STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION ((X3) DATE SURVEY COMPLETED 01/09/2023	
NAME OF PROVIDER OF SEYMOUR CROSS		707 S	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR OUR, IN 47274		
PREFIX (EACE TAG REGUL	UMMARY STATEMENT OF DEFICIENCIE DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
conducted accordance Survey Day Facility No Provider I AIM Num At this Encorosing Emergency Medicare and Supply The facility the survey Quality Row The requirement MET as expected to the survey of the survey	by the Indiana Department of Health in e with 42 CFR 483.73. Inte: 01/09/23 Inte: 01/09/23 Inte: 000272 Inte: 100274710 Intergency Preparedness survey, Seymour was found not in compliance with by Preparedness Requirements for and Medicaid Participating Providers iters, 42 CFR 483.73. Interpretation of the census was 68. Interpr	E 0000	This Plan of Correction constitute the facility's written allegation of compliance for the deficiencies cited. This submission of this P of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please review the attachments provided with this plan of correction, which includ audit and re-education tools. Please feel free to contact Jay Myers, Executive Director, shor you need any additional information to support the desk review at 812-522-2419. Thank for your consideration.	e uld	
(e) Emer	e), §485.625(e) gency and standby power systems.	OVEN LETTER S	TITLE	(X6) DATE	

John Myers HFA 02/03/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VNMX21 Facility ID: 000272 If continuation sheet Page 1 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		ľ í	UILDING	INSTRUCTION	COMPL 01/09/	ETED
	PROVIDER OR SUPPLIER			707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
TAG	The [LTC facility a implement emerge systems based or forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Co Interim Amendment 2-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built o structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §483 Emergency generand LTC facilities] source to power enand LTC facilities] source to power enand and the power systems open emergency, unless *[For hospitals at §483.73(g), and Cathe the power standards incomplete the standards in	and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 83.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must intergency power system ind, and [maintenance] and in the Health Care FPA 110, and Life Safety 83.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs is that maintain an onsite fuel intergency generators must is wit will keep emergency interpretational during the sit evacuates. §482.15(h), LTC at isorporated by reference in		TAG	DEFICIENCY)		DATE
		oproved for incorporation by Director of the Office of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 2 of 32

PRINTED: 02/10/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	LETED
		155377	B. W	NG		01/09	/2023
NAME OF S	DD OLUBED OD GUDDU IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	K		707 S J	ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMC	OUR, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	in accordance with 5 U.S.C.					
	, ,	R part 51. You may obtain					
	the material from	the sources listed below.					
	You may inspect	a copy at the CMS					
	Information Reso	urce Center, 7500 Security					
	Boulevard, Baltim	nore, MD or at the National					
	Archives and Rec	cords Administration					
	(NARA). For infor	mation on the availability of					
	this material at N	ARA, call 202-741-6030, or					
	go to:						
	http://www.archives.gov/federal_register/code						
		lations/ibr_locations.html.					
		this edition of the Code are					
	•	eference, CMS will publish a					
	document in the F	Federal Register to					
	announce the cha	_					
	(1) National Fire F	Protection Association, 1					
	Batterymarch Par	·k,					
	Quincy, MA 0216	9, www.nfpa.org,					
	1.617.770.3000.						
		lth Care Facilities Code,					
	· ·	ied August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued	•					
	` '	FPA 99, issued August 9,					
	2012.						
	(iv) TIA 12-4 to N	FPA 99, issued March 7,					
	2013.						
	, ,	FPA 99, issued August 1,					
	2013.						
	(vi) TIA 12-6 to Ni 2014.	FPA 99, issued March 3,					
	(vii) NFPA 101, Li	ife Safety Code, 2012					
	edition, issued Au	ıgust 11, 2011.					
	(viii) TIA 12-1 to N	NFPA 101, issued August					
	11, 2011.	5					
		FPA 101, issued October					
	30, 2012.						

FORM CMS-2567(02-99) Previous Versions Obsolete

22, 2013.

(x) TIA 12-3 to NFPA 101, issued October

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 3 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIEI	R		707 S .	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR DUR, IN 47274			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 2009	FPA 101, issued October Standard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,						
	Based on record review, observation and		E 0	041	What corrective action(s) will	II	01/31/2023	
		ity failed to implement the			be accomplished for those			
	emergency power system inspection, testing and				residents found to have been	n		
	maintenance requirements found in the Health				affected by the deficient			
	Care Facilities Code, NFPA 110, and Life Safety				practice?			
	Code in accordance with 42 CFR 483.73(e)(2).				No residents were affected by	tne tne		
	This deficient practice could affect all residents, staff and visitors.				alleged deficient practice.			
	Findings include:				How will you identify other	- I		
					residents having the potention to be affected by the same	aı		
	Findings include.				deficient practice and what			
	Based on review of	the emergency generator			corrective action will be take	n?		
		or's preventive maintenance			Testing of the batteries and fu			
	_	ntation dated 10/27/22 with the			will be done in a timely manner			
		tor and the Field Maintenance			and reported in TELS. If at ar			
		record review from 9:40 a.m. to			time there is test failure the El	•		
		9/23, the emergency generator			will be notified for immediate r			
	starting batteries w	ere listed as "Batteries Failed".			or replacement.	•		
	In addition, review	of the inspection contractor's			What measures will be put in	nto		
	"Fuel Analysis Rep	oort" documentation dated			place or what systemic			
	10/27/22 listed the	results for annual diesel fuel			changes you will make to			
	sampling as "Fail"	due to water contamination.			ensure that the deficient			
	Based on interview	at the time of record review,			practice does not recur?			
		irector stated the starting			Maintenance director to test			
		he is still able to start and run			batteries and schedule fuel te	sting		
	_	acility has a work order for			per regulation and report findi	•		
		t and the starting batteries			in TELS for later regulatory re			
		tomorrow but agreed work			How the corrective action(s)			
		on for battery replacement was			will be monitored to ensure	the		
		view at the time of record			deficient practice will not			
		n, the Maintenance Director			recur, i.e., what quality			
	1	ded fuel to the diesel fuel			assurance program will be p	ut		
	_	10/27/22 but documentation of			into place?			
	any investigation of	f diesel fuel sampling failure			To ensure compliance, the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 4 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/09/2023	
	ROVIDER OR SUPPLIER		707 S	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR OUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	(X5) COMPLETION DATE
	survey. Based on o Maintenance Direct Supervisor during a p.m. to 2:30 p.m. or diesel fired emerger the building on the near the service half documentation affix indicated it was diesel 08/10/15 and was raaffixed to the startin batteries were install. This finding was rethe Maintenance Direct Supervisor Direct Superv	bservations with the or and the Field Maintenance tour of the facility from 12:30 in 01/09/23, the facility has one nevy generator located outside mortheast side of the property lexit door. Manufacturer's seed to the emergency generator seel fuel fired, manufactured ated at 275 kW. Documentation neg batteries indicated the led in December 2017.		Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for period of not less than 12 months. Executive Director to complete random checks of T and audit reports, reporting findings to QA meeting for a proof not less than six months.	a D ELS
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/09 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Crossing was found Requirements for Pa Medicare/Medicaid Life Safety From Fi National Fire Protect	00272 155377 274710 Code survey, Seymour not in compliance with	K 0000	This Plan of Correction constitute facility's written allegation compliance for the deficiencie cited. This submission of this of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desireview and ask that your offic accept this plan as our facility compliance. Please review the attachments provided with this plan of correction, which inclusive audit and re-education tools. Please feel free to contact Jay Myers, Executive Director, shi	of es Plan sion s k e 's e s de

