and a drill or staff training second and third shi calendar quarters w | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION The Administrator and the visor during record review 2:00 p.m. on 01/26/23, second shift and a third shift uning documentation on fire drill record quarter (April, May, d quarter (July, August, as not available for review. at the time of record review, rated the facility operates three greed documentation of a fire g on fire drill procedures for the ifts in the aforementioned as not available for review. | 501 N | N 17TH AVE CH GROVE, IN 46107  PROVIDER'S PLAN OF CORRECTION   | d on he e ce n; ial to ged I fire e  This d on to ure ctice |
|  |  |   |       | varying conditions, at least quarterly on each shift.  Maintenance staff were inserved on the required fire drill sche and requriement of conducting drills quarterly on each shift. | dule  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |       |                     | (X3) DATE SURVEY COMPLETED 01/26/2023   |       |                            |
|--|---|---|-------|---------------------|---|-------|----------------------------|
|  |   | 155859  | B. WI | NG                  |   | 01/26 | /2023                      |
|  | PROVIDER OR SUPPLIE   |   |       | 501 N 1             | ADDRESS, CITY, STATE, ZIP COD<br>I TTH AVE<br>I GROVE, IN 46107   |       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION |       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | ATE   | (X5)<br>COMPLETION<br>DATE |
| K 0918<br>SS=F<br>Bldg. 01   | NFPA 101 Electrical System Electrical System System Maintena The generator or source and assoc of supplying servi 10-second criterio monthly test, a pr annually confirm safety and critical and testing of the switches are perf NFPA 110. Generator sets are exercised under I year in 20-40 day once every 36 mc Scheduled test un a complete simula automatic or man loads, and are co personnel. Mainte energy power sou | s - Essential Electric Syste<br>s - Essential Electric                                    |       | IAU                 | How will the corrective action monitored or QA will be put in place to ensure the alleged deficient practice will not recomposed. This system will be monitored monthly by the maintenance Director and/or designee and report and findings provided to QA committee that will also monitor compliance. | ur;   |                            |

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| · ´           |  | X1) PROVIDER/SUPPLIER/CLIA                                 | (X2) MULTIPLE CONSTRUCTION |               |   | (X3) DATE SURVEY |                    |
|---------------|--|--|----------------------------|---------------|---|------------------|--------------------|
| AND PLAN      | OF CORRECTION                              | IDENTIFICATION NUMBER                                      | A. BU                      | JILDING       | 01  | COMPL            |                    |
|               |  | 155859   | B. W                       | ING           |   | 01/26/           | 2023               |
| NAME OF 1     | PROVIDER OR SUPPLIEF                       | <b>.</b>   |                            |               | ADDRESS, CITY, STATE, ZIP COD   |                  |                    |
|               |  |  |                            |               | 17TH AVE  |                  |                    |
| ENVIVE        | OF BEECH GROVE                             | <b>=</b>   |                            | REECH         | I GROVE, IN 46107   |                  |                    |
| (X4) ID       |  | STATEMENT OF DEFICIENCIE                                   |                            | ID            | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)               |
| PREFIX<br>TAG |  | ICY MUST BE PRECEDED BY FULL                               |                            | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE              | COMPLETION<br>DATE |
| TAU           |  | R LSC IDENTIFYING INFORMATION Te inspected annually, and a | +                          | IAU           |   |                  | DATE               |
|               |  | dically exercising the                                     |                            |               |   |                  |                    |
|               |  | tablished according to                                     |                            |               |   |                  |                    |
|               | manufacturer requirements. Written records |  |                            |               |   |                  |                    |
|               |  | nd testing are maintained                                  |                            |               |   |                  |                    |
|               |  | ble. EES electrical panels                                 |                            |               |   |                  |                    |
|               |  | arked, readily identifiable,                               |                            |               |   |                  |                    |
|               |  | n normal power circuits.                                   |                            |               |   |                  |                    |
|               | -  | ssibility of damage of the                                 |                            |               |   |                  |                    |
|               |  | source is a design   |                            |               |   |                  |                    |
|               | consideration for i                        | new installations.   |                            |               |   |                  |                    |
|               | 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,   |  |                            |               |   |                  |                    |
|               | NFPA 111, 700.10 (NFPA 70)                 |  |                            |               |   |                  |                    |
|               |  | review and interview, the                                  | K 0                        | 918           | What corrective action will be  |                  | 02/26/2023         |