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 5 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

1 1	ING	01	COMPLETED 01/09/2023
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has three detached storage sheds which were not sprinklered. Quality Review completed on 01/12/23 K 0222 NFPA 101 SS=F Egress Doors Bidg. 01 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.5.1, 19.2.2.2.6	140	you need any additional information to support the desireview at 812-522-2419. Than for your consideration.	k

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet

Page 6 of 32

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155377	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER JR CROSSING			707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	SPECIAL NEEDS ARRANGEMENTS Where special loc safety needs of th the Clinical or Sec are being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both the systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRE ARRANGEMENTS Approved, listed de systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe detection system automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblies	LOCKING Sking arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised or system and the locked I by a complete smoke (or is constantly monitored ation within the locked the sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet

Page 7 of 32

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155377	B. W	ING		01/09/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L		1	JACKSON PARK DR		
SEYMOL	JR CROSSING				DUR, IN 47274		
		CT L TEL CENT OF DEPLOYER AND	<u> </u>		, 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
		ection system and an sed automatic sprinkler					
	system.	sed automatic spiliniei					
	18.2.2.2.4, 19.2.2.	24					
		ation and interview, the facility	K O	222	K222		01/31/2023
		means of egress through 1 of			What corrective action(s) will	I	01/31/2023
		y accessible for residents			be accomplished for those	· -	
		agnosis requiring specialized			residents found to have been	n	
	security measures. Doors within a required means				affected by the deficient		
		be equipped with a latch or			practice?		
	lock that requires the use of a tool or key from the				The D-wing center hall exit do	or	
	egress side unless otherwise permitted by LSC				has had a LSC 7.2.1.6.1 appr		
	Section 19.2.2.2.4. Door-locking arrangements				signage placed on it stating th		
	shall be permitted in accordance with 19.2.2.2.5.2.				doors can be opened in 15		
	This deficient practice could affect all residents,				seconds by pushing on the do	or,	
		needing to exit the facility			additionally lobby door has ha		
	using main entrance	e lobby.			sign posted with code to get in		
					and get out of the building usi	ng	
	Findings include:				the key code.		
	D4 1				How will you identify other		
		ons with the Maintenance			residents having the potentia	al	
		eld Maintenance Supervisor facility from 12:30 p.m. to 2:30			to be affected by the same		
	_	ne exit door at the main entrance			deficient practice and what corrective action will be take	n2	
	_	as a facility exit with an exit			A 100% inspection of all exit	1111	
		pened by entering a code into			doors along with kitchen doors	8	
		r. However, the code was not			has been conducted to ensure		
		oor. Based on interview at the			compliance with K222	-	
	•	tions, the Maintenance			What measures will be put in	nto	
		receptionist can release the			place or what systemic	-	
		normal business hours but			changes you will make to		
	the door is locked d	aily after 8:00 p.m. and agreed			ensure that the deficient		
	the keypad code to	release the exit door to open			practice does not recur?		
	was not posted at th	e keypad.			Maintenance director to inspe	ct all	
					exit doors weekly to ensure		
	_	viewed with the Administrator,			compliance and means of egr		
	the Maintenance Di				for all residents staff and visito		
	Maintenance Supervisor during the exit				documenting results in TELS.		
	conference.				How the corrective action(s)		
					will be monitored to ensure	the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 8 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155377			UILDING	onstruction 01	(X3) DATE COMPL 01/09/	ETED	
	PROVIDER OR SUPPLIEI UR CROSSING	3	STREET ADDRESS, CITY, STATE, ZIP COD 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	3.1-19(b) 2. Based on observer failed to ensure the 1 delayed egress locally residents, staff and Delayed Egress Local delayed egress locally residents in the detection of the detection system in throughout by an any fire detection system in Section 9.6, or an any sprinkler system in Section 9.7, and with through 42, provide (a) The doors unlocal approved, supervised in accordant the actuation of any than two smoke described automation in the doors unlocally controlling the local (c) An irreversible within 15 seconds the release devicer not be required to experiment of the continuously applied. The initiation of the an audible signal in the door lock has been of force to the release by manual means of Exception: Where a having jurisdiction seconds shall be per (d) On the door adj	proved, supervised automatic m installed in accordance with pproved, supervised automatic stalled in accordance with here permitted in Chapters 12 ed: ek upon actuation of an ed automatic sprinkler system nee with Section 9.7, or upon wheat detector or not more fectors of an approved, ic fire detection system nee with Section 9.6. ek upon loss of power to rolcking mechanism. process shall release the lock upon application of a force to equired in 7.2.1.5.4 that shall exceed 15 lbf nor required to be ad for more than 3 seconds. e release process shall activate the vicinity of the door. Once the released by the application using device, relocking shall be only. approved by the authority a delay not exceeding 30		TAG	deficient practice will not recur, i.e., what quality assurance program will be pinto place? To ensure compliance, the Maintenance Director will brin results of TELS Inspections to monthly QA meeting for revier and recommendation monthly period of not less than 12 months. Executive Director to review TELS Reports weekly complete random checks of d and means of egress reportin findings to QA meeting for a pof not less than six months.	g w for a and oors	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 9 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155377		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIE	R	•	707 S J	ODDRESS, CITY, STATE, ZIP CO ACKSON PARK DR OUR, IN 47274	DD .	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
	letters not less than	1 inch high and at least 1/8					
		h on a contrasting background					
	that reads:	5 5					
	"PUSH UNTIL AI	ARM SOUNDS.					
	DOOR CAN BE O	PENED IN 15 SECONDS".					
	This deficient prac	tice could affect over two staff					
	and visitors if need	ling to exit the facility by the					
	exit door in the D	Wing by Room 110.					
	Findings include:						
	Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the exit door to the outside of						
	_						
	1	Wing by Room 110 was					
		y exit with an exit sign. The					
		pad at the exit door to release					
	_	The code to release the door to the exit door. The door was					
		layed egress door with the					
		egress signage. The door was					
		oor as the door released to					
		for 15 seconds. Based on					
		ne of the observations, the Field					
		rvisor stated the door was a					
	_	or as well and agreed the door					
		h the necessary delayed egress					
	signage.	in the necessary delayed egress					
	This finding was re	eviewed with the Administrator,					
		irector and the Field					
		rvisor during the exit					
	conference.	-					
	3.1-19(b)						
K 0291	NFPA 101						
SS=F	Emergency Lighti	ina					
Bldg. 01	Emergency Lighti	_					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 10 of 32

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155377	B. W	NG		01/09/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		l	IACKSON PARK DR		
SEYMOL	JR CROSSING			l	OUR, IN 47274		
OL TWO	·			OLTIVIC			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ig of at least 1-1/2-hour					
	•	ed automatically in					
	accordance with 7.9.						
	18.2.9.1, 19.2.9.1		17.0	201) A/I - 4		01/21/2022
	Based on record review, observation and interview; the facility failed to document annual		K 0	291	What corrective action(s) will	ı	01/31/2023
		-			be accomplished for those residents found to have been	_	
		ry backup lights in accordance				1	
	with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to				affected by the deficient		
	be conducted as follows:				practice? Facility will begin documenting	,	
	(1) Functional testing shall be conducted monthly,				annual testing for all back up	3	
	with a minimum of 3 weeks and a maximum of 5				lighting in accordance with		
	weeks between tests, for not less than 30				regulations.		
	seconds, except as otherwise permitted by				How will you identify other		
	7.9.3.1.1(2).				residents having the potentia	al	
		I shall be permitted to be			to be affected by the same	41	
		O days with the approval of the			deficient practice and what		
	authority having jur				corrective action will be take	n?	
		ng shall be conducted annually			There were no resdents effect		
		1/2 hours if the emergency			by alleged deficient practices.		
	lighting system is b	attery powered.			What measures will be put in	to	
	(4) The emergency	lighting equipment shall be			place or what systemic		
	fully operational for	r the tests required by			changes you will make to		
	7.9.3.1.1(1) and (3)				ensure that the deficient		
	(5) Written records	of visual inspections and tests			practice does not recur?		
		owner for inspection by the			Maintenance director to compl	lete	
	authority having ju				testing in accordance with		
	_	ice could affect all residents,			regulations at all locations of		
	staff and visitors.				battery operated lighting		
					documenting in TELS findings	and	
	Findings include:				completion.		
		PP: . a 1 mprat 1 1			How the corrective action(s)	_	
		Direct Supply TELS Logbook			will be monitored to ensure t	ne	
		mergency and Exit Lighting:			deficient practice will not		
	Conduct a 90 minut	•			recur, i.e., what quality		
		ed 04/24/22 with the			assurance program will be p	ut	
	Maintenance Director and the Field Maintenance				into place?		
	_	ecord review from 9:40 a.m. to			To ensure compliance, the	~	
	_	9/23, annual battery operated			Maintenance Director will bring	_	
	I light testing docum	entation for the most recent	ı		results of audit to monthly QA		I

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		JILDING	01	COMPL 01/09/	ETED
	ROVIDER OR SUPPLIER JR CROSSING		707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
AAG	twelve month period battery operated light minutes. The batter Enclosure" was the documented as beint minimum of 90 minutwelve month period TELS Logbook Doc Exit Lighting: Chec and exit signs" for "battery operated light facility including generator enclosure the Maintenance Dis Maintenance Supervised facility from 12:30 period of four battery were noted in the face mergency generator transfer switch and 701 and Room 713 lighting system illustest button was push interview at the time observations, the Misch Field Maintenance Sminute testing documents of the state of the	I documented only one at location was tested for 90 y light at the "Generator only battery operated light g tested annually for a utes within the most recent d. Review of Direct Supply sumentation "Emergency and k illumination of exit lighting 30 seconds" indicated four atting systems are installed in g inside the emergency. Based on observations with rector and the Field visor during a tour of the form. to 2:30 p.m. on 01/09/23, a operated lighting systems cility which included the ar location, at the emergency in the corridor outside Room and each battery operated minated when its respective attended the art of the formation of the saintenance Director and the Supervisor agreed annual 90 mentation did not include all atting system locations in the		meeting for review and recommendation monthly for a period of not less than 12 months. Executive Director to complete random checks of testing and audit reports, report findings to QA meeting for a period find the six months.	rting	
K 0353 SS=F Bldg. 01		Maintenance and Testing Maintenance and Testing				'

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $VNMX21 \quad \text{Facility ID:} \quad 000272$