|               | -  | sure an annual fuel quality test                           |                            |               | accomplished for those reside   |                  |                    |
|               | _  | the facility's two diesel fuel                             |                            |               | found to have been affected b   | y the            |                    |
|               |  | nerators. NFPA 99, Health                                  |                            |               | alleged deficient practice;   |                  |                    |
|               |  | e, 2012 Edition, Section                                   |                            |               |   |                  |                    |
|               |  | ype 2 EES (Essential Electrical                            |                            |               | A.The appropriate vendor was  | 3                |                    |
|               |  | sets shall be inspected and                                |                            |               | scheduled to complete the   |                  |                    |
|               |  | e with Section 6.4.4.1.1.3.                                |                            |               | appropriate fuel analysis on e  |                  |                    |
|               |  | states maintenance shall be                                |                            |               | generator to be in compliance   | with             |                    |
|               | 1 -  | dance with NFPA 110, Standard                              |                            |               | this standard.  |                  |                    |
|               |  | Standby Power Systems, 2010                                |                            |               | D. The appropriate wards were   |                  |                    |
|               | _  | NFPA 110, Section 8.3.8 states nall be performed at least  |                            |               | B.The appropriate vendor was  |                  |                    |
|               |  | s approved by ASTM   |                            |               | called and scheduled to comp<br>the required annual load test t                       |                  |                    |
|               |  | icient practice could affect all                           |                            |               | each generator to be in   | lO .             |                    |
|               | residents, staff and                       |  |                            |               | compliance with this standard   |                  |                    |
|               | residents, starr and                       | v 1010013.   |                            |               | Compliance with this standard   | •                |                    |
|               | Findings include:                          |  |                            |               | c. The appropriate vendor was   | s                |                    |
|               |  |  |                            |               | called and scheduled to comp  |                  |                    |
|               | Based on record rev                        | view with the Administrator                                |                            |               | the required supplemental loa   |                  |                    |
|               | and the Maintenanc                         | ee Supervisor during from 9:10                             |                            |               | testing for four hours that is to   |                  |                    |
|               | a.m. to 12:00 p.m. o                       | on 01/26/23, documentation of                              |                            |               | occur within the most recent the  | hree             |                    |
|               | _  | ity test for the facility's two                            |                            |               | years.  |                  |                    |
|               |  | ergency generators was not                                 |                            |               |   |                  |                    |
|               |  | v. Based on interview at the                               |                            |               | How other residents having th   | ie               |                    |
|               |  | ew, the Administrator stated the                           |                            |               | potential to be affected by the   |                  |                    |
|               | facility has two dies                      | sel fuel fired emergency                                   |                            |               | same alleged deficient practic  | e                |                    |

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| STATEMEN  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M | ULTIPLE CO | ONSTRUCTION  | (X3) DATE | SURVEY     |
|-----------|----------------------|-----------------------------------|--------|------------|--|-----------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER             | A. BU  | JILDING    | 01   | COMPL     | ETED       |
|           |                      | 155859                            | B. W   | NG         |  | 01/26/    | /2023      |
|           |                      |                                   |        | CTREET     | ADDRESS, CITY, STATE, ZIP COD  |           |            |
| NAME OF I | PROVIDER OR SUPPLIE  | R                                 |        |            | 17TH AVE   |           |            |
| ENIVIVE   | OF BEECH GROV        | E                                 |        |            | 17 111 AVE<br>1 GROVE, IN 46107  |           |            |
| EINVIVE   | OF BEECH GROV        | <u> </u>                          |        | BEECI      | 1 GROVE, IN 40107  |           |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | ATE       | COMPLETION |
| TAG       | REGULATORY O         | R LSC IDENTIFYING INFORMATION     |        | TAG        | DEFICIENCY)  |           | DATE       |
|           |                      | eed documentation of an           |        |            | will be identified and what  |           |            |