If continuation sheet

Page 12 of 32

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
		155377	B. W	ING		01/09/	2023
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
CEVMOI	JR CROSSING				IACKSON PARK DR		
SETIMOL	JK CKOSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Automatic sprinkle	er and standpipe systems					
	are inspected, tes	ted, and maintained in					
	accordance with N	NFPA 25, Standard for the					
	Inspection, Testin	g, and Maintaining of					
	Water-based Fire	Protection Systems.					
	Records of system design, maintenance,						
	inspection and testing are maintained in a						
	secure location and readily available.						
	a) Date sprinkler	system last checked					
	b) Who provided system test						
	c) Water system	supply source					
	Provide in PEMAI	 RKS information on					
		non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8	-					
		ation and interview, the facility	K 0	353	What corrective action(s) wil	ı	05/01/2023
		f 1 sprinkler systems were		333	be accomplished for those	•	03/01/2023
		ninimum number of spare			residents found to have been	1	
	_	e sprinkler cabinet on the			affected by the deficient	•	
		pes and temperature ratings of			practice?		
		e property. NFPA 25,			No residents were found to b	ne .	
	_	spection, Testing, and			affected the alleged deficient		
		nter-Based Fire Protection			practice		
		tion, Section 5.4.1.4 states a			How will you identify other		
	I	inklers (never fewer than six)			residents having the potentia	al	
		on the premises so that any			to be affected by the same		
		been operated or damaged in			deficient practice and what		
	_	omptly replaced. The sprinklers			corrective action will be take	n?	
		the types and temperature			A 100% inspection of all fire		
	_	klers on the property. The			pendants with two new penda	nts	
	sprinklers shall be l	kept in a cabinet located where			ordered for the attic and the		
		which they are subjected will at			sidewall along with the orderin	ıg	
	no time exceed 100	degrees Fahrenheit. A special			and replacement of the six	-	
		nall be provided and kept in the			pendants identified in the kitch	nen	
	cabinet to be used i	n the removal and installation			as needing replaced. facility		
	of sprinklers. This	deficient practice could affect			respectfully requests waiver of	f	
	all residents, staff a	and visitors.			pendants due to supplier unab		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 13 of 32

PRINTED: 02/10/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155377	B. WI	NG		01/09	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		l	JACKSON PARK DR		
SFYMOL	JR CROSSING				OUR, IN 47274		
	1				T		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					deliver for eight to ten weeks.		
	Findings include:				Waiver request is attached.		
					What measures will be put in	ito	
		ons with the Maintenance			place or what systemic		
	Director and the Field Maintenance Supervisor				changes you will make to		
	during a tour of the facility from 12:30 p.m. to 2:30				ensure that the deficient		
	p.m. on 01/09/23, sidewall sprinklers were installed				practice does not recur?		
	at exterior canopies and attic type sprinklers were				Maintenance director to inspec		
installed throughout the attic. No sidewall spare				pendants weekly for a period of			
sprinklers and no attic spare sprinklers were				less than six months to ensure)		
stored in the spare sprinkler cabinet at the				compliance with K353 and the			
sprinkler system riser or on the premises. Based				safety of all residents, staff an	d		
		time of the observations, the			visitors. Maintenance Director	r to	
		tor and the Field Maintenance			report any needs related to re	pair	
		the spare sprinkler cabinet did			or replacement immediately to)	
	not contain any side	ewall spare or attic spare			Executive Director for immedia	ate	
	sprinklers.				repair. Maintenance Director	to	
					present results of inspections		
	_	eviewed with the Administrator,			monthly to QA Committee.		
		irector and the Field			How the corrective action(s))	
	Maintenance Super	visor during the exit			will be monitored to ensure t	he	
	conference.				deficient practice will not		
					recur, i.e., what quality		
	3.1-19(b)				assurance program will be p	ut	
					into place?		
	2. Based on record	review and interview, the			To ensure compliance, the		
	facility failed to ma	aintain automatic sprinkler			Maintenance Director will bring	g	
	systems in accorda	nce with NFPA 25. LSC 9.7.5			results of weekly inspection at	udit	
	requires all sprinkle	er systems shall be inspected,			to monthly QA meeting for rev	iew	
	· /	ned in accordance with NFPA			and recommendation for a per	riod	
		e Inspection, Testing, and			of not less than 6 months. In	the	
		ater-Based Fire Protection			event of less than 100%		
		5, 2011 Edition, Section 4.1.4.1			compliance each week		
	states the property	owner or designated			maintenance director to		
	representative shall	correct or repair deficiencies			immediately inform Executive		
	or impairments that	t are found during the			Director in order to bring		
	inspection, test and	maintenance required by this			compliance back to 100%.		
	standard. Correction	ons and repairs shall be			Executive Director to report to	the	

performed by qualified maintenance personnel or

a qualified contractor. Section 5.2.1.1.1 states

QA Committee for a period of no

less than six months any time

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155377	 UILDING	onstruction 01	(X3) DATE COMPL 01/09/	ETED
	PROVIDER OR SUPPLIEI JR CROSSING		707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	sprinklers shall not be free of corrosion physical damage; a correct orientation sidewall). Furtherr that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. NFPA 25, 4.3.1 recall inspections, test system components to the authority have	painted by the sprinkler uires records shall be made for s, and maintenance of the and shall be made available ing jurisdiction upon request. ice could affect all kitchen staff	TAG	compliance is not at 100%.		DATE
	Based on review of inspection contract. Testing and Mainte Sprinkler Systems" with the Maintenan Maintenance Super from 9:40 a.m. to 1 sprinklers in the kit of corrosion and ph II.A.4.b.2 of the 06 "Deficiency Summ report stated "(6) do need to be replaced Based on interview the Maintenance D	The sprinkler system or's "Form for Inspection, nance of Dry Pipe Fire documentation dated 06/07/22 ce Director and the Field visor during record review 2:30 p.m. on 01/09/23, dry chen were not listed as "Free ysical damage" in Part //07/22 inspection report. The ary" section of the 06/07/22 ry pendants in the kitchen with anti-corrosion heads". at the time of record review, irector stated the facility had the contractor to replace the six				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 15 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		ľ í	JILDING	nstruction 01	(X3) DATE S COMPL 01/09/	ETED	
	ROVIDER OR SUPPLIER JR CROSSING			STREET ADDRESS, CITY, STATE, ZIP COD 707 S JACKSON PARK DR SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	scheduled to be repl documentation to co system annual inspe available for review This finding was rev the Maintenance Di	n the kitchen, they were laced soon but agreed orrect the 06/07/22 sprinkler section deficiencies was not at the time of record review. Viewed with the Administrator, rector and the Field wisor during the exit					
K 0362 SS=E Bldg. 01	walls constructed resistance rating. compartments, pa resist the transfer nonsprinklered bu underside of the fluceiling. Corridor w underside of ceiling permitted by Code Fixed fire window are in accordance sprinklered comparestrictions in area or frames. If the walls have a the rating terminate at the unbrief description in ceiling throughout 19.3.6.2, 19.3.6.2. Based on observation resistance are single ceiling throughout 19.3.6.2, 19.3.6.2.	arated from use areas by with at least 1/2-hour fire In fully sprinklered smoke rititions are only required to of smoke. In ildings, walls extend to the oor or roof deck above the ralls may terminate at the rigs where specifically e. assemblies in corridor walls with Section 8.3, but in artments there are no a or fire resistance of glass or fire resistance rating, give if the walls nderside of the ceiling, give a REMARKS, describing the the floor area.	K 03	362	What corrective action(s) will be accomplished for those		01/31/2023
	failed to ensure corr	ridor walls in 1 of 10 smoke			be accomplished for those		01/01/2020