|           |                      | test for each of the two diesel   |        |            | corrective action will be taken  | ;         |            |
|           | _                    | cy generators was not available   |        |            |  |           |            |
|           | for review at the ti | me of the survey.                 |        |            | All residents residing at this   |           |            |
|           |                      |                                   |        |            | facility have the potential to be                                      | 9         |            |
|           |                      | eviewed with the Administrator    |        |            | affected by the alleged deficie  | nt        |            |
|           | during the exit con  | ference.                          |        |            | practice.  |           |            |
|           |                      |                                   |        |            |  |           |            |
|           | 3.1-19(b)            |                                   |        |            | A.The appropriate vendor was   | 3         |            |
|           |                      |                                   |        |            | called out to complete the   |           |            |
|           |                      | review and interview, the         |        |            | appropriate fuel analysis on e   |           |            |
|           |                      | ercise 2 of 2 emergency           |        |            | generator to be in compliance  | with      |            |
|           | -                    | y to meet the requirements of     |        |            | this standard.   |           |            |
|           |                      | Edition, the Standard for         |        |            |  |           |            |
|           |                      | andby Powers Systems, Chapter     |        |            | B.The appropriate vendor was   |           |            |
|           |                      | 2 states diesel generator sets in |        |            | called and scheduled to comp   |           |            |
|           |                      | ercised at least once monthly,    |        |            | the required annual load test t  | iO        |            |
|           |                      | 30 minutes, using one of the      |        |            | each generator to be in  |           |            |
|           | following methods    |                                   |        |            | compliance with this standard  |           |            |
|           |                      | aintains the minimum exhaust      |        |            |  |           |            |
|           |                      | s recommended by the              |        |            | c. The appropriate vendor was  |           |            |
|           | manufacturer         |                                   |        |            | called and scheduled to comp   |           |            |
|           |                      | g temperature conditions and at   |        |            | the required supplemental loa  |           |            |
|           | _                    | rcent of the EPS (Emergency       |        |            | testing for four hours that is to                                      |           |            |
|           | Power Supply) nar    | -                                 |        |            | occur within the most recent the                                       | nree      |            |
|           |                      | tes diesel-powered EPS            |        |            | years.   |           |            |
|           |                      | o not meet the requirements of    |        |            |  |           |            |
|           |                      | eised monthly with the available  |        |            | What measures will be put into   | 0         |            |
|           | ` .                  | Power Supply System) load and     |        |            | place and what systematic  |           |            |
|           |                      | annually with supplemental        |        |            | changes will be made to ensu   |           |            |
|           |                      | Test) at not less than 50 percent |        |            | that the alleged deficient pract                                       | tice      |            |
|           | _                    | ate kW rating for 30 continuous   |        |            | does not recur;  |           |            |
|           |                      | less than 75 percent of the EPS   |        |            | The Maintain 4 of  |           |            |
|           |                      | ng for 1 continuous hour for a    |        |            | The Maintenance staff were   | 4         |            |
|           |                      | of not less than 1.5 continuous   |        |            | inserviced on required genera  | itor      |            |
|           |                      | ent practice could affect all     |        |            | fuel testing, proper load  |           |            |
|           | residents, staff and | VISITORS.                         |        |            | documentation, required time   |           |            |
|           | Dim dies in 1 1      |                                   |        |            | frames of completion of load   |           |            |
|           | Findings include:    |                                   |        |            | times.   |           |            |
| I         | 1                    |                                   | 1      |            | 1  |           | I          |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155859 |  | (X2) MULTIPLE C A. BUILDING B. WING  | onstruction<br><u>01</u> | (X3) DATE SURVEY  COMPLETED  01/26/2023   |                      |
|--|--|--|--------------------------|---|----------------------|
|  | PROVIDER OR SUPPLIER   |  | 501 N                    | ADDRESS, CITY, STATE, ZIP COD<br>17TH AVE<br>H GROVE, IN 46107  |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)   | (X5) COMPLETION DATE |
|  | Monthly Test Log" recent twelve month during record review on 01/26/23, the face emergency generate has a name plate rat load testing docume load testing achieve testing which does name plate rating.  | "Emergency Generator - documentation for the most in period with the Administrator w from 9:10 a.m. to 12:00 p.m. wility has two diesel fuel fired ors. One emergency generator ing of 350 kW and monthly entation indicated monthly s 40 kW to 45 kW during load not meet or exceed 30% of the The second emergency the plate rating of 60 kW and |                          | Scheduled logs/calendars we added for documentation and scheduling to ensure the alleg deficient practice does not reoccur.  How will the corrective action monitored or QA will be put in place to ensure the alleged deficient practice will not reco | s be<br>to<br>ur;    |
|  | monthly load testing testing. Based on it review, the Administ two diesel fuel fired 220 kW load value emergency generated agreed documentatifor each of the two generators within the   | g documentation indicated g achieves 220 kW during load atterview at the time of record strator stated the facility has a lemergency generators, the documented for the 60 kW or value was in error and on of an annual load bank test diesel fuel fired emergency are most recent twelve month lable for review at the time of                    |                          | This system will be monitored monthly by the maintenance Director and/or designee and report findings to be provided the QA committee that will als monitor compliance.   | to                   |
|  | during the exit conf<br>3.1-19(b)  3. Based on record of facility failed to doc<br>emergency generate<br>generators in accord<br>NFPA 110. NFPA<br>2012 Edition, Section<br>Type 2 essential election (EPSS) shall be class<br>Level 1 generators of | review and interview, the cument 36 month period or testing for 2 of 2 emergency dance with NFPA 99 and 99, Health Care Facilities Code, on 6.4.1.1.6.1 states Type 1 and ctrical system power sources saffied as Type 10, Class X, ets per NFPA 110. NFPA 110, nergency and Standby Powers  |                          |   |                      |

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|                          | TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155859  | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 01  | (X3) DATE SURVEY COMPLETED 01/26/2023 |
|--------------------------|--|--------------------------------------|---|---------------------------------------|
|                          | PROVIDER OR SUPPLIER OF BEECH GROVE  | 501 N 1                              | ADDRESS, CITY, STATE, ZIP COD<br>7TH AVE<br>GROVE, IN 46107   |                                       |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | (X5) COMPLETION DATE                  |
|                          | Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on record review with the Administrator and the Maintenance Supervisor during record review from 9:10 a.m. to 12:00 p.m. on 01/26/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's two diesel fuel fired emergency generators was not available for review. Based on interview at the time of record review, the Administrator stated the facility has two diesel fuel fired emergency generators and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review at the time of the survey.  This finding was reviewed with the Administrator during the exit conference. |                                      |   |                                       |
| K 0000                   |  |                                      |   |                                       |
| Bldg. 02                 | A Life Safety Code Recertification and State   | K 0000                               |   |                                       |

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| STATEMEN  | IT OF DEFICIENCIES            | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M | IULTIPLE CO | NSTRUCTION  | (X3) DATE | SURVEY     |
|-----------|-------------------------------|-----------------------------------|--------|-------------|---|-----------|------------|
| AND PLAN  | OF CORRECTION                 | IDENTIFICATION NUMBER             | A. B   | UILDING     | 02  | COMPL     | LETED      |
|           |                               | 155859                            | B. W   | /ING        |   | 01/26     | /2023      |
|           |                               |                                   |        | STREET A    | ADDRESS, CITY, STATE, ZIP COD                                       | <u> </u>  |            |
| NAME OF P | PROVIDER OR SUPPLIER          |                                   |        |             | 7TH AVE   |           |            |
| ENVIVE    | OF BEECH GROVE                | <u> </u>                          |        |             | GROVE, IN 46107   |           |            |
| (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 APPROPRIA | ATE       | COMPLETION |
| TAG       |                               | LSC IDENTIFYING INFORMATION       | _      | TAG         | DEFICIENCY)   |           | DATE       |
|           | -                             | ras conducted by the Indiana      |        |             |   |           |            |
|           | Department of Heal 483.90(a). | th in accordance with 42 CFR      |        |             |   |           |            |
|           | Survey Date: 01/26            | /23                               |        |             |   |           |            |
|           | Facility Number: 0            | 00391                             |        |             |   |           |            |
|           | Provider Number:              |                                   |        |             |   |           |            |
|           | AIM Number: 1002              |                                   |        |             |   |           |            |
|           |                               |                                   |        |             |   |           |            |
|           |                               | Code survey, Envive of Beech      |        |             |   |           |            |
|           |                               | ot in compliance with             |        |             |   |           |            |
|           | Requirements for Pa           | articipation in Medicaid, 42      |        |             |   |           |            |