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 16 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	DENTIFICATION NUMBER A		2) MULTIPLE CONSTRUCTION L. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER	₹	<u> </u>	707 S .	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR	•	
SETIVIOU	JR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e constructed to resist the			residents found to have been	n	
		LSC 8.3.3.1 states fire window			affected by the deficient		
		r accompanying hardware,			practice?		
	_	s, closing devices, anchorage			No residents were affected by	the	
	and sills shall be in accordance with the				alleged deficient		
	requirements of NFPA 80, Standard for Fire Doors				How will you identify other		
	and Other Openings Protectives. NFPA 80, 2010				residents having the potential	al	
	Edition, Section 4.8.2.11 states for service counter				to be affected by the same		
	fire doors, sills shall be provided as part of the fire door assembly. Section 4.8.2.2 states sills shall be				deficient practice and what	_	
	constructed of noncombustible materials. Section				corrective action will be take		
					the rolling fire door without a s		
		pecial-purpose horizontally			has had a sill added per regul		
	_	r folding doors with frames			constructed of non-combustib	le	
	having a jamb depth of 4 inches or less, the sill width shall be equal to the jamb depth. Section				materials.	á	
	_				What measures will be put in	ito	
	_	en holes or breaks shall exist in			place or what systemic		
		ne door or frame. This deficient		changes you will make to			
	_	et over 20 residents, staff and			ensure that the deficient		
	visitors in the vicin	ity of the main dining room.			practice does not recur?	o.t	
	Findings include:				Maintenance director to inspe rolling fire door weekly for fou		
	Findings include.				weeks, bi weekly for eight wee		
	Rased on observation	ons with the Maintenance			then monthly for four months		
		eld Maintenance Supervisor			ensure continued comp	.0	
		facility from 12:30 p.m. to 2:30			How the corrective action(s)		
		he main dining room was open			will be monitored to ensure		
		e rolling fire door for the			deficient practice will not		
		est wall of the corridor wall for			recur, i.e., what quality		
		om. The rolling fire door served			assurance program will be p	ut	
	_	ective for the kitchen serving			into place?		
		ing area. The rolling fire door			To ensure compliance, the		
		thout a sill for a two inch			Maintenance Director will brin	a	
		m of the north end of the			results of audit to monthly QA	-	
		dition, it could not be ensured			meeting for review and		
		cted of noncombustible			recommendation monthly for a	а	
	materials. All obse	ervations were made with the			period of not less than 7 mont		
	rolling fire door in	the fully closed position.			Executive Director to complete		
	Based on interview	at the time of the			random checks of rolling door		
	observations, the M	laintenance Director agreed			audit reports, reporting finding		
	there was a two inc	h section of the sill missing at			QA meeting for a period of no	t	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 17 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		ľ	JILDING	onstruction 01	(X3) DATE COMPL 01/09/	ETED	
	PROVIDER OR SUPPLIER	l		707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	which would not resit could not be ensu noncombustible ma This finding was rethe Maintenance Di	orth end of the rolling door sist the passage of smoke and red the sill was constructed of terials. viewed with the Administrator, rector and the Field visor during the exit			less than seven months.		
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller is CMS regulation. The apply to auxiliary solid flammable or complements of covering is not expected to covering is not expected with a control of the door closed with a public of the door closed with a public of the door release when the permitted. Nonrate	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 18 of 32

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155377	B. W	ING		01/09	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			JACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN 47274		
	· · · · · · · · · · · · · · · · · · ·	OT A TEN VENUE OF DEFICIENCE			T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	ELITORING!		DATE
		6 are permitted. Door beled and made of steel or					
		compliance with 8.3,					
		•					
	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments						
		ctions in area or fire					
		s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,					
	483, and 485						
Show in REMARKS details of doors such as							
	fire protection ratio	ngs, automatics closing					
	devices, etc.	-					
		on and interview, the facility	K 0	K 0363 What corrective action(s) will		I	02/09/2023
		f over 50 corridor doors to		be accomplished for thos			
		oms had no impediment to			residents found to have been	1	
	-	g into the door frame and			affected by the deficient		
	_	ssage of smoke. This deficient			practice?		
	-	et over 20 residents, staff and			Rooms 806, 825, and 914 hav		
	visitors.				had the privacy curtains move		1
	Triadia 1 1 1				ensure there is no impediment	t	
	Findings include:				from closing.		
	Rosed on absorbe	ons with the Maintenance			How will you identify other	-I	1
		eld Maintenance Supervisor			residents having the potentia	aı	
		facility from 12:30 p.m. to 2:30			to be affected by the same		
	-	he ceiling mounted track for the			deficient practice and what corrective action will be take	n?	1
		the resident bed nearest the			All residents have potential to		
		ident Room 806, Room 825 and			affected by alleged deficient	20	
		alled such that the privacy			practice. A 100% inspection of	of	
		eath of the swing of the			privacy curtains and doors wa		1
	_	privacy curtain was fully			completed ensuring all close a		
		m and prevented the corridor			latch appropriately		
	_	three resident sleeping rooms			What measures will be put in	ito	
		and latching into the door			place or what systemic		1
		terview at the time of the			changes you will make to		
	observations, the M	laintenance Director agreed			ensure that the deficient		
		in the aforementioned rooms			practice does not recur?		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $VNMX21 \quad \text{Facility ID:} \quad 000272 \qquad \qquad \text{If continuation sheet} \quad \text{Page 19 of 32}$