|           | CFR Subpart 483.90            | 0(a), Life Safety from Fire and   |        |             |   |           |            |
|           |                               | the National Fire Protection      |        |             |   |           |            |
|           |                               | ) 101, Life Safety Code (LSC),    |        |             |   |           |            |
|           |                               | g Health Care Occupancies and     |        |             |   |           |            |
|           | 410 IAC 16.2.                 |                                   |        |             |   |           |            |
|           | This facility was on          | rveyed as three separate          |        |             |   |           |            |
|           |                               | different construction types      |        |             |   |           |            |
|           | -                             | s of the building. Building       |        |             |   |           |            |
|           | -                             | health care center constructed    |        |             |   |           |            |
|           |                               | nined to be of Type II (000)      |        |             |   |           |            |
|           |                               | lly sprinklered. Building 0102    |        |             |   |           |            |
|           |                               | ke detectors located near         |        |             |   |           |            |
|           |                               | in all resident sleeping rooms.   |        |             |   |           |            |
|           |                               | sisting of the first floor of the |        |             |   |           |            |
|           | _                             | ree story building with a         |        |             |   |           |            |
|           |                               | o the health care center, and     |        |             |   |           |            |
|           | separated by a two l          | hour wall was determined to       |        |             |   |           |            |
|           | be of Type I (332) o          | construction. The first floor     |        |             |   |           |            |
|           | and the basement of           | f the adjacent building which     |        |             |   |           |            |
|           | was constructed in            | 1959 was surveyed due to          |        |             |   |           |            |
|           |                               | the chapel and Salon in the       |        |             |   |           |            |
|           |                               | 0202 had a complete corridor      |        |             |   |           |            |
|           |                               | stem. Building 0302 is a split    |        |             |   |           |            |
|           | •                             | ting of the Therapy Wing          |        |             |   |           |            |
|           |                               | of the two floors exiting at      |        |             |   |           |            |
|           | ground level was de           | etermined to be of Type V (111)   |        |             |   |           |            |

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| STATEMEN | T OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUI | TIPLE CO | NSTRUCTION   | (X3) DATE | SURVEY     |
|----------|--|---|----------|----------|--|-----------|------------|
| AND PLAN | OF CORRECTION  | IDENTIFICATION NUMBER   | A. BUII  | LDING    | 02   | COMPL     | ETED       |
|          |  | 155859  | B. WIN   | G        |  | 01/26/    | 2023       |
|          | ROVIDER OR SUPPLIER  |   |          | 501 N 1  | ADDRESS, CITY, STATE, ZIP COD<br>7TH AVE<br>GROVE, IN 46107  |           |            |
| (X4) ID  | SUMMARY S  | STATEMENT OF DEFICIENCIE  | 1        | ID       | DROWDERS BY AN OF CORRECTION   |           | (X5)       |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL   | P        | REFIX    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' | TE        | COMPLETION |
| TAG      | REGULATORY OR  | LSC IDENTIFYING INFORMATION   |          | TAG      | DEFICIENCY)  | 16        | DATE       |
|          | Wing addition was of fire alarm system we located near smoke capacity of 52 and hof this visit.  All areas where residence sprinklered. To garage providing fawas not sprinklered. | ally sprinklered. The Therapy constructed in 2015 and has a with hard wired smoke detection barriers. The facility has a mad a census of 32 at the time detection barriers are success. The facility has one detached cility storage services which a mpleted on 01/30/23 |          |          |  |           |            |
| K 0711   | NFPA 101   |   |          |          |  |           |            |
| SS=E     | Evacuation and R   |   |          |          |  |           |            |
| Bldg. 02 | Evacuation and R   |   |          |          |  |           |            |
|          |  | plan for the protection of all  |          |          |  |           |            |
|          |  | eir evacuation in the event   |          |          |  |           |            |
|          | of an emergency.   | oi a di a allo din akon aka di ana d  |          |          |  |           |            |
|          |  | riodically instructed and<br>ntheir duties under the plan,  |          |          |  |           |            |
|          | •  | plan is readily available   |          |          |  |           |            |
|          | • •  | erator or with security. The  |          |          |  |           |            |
|          | ·  | e basic response required   |          |          |  |           |            |
|          |  | 7.2.1.2 and provides for all  |          |          |  |           |            |
|          | -  | lan components per  |          |          |  |           |            |
|          | 18/19.2.2.   |   |          |          |  |           |            |
|          | 18.7.1.1 through 1   | 8.7.1.3, 18.7.2.1.2,  |          |          |  |           |            |
|          | 18.7.2.2, 18.7.2.3,  | , 19.7.1.1 through 19.7.1.3,  |          |          |  |           |            |
|          | 19.7.2.1.2, 19.7.2.  |   |          |          |  |           |            |
|          |  | view and interview, the facility  | K 07     | 11       | What corrective action will be   |           | 03/26/2023 |
|          | •  | of 1 written emergency fire   |          |          | accomplished for those reside  |           |            |
|          | • •  | orporated all items listed in   |          |          | found to have been affected by   | y the     |            |
|          | NFPA 101, Section  | 19.7.2.2.   |          |          | alleged deficient practice;  |           |            |
|          | 1. Use of alarms.  | alamas to fine demonstrative  |          |          | This Dusyiden defect the C   |           |            |
|          |  | alarms to fire department.  |          |          | This Provider updated the fire   |           |            |
|          | ~  | ne call to fire department  |          |          | safety plan to discuss the   |           |            |
|          | <ul><li>4. Response to alar.</li><li>5. Isolation of fire.</li></ul>   |   |          |          | extinguishment of fire in the  |           |            |
|          | 3. Isolation of fire.  |   | 1        |          | kitchen and explicitly states th   | ie        |            |

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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 <u>02</u>      |  | 02   | COMPLETED  |            |
|                           |  | 155859                         | B. WING                    |  | 01/26/   | 01/26/2023 |            |
|                           |  |                                |                            | CTDEET /   | ADDRESS, CITY, STATE, ZIP COD  |            |            |
| NAME OF F                 | PROVIDER OR SUPPLIEI                                 | R                              |                            |  | I7TH AVE   |            |            |
| ENI\/I\/E                 | OF BEECH GROVI                                       | =                              |                            |  | I GROVE, IN 46107  |            |            |
| LINVIVL                   |  |                                |                            | DELOIT   |  |            |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | .TE        | COMPLETION |
| TAG                       |  | R LSC IDENTIFYING INFORMATION  | ļ                          | TAG DEFICIENCY)  |  |            | DATE       |
|                           | 6. Evacuation of in                                  |                                |                            |  | use of K Class portable fire   |            |            |
|                           |  | moke compartment.              |                            | extinguishers in the kitchen due to                                  |  | ue to      |            |
|                           | -  | loors and building for         |                            | fire.  |  |            |            |
|                           | evacuation.  |                                |                            |  |  |            |            |
|                           | 9. Extinguishment of fire.                           |                                |                            | How other residents having the                                       |  |            |            |
|                           | _  | tice could affect over 2 staff |                            | potential to be affecte  |  |            |            |
|                           | and visitors in the k                                | kitchen.                       |                            | same alleged deficient pract   |  |            |            |
|                           |  |                                |                            |  | will be identified and what  |            |            |
|                           | Findings include:                                    |                                |                            |  | corrective action will be taken;                                       |            |            |
|                           |  |                                |                            |  |  |            |            |
|                           | Based on review of "Emergency Disaster               |                                |                            |  | All residents residing in the fa                                       | cility     |            |
|                           | Preparedness: Emergency Procedure - Fire"            |                                |                            | have the potential to be affected by the alleged deficient practice. |  | ed         |            |
|                           | documentation dated 01/06/23 with the                |                                |                            |  |  | ce.        |            |
|                           | Administrator and the Maintenance Supervisor         |                                |                            |  |  |            |            |
|                           |  | w from 9:10 a.m. to 12:00 p.m. |                            |  | This Provider updated the fire   |            |            |
|                           | on 01/26/23, the written fire safety plan did not    |                                |                            |  | safety plan to discuss the   |            |            |
|                           | discuss the extinguishment of fire in the kitchen    |                                |                            |  | extinguishment of fire in the  |            |            |
|                           | and did not explicitly state the use of K Class      |                                |                            |  | kitchen and explicitly states the                                      | пе         |            |
|                           | portable fire extinguishers in the kitchen due to    |                                |                            | use of K Class portable fire   |  |            |            |
|                           | fire. Based on interview at the time of record       |                                |                            |  | extinguishers in the kitchen due to                                    |            |            |