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER JR CROSSING		707 S .	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	door to the room an would close and late. This finding was rethe Maintenance Di Maintenance Superconference. 3.1-19(b)			Weekly audits to be completed the maintenance director or designee reporting any deficiencies to the Executive Director immediately for repair audits to be presented to QA Committee for review and recommendation. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? To ensure compliance, the Maintenance Director will complete an audit resident rodoors ensuring proper closure audit will be completed 1 time month for 12 months. The resident rodo complete audits will be reviewed the CQI committee monthly a action plans will be developed needed.	om e This e per sults ed by nd
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Constructic 2012 EXISTING Smoke barriers sh 1/2-hour fire resist barriers shall be p atrium wall. Smok in duct penetration systems where an	rall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 20 of 32

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETE	
		155377	B. W	ING		01/09/202	23
NAME OF F	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP COD	-	
		· ·		1	JACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	chanical smoke control					
	system in REMAR		17.0	272	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		2/17/2022
		ation and interview, the facility	KO	372	What corrective action(s) will	II 0.	2/17/2023
		f 10 smoke barrier walls were			be accomplished for those	_	
	1 ~	in the fire resistance rating of			residents found to have bee	n	
		rall. LSC Section 19.3.7.5 riers to be constructed in			affected by the deficient		
	*	C Section 8.5 and shall have a			practice?	tod	
					There were no residents effect		
minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents,				by the alleged deficient practic	Je		
staff and visitors near the vicinity of the smoke				How will you identify other	a		
barrier wall by Room 825 in the B Wing.				residents having the potenti to be affected by the same	aı		
	barrier wan by Room 823 in the B wing.				deficient practice and what		
Findings include:				corrective action will be take			
	rindings include.				The annualizer space surroun		
	Rased on observation	ons with the Maintenance			the four inch diameter horizon	-	
		eld Maintenance Supervisor	sprinkler pipe which penetrated				
		facility from 12:30 p.m. to 2:30		the attic barrier has had fire stop			
	_	ne annular space surrounding a			applied in order to be in	ا ۲۰۰	
	1 ~	er horizontal sprinkler pipe			compliance with regulation.		
		e attic smoke barrier wall			Additionally the two ducts on	, l	
	_	door set by Room 825 in the B			Wing have had covers placed		
		opped. In addition, part of the			them that resist the transfer of		
	_	space for the sprinkler pipe			smoke and fire per regulation.		
		ed with brick and mortar but			What measures will be put in		
	1 ~	n the brick by the penetration			place or what systemic		
		black data cables through the			changes you will make to		
		which were not firestopped.			ensure that the deficient		
	Based on interview				practice does not recur?		
		aintenance Director agreed			Maintenance director to inspe	ct	
		openings in the attic smoke			fire barriers mothly repairing		
		ot firestopped to maintain the			immediately those found not i	n	
	fire resistance rating	g of the smoke barrier wall.			compliance and reporting to the		
					Quality Assurance Committee		
	This finding was re-	viewed with the Administrator,			findings		
	the Maintenance Di	rector and the Field			How the corrective action(s)		
	Maintenance Super	visor during the exit			will be monitored to ensure		
	conference.				deficient practice will not		
					recur, i.e., what quality		
	3.1-19(b)				assurance program will be p	ut	

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155377	B. W	NG		01/09/	/2023
				STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			ACKSON PARK DR		
SEVMOI	JR CROSSING				OUR, IN 47274		
SETIMO	JK CKOSSING			SETIVIC	OOK, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					into place?		
		ation and interview, the facility			To ensure compliance, the		
	_	nings through 1 of 1 ceiling			Maintenance Director will brin	9	
		protected to maintain the fire			results of audit to monthly QA		
	resistance rating of the smoke barrier. LSC				meeting for review and		
	19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states				recommendation monthly for a	ì	
	penetrations for cables, conduits, pipes and				period of not less than 12		
	similar items that pass through a floor/ceiling				months. Executive Director to		
	assembly constructed as a smoke barrier, or				complete random checks of		
	through the ceiling membrane of a ceiling smoke				smoke and fire barrier and aud		
		ected by a system or material			reports, reporting findings to C		
		the transfer of smoke. Where			meeting for a period of not les	S	
		lso constructed as a fire barrier,			than six months.		
	1 -	all be protected in accordance					
	_	nts of Section 8.3.5 to limit the					
	_	time period equal to the fire					
		sembly and Section 8.5.6. This					
		ould affect over two staff and					
	visitors in the D Wi	ng.					
	Findings include:						
	Rosed on observative	ons with the Maintenance					
		eld Maintenance Supervisor					
		facility from 12:30 p.m. to 2:30					
		IVAC ductwork had been					
	1 ~	former ceiling mounted air					
		grills in the corridor by Room					
		in the D Wing which exposed					
		sed on interview at the time of					
		e Maintenance Director					
	· ·	the ceiling caused by the					
		ductwork did not ensure the D					
		e barrier was protected to					
		sistance rating of the smoke					
	barrier.	salure rading of the smoke					
	ourrer.						
	This finding was re	viewed with the Administrator,					
		rector and the Field					
		visor during the exit					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 22 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2023		
	ROVIDER OR SUPPLIER JR CROSSING		707 S .	ADDRESS, CITY, STATE, ZIP COD JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0374 SS=D Bldg. 01	3.1-19(b) NFPA 101 Subdivision of Bui Barrie	lding Spaces - Smoke			
	Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that in Nonrated protective are permitted. Doof fixed fire window a are self-closing or require latching, a in the direction of provides a minimular for swinging or hour 19.3.7.6, 19.3.7.8. Based on observation failed to ensure doo walls in the D Wing of smoke for at least 19.3.7.8 requires the comply with LSC, \$8.5.4.1 requires doo the opening leaving necessary for properas 1/8 inch to restrict This deficient pract residents, staff and facility by the D Wing Findings include: Based on observation	re plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing regress travel. Door opening am clear width of 32 inches rizontal doors. 19.3.7.9 In and interview, the facility are in 1 of 1 attic smoke barrier awould restrict the movement at 20 minutes. LSC, Section at doors in smoke barriers shall section 8.5.4. LSC, Section are in smoke barriers to close only the minimum clearance or operation which is defined but the movement of smoke. See could affect over 20 visitors if needing to exit the	K 0374	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be taken The smoke barrier door in the above the corridor door set by room 102 in D wing has had the data wires removed allowing doto shut completely. What measures will be put into those the corrective action will be put into the corrective action will be taken the smoke barrier door in the above the corridor door set by room 102 in D wing has had the data wires removed allowing deto shut completely.	I 1? attic e oor