|                           | review, the Administrator agreed the written fire    |                                |                            | fire.  |  |            |            |
|                           | safety plan did not discuss the extinguishment of    |                                |                            |  |  |            |            |
|                           | fire in the kitchen and did not explicitly state the |                                |                            |  | What measures will be put into   | <b>o</b>   |            |
|                           | use of K Class portable fire extinguishers in the    |                                |                            | place and what systematic  |  |            |            |
|                           | kitchen due to fire.                                 |                                |                            | changes will be made to ensure                                       |  |            |            |
|                           |  |                                |                            | that the alleged deficient practice does not recur;                  |  |            |            |
|                           | This finding was reviewed with the Administrator     |                                |                            |  |  |            |            |
|                           | during the exit conference.                          |                                |                            |  |  |            |            |
|                           |  |                                |                            |  | The maintenance Staff were   |            |            |
|                           | 3.1-19(b)  |                                |                            |  | inserviced on the updated fire   | · ·        |            |
|                           |  |                                |                            |  | safety plan including the  |            |            |
|                           |  |                                |                            |  | extinguishment of fire in the  |            |            |
|                           |  |                                |                            |  | kitchen and explicitly states the                                      | пе         |            |
|                           |  |                                |                            |  | use of K Class portable fire   |            |            |
|                           |  |                                |                            |  | extinguishers in the kitchen du  | ue to      |            |
|                           |  |                                |                            |  | fire   |            |            |
|                           |  |                                |                            |  |  |            |            |
|                           |  |                                |                            |  | The system change and corre  | ction      |            |
|                           |  |                                |                            |  | was this Provider updated the  | fire       |            |
|                           |  |                                | 1                          |  | safety plan to discuss the   |            |            |

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| STATEMENT OF DEFICIENCIES |  | X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE CONSTRUCTION  |          | NSTRUCTION   | (X3) DATE SURVEY |      |
|---------------------------|--|-----------------------------|---|----------|--|------------------|------|
| AND PLAN OF CORRECTION    |  | IDENTIFICATION NUMBER       | A. BUILDING <u>02</u>   |          | COMPLETED  |                  |      |
|                           |  | 155859                      | B. WING   |          |  | 01/26/2023       |      |
|                           |  |                             |   | CTDEET A | ADDRESS, CITY, STATE, ZIP COD  |                  |      |
| NAME OF P                 | ROVIDER OR SUPPLIER  |                             |   |          |  |                  |      |
| ENVIVE OF BEECH GROVE     |  |                             | 501 N 17TH AVE<br>BEECH GROVE, IN 46107                                     |          |  |                  |      |
| (X4) ID                   | SUMMARY S  | STATEMENT OF DEFICIENCIE    |   | ID       | PROVIDER'S PLAN OF CORRECTION  |                  | (X5) |
| PREFIX                    | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT |          | TE   | COMPLETION       |      |
| TAG                       | REGULATORY OR  | LSC IDENTIFYING INFORMATION |   | TAG      | DEFICIENCY)  | DATE             |      |
| K 0000                    |  |                             |   |          | extinguishment of fire in the kitchen and explicitly states the use of K Class portable fire extinguishers in the kitchen due to fire.  How will the corrective actions be monitored or QA will be put into place to ensure the alleged deficient practice will not recur;  The Fire safety plan will be reviewed monthly by the maintenance staff to ensure it is updated and consistent with this standard. The maintenance will report monthly findings and ongoing compliance to the QA team each month. |                  |      |
| Bldg. 03                  | Licensure Survey w Department of Heal 483.90(a).  Survey Date: 01/26/ Facility Number: 00 Provider Number: 1002  At this Life Safety C Grove was found no Requirements for Pa Subpart 483.90(a), I 2012 Edition of the | 00391<br>15E247             | K 00  | 000      |  |                  |      |

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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 <u>03</u> COMPLE |                                  | ETED   |   |      |
| 155859                    |   | 155859  | B. WING                      |                                  |  | 01/26/2023  |      |
| l                         |   |   |                              | STREET A                         | ADDRESS, CITY, STATE, ZIP COD  |   |      |
| NAME OF P                 | ROVIDER OR SUPPLIER   |   |                              |                                  | 7TH AVE  |   |      |