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 23 of 32

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155377		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(x3) date survey completed 01/09/2023
	PROVIDER OR SUPPLIER JR CROSSING	707 S J	ADDRESS, CITY, STATE, ZIP COD IACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, the smoke barrier door in the attic above the corridor door set by Room 102 in the D Wing was propped in the fully open position. In addition, numerous data cables were run through the opening for the smoke barrier door which would would not ensure the door would fully self close to restrict the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the smoke barrier door in the attic above the corridor door set by Room 102 in the D Wing was propped in the fully open position with data cables being run through the door opening which did not ensure the door would restrict the movement of smoke. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance director to condu weekly tests of all smoke barri doors ensuring functionality, reporting to executive director issues immediately for replacement or repair. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? Executive Director to review will QA Committee results of inspections monthly for a perion not less than six months noting any repairs or replacements the were made.	er any he ut ith od of
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the attic above the main fire alarm control panel room was maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical	K 0511	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 24 of 32

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED	
155377		B. WING 01/09/2023					
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN 47274		
	T				· - , ·· - · ·	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		IPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ent to comply with NFPA 70,			the junction box mounted in th		
		Code. NFPA 70, 2011 Edition,			attic above the attic access do		
		e) states junction boxes shall be			in the main fire alarm control p	panel	
	_	rs compatible with the box and			room in the D wing has had a		
		ditions of use. Where used,			cover plate installed.		
		comply with the grounding			How will you identify other	_,	
	_	0.110. This deficient practice			residents having the potentia	ai	
	facility.	dents, staff and visitors in the			to be affected by the same		
	iacility.				deficient practice and what		
	Findings in abod -				corrective action will be take	m <i>r</i>	
	Findings include:				A 100% inspection of all attic	tod	
	Dagad or abases:	one with the Maintenance			cover plates has been conducted an arrangement of the conducted arrangemen		
	Based on observations with the Maintenance Director and the Field Maintenance Supervisor				to ensure compliance with K5		
		facility from 12:30 p.m. to 2:30			What measures will be put in		
	-	ne of one electrical junction			place or what systemic		
	_	he attic above the attic access			changes you will make to		
		e alarm control panel room in			ensure that the deficient		
		thout a cover which exposed			practice does not recur?	_+	
	_	al wiring in the junction box.			Maintenance director to inspe cover plates weekly to ensure		
	Based on interview	- ·			compliance and, document re		
		laintenance Director agreed			in TELS.	Suits	
		electrical junction box location			How the corrective action(s)		
		er plate installed which			will be monitored to ensure t	he	
		electrical wiring in the			deficient practice will not		
	junction box.				recur, i.e., what quality		
	Janetica com				assurance program will be p	_{ut}	
	This finding was re	viewed with the Administrator,			into place?		
		rector and the Field			To ensure compliance, the		
		visor during the exit			Maintenance Director will brin	<u> </u>	
	conference.				results of TELS Inspections to	-	
					monthly QA meeting for review		
	3.1-19(b)				and recommendation monthly		
					period of not less than 12		
					months. Executive Director to	,	
					review TELS Reports weekly		
					complete random checks of de		
					and means of egress reporting		
					findings to QA meeting for a p		
					of not less than six months.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 25 of 32

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155377	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG 01	(X3) DATE SUR COMPLETE 01/09/202	D
NAME OF PROVIDER OR SUPPLIER 707 S JA		REET ADDRESS, CITY, STATE, ZIP C 7 S JACKSON PARK DR EYMOUR, IN 47274	OD			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	CROSS-REFERENCED TO THE A	JOHI D DE	(X5) OMPLETION DATE
K 0521 SS=F Bldg. 01	comply with 9.2 ar accordance with the specifications. 18.5.2.1, 19.5.2.1, Based on record revinterview; the facility dampers in the facility dampers in the facility recent four year per 90A. LSC 9.2.1 recair conditioning (Hequipment shall be Standard for the Instand Ventilating System Edition, Section 5.4 maintained in according for Fire Doors and ONFPA 80, 2010 Edity damper shall be testing to ensure full so equipped. The difference of the fire of the form closure in any testing shall be documentation when and how the description 19.4.3 state the fire damper shall	riew, observation and ty failed to ensure all fire ity were inspected and maintenance within the most iod in accordance with NFPA quires heating, ventilating and VAC) ductwork and related in accordance with NFPA 90A, tallation of Air-Conditioning tems. NFPA 90A, 2012 8.1 states fire dampers shall be dance with NFPA 80, Standard Other Opening Protectives. tion, Section 19.4.1 states each red and inspected 1 year after st and inspection frequency rs. If the damper is equipped the link shall be removed for 1 closure and lock-in-place if amper shall not be blocked way. All inspections and amented, indicating the damper, date of inspection, and deficiencies discovered. shall have a space to indicate deficiencies were corrected. Is full unobstructed access to 1 be verified and corrected as scient practice could affect all	K 0521	What corrective action be accomplished for residents found to hat affected by the deficiency practice? The three separate fire noted on the ceiling in work in the corridor on all been inspected with noted on each one. How will you identify residents having the to be affected by the deficient practice and corrective action will A 100% inspection of a dampers has been corrective action will what measures will be place or what system changes you will maken sure that the deficiency practice does not recompliance director to fire dampers monthly to compliance, document in TELS. How the corrective action will be monitored to see the corrective action.	n(s) will those ve been ent e dampers HVAC duct D hall have dates other potential same what be taken? all fire educted to h K521 e put into ic e to ent ur? o inspect all o ensure ting results etion(s)	2/10/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 26 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		ILDING	<u>01</u>	COMPL	
	155377 B. WING		01/09/2023		2023		
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING (V.O. ID. SUMMARY STATEMENT OF DEFICIENCIE)			STREET ADDRESS, CITY, STATE, ZIP COD 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE
	Findings include: Based on record review with the Maintenance Director and the Field Maintenance Supervisor from 9:40 a.m. to 12:30 p.m. on 01/09/23, documentation of fire damper inspections conducted within the most recent four year period was not available for review. Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:30 p.m. on 01/09/23, three separate fire dampers were noted on the ceiling in HVAC ductwork in the corridor in the D Hall. Documentation affixed to the fire dampers did not provide the date of the most recent inspection and necessary maintenance. Based on interview at the time of record review and of the observations, the Maintenance Director agreed documentation of fire damper inspections conducted within the most recent four year period was not available for review. This finding was reviewed with the Administrator, the Maintenance Director and the Field Maintenance Supervisor during the exit conference.				deficient practice will not recur, i.e., what quality assurance program will be printed place? To ensure compliance, the Maintenance Director will bring results of TELS Inspections to monthly QA meeting for review and recommendation monthly period of not less than 12 months.) / for a	
K 0918 SS=F Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro-	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 27 of 32