| ENVIVE OF BEECH GROVE     |   |   | BEECH GROVE, IN 46107        |                                  |  |   |      |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | CH CORRECTIVE ACTION SHOULD BE<br>S-REFERENCED TO THE APPROPRIATE |      |
| TAG                       |   | REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) |                              | DATE                             |  |   |      |
|                           | Chapter 19, Existing 410 IAC 16.2.  | g Health Care Occupancies and                             |                              |                                  |  |   |      |
|                           | 410 IAC 10.2.   |   |                              |                                  |  |   |      |
|                           | This facility was surveyed as three separate  |   |                              |                                  |  |   |      |
|                           | -   | different construction types                              |                              |                                  |  |   |      |
|                           | of different portions   | s of the building. Building                               |                              |                                  |  |   |      |
|                           | 0102, the one story   | health care center constructed                            |                              |                                  |  |   |      |
|                           | in 1997, was determined to be of Type II (000)  |   |                              |                                  |  |   |      |
|                           | construction and fully sprinklered. Building 0102   |   |                              |                                  |  |   |      |
|                           | had hard wired smoke detectors located near   |   |                              |                                  |  |   |      |
|                           |   | in all resident sleeping rooms.                           |                              |                                  |  |   |      |
|                           | Building 0202, consisting of the first floor of the   |   |                              |                                  |  |   |      |
|                           | fully sprinklered three story building with a   |   |                              |                                  |  |   |      |
|                           | basement adjacent to the health care center, and  |   |                              |                                  |  |   |      |
|                           | separated by a two hour wall was determined to  |   |                              |                                  |  |   |      |
|                           | be of Type I (332) construction. The first floor  |   |                              |                                  |  |   |      |
|                           | and the basement of the adjacent building which was constructed in 1959 was surveyed due to       |   |                              |                                  |  |   |      |
|                           |   | the chapel and Salon in the                               |                              |                                  |  |   |      |
|                           | -   | -   |                              |                                  |  |   |      |
|                           | building. Building 0202 had a complete corridor smoke detection system. Building 0302 is a split  |   |                              |                                  |  |   |      |
|                           | level facility consisting of the Therapy Wing   |   |                              |                                  |  |   |      |
|                           | addition with each of the two floors exiting at ground level was determined to be of Type V (111) |   |                              |                                  |  |   |      |
|                           |   |   |                              |                                  |  |   |      |
|                           | construction and ful  | ly sprinklered. The Therapy                               |                              |                                  |  |   |      |
|                           |   | constructed in 2015 and has a                             |                              |                                  |  |   |      |
|                           | fire alarm system with hard wired smoke detection   |   |                              |                                  |  |   |      |
|                           |   | barriers. The facility has a                              |                              |                                  |  |   |      |
|                           |   | and a census of 32 at the time                            |                              |                                  |  |   |      |
|                           | of this visit.  |   |                              |                                  |  |   |      |
|                           | All areas where resi  | dents have customary access                               |                              |                                  |  |   |      |
|                           |   | The facility has one detached                             |                              |                                  |  |   |      |
|                           | _   | cility storage services which                             |                              |                                  |  |   |      |
|                           | was not sprinklered   | -   |                              |                                  |  |   |      |
|                           | was not sprinklered.  |   |                              |                                  |  |   |      |
|                           | Quality Review con  | npleted on 01/30/23                                       |                              |                                  |  |   |      |
|                           | •   | -   | I                            |                                  |  |   |      |

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