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. B	JILDING	01	COMPL	ETED	
		155377	B. W	B. WING			01/09/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹						
CEVMOL	SEAMOTIB CBOSSING			707 S JACKSON PARK DR SEYMOUR, IN 47274				
SEYMOUR CROSSING				SETIVIC	JUR, IN 47274			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	safety and critical	branches. Maintenance				•		
	and testing of the	generator and transfer						
		ormed in accordance with						
	NFPA 110.							
	Generator sets ar	e inspected weekly,						
	exercised under lo	oad 30 minutes 12 times a						
	year in 20-40 day	intervals, and exercised						
	once every 36 mo	onths for 4 continuous hours.						
	Scheduled test un	nder load conditions include						
	a complete simula	ated cold start and						
	automatic or man	ual transfer of all EES						
	loads, and are cor	nducted by competent						
	personnel. Mainte	nance and testing of stored						
	energy power sou	rces (Type 3 EES) are in						
	accordance with N	NFPA 111. Main and feeder						
	circuit breakers ar	re inspected annually, and a						
	program for period	dically exercising the						
	components is es	tablished according to						
	manufacturer requ	uirements. Written records						
	of maintenance a	nd testing are maintained						
	and readily availa	ble. EES electrical panels						
	and circuits are m	arked, readily identifiable,						
	and separate from	n normal power circuits.						
	Minimizing the po	ssibility of damage of the						
	emergency power	source is a design						
	consideration for i	new installations.						
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.10	0 (NFPA 70)						
	Based on record rev	view, observation and	K 0	918	What corrective action(s) will	l	01/31/2023	
		ty failed to maintain 1 of 1			be accomplished for those			
		upply systems (EPSS) in			residents found to have beer	1		
		FPA 110. NFPA 110, Standard			affected by the deficient			
		Standby Power Systems, 2010			practice?			
		3.1 states EPSS shall be			No residents were affected by	the		
		re to a reasonable degree that			alleged deficient practice.			
		le of supplying service within			How will you identify other			
	•	or the type and for the duration			residents having the potentia	al		
	_	ss. This deficient practice			to be affected by the same			
	affects all residents	, staff and visitors.			deficient practice and what			
					corrective action will be take	n?		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 28 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155377		l í	JILDING	onstruction 01	(X3) DATE COMPL 01/09/	ETED		
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			•	STREET ADDRESS, CITY, STATE, ZIP COD 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	Based on review of inspection contractionspection document Maintenance Direct Supervisor during in 12:30 p.m. on 01/0 starting batteries will in addition, review "Fuel Analysis Rep 10/27/22 listed the sampling as "Fail". Based on interview the Maintenance Dibatteries still work, the generator, the fabattery replacements should be replaced order documentation at available for review. In additions stated they have adstorage tank since any investigation of was not available for survey. Based on Maintenance Direct Supervisor during a p.m. to 2:30 p.m. of diesel fired emerge the building on the near the service hald documentation affinindicated it was die 08/10/15 and was raffixed to the starting batteries were installed.	The emergency generator or's preventive maintenance natation dated 10/27/22 with the tor and the Field Maintenance record review from 9:40 a.m. to 9/23, the emergency generator ere listed as "Batteries Failed". of the inspection contractor's rort" documentation dated results for annual diesel fuel due to water contamination. at the time of record review, irrector stated the starting he is still able to start and run acility has a work order for and the starting batteries tomorrow but agreed work on for battery replacement was view at the time of record ded fuel to the diesel fuel 10/27/22 but documentation of f diesel fuel sampling failure for review at the time of the observations with the tor and the Field Maintenance of tour of the facility from 12:30 of 101/09/23, the facility has one may generator located outside northeast side of the property lexit door. Manufactured ated at 275 kW. Documentation and batteries indicated the lled in December 2017.			Testing of the batteries and full will be done in a timely manner and reported in TELS. If at an time there is test failure the E will be notified for immediate for replacement. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance director to test batteries and schedule fuel te per regulation and report finding in TELS for later regulatory recurs. Will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place? To ensure compliance, the Maintenance Director will bring results of audit to monthly QA meeting for review and recommendation monthly for period of not less than 12 months. Executive Director to complete random checks of T and audit reports, reporting findings to QA meeting for a pof not less than six months.	er ny D repair nto sting ngs view. the g a			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet

Page 29 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 155377	A. BUILDI B. WING		01	COMPLI 01/09/	ETED
	PROVIDER OR SUPPLIER JR CROSSING		70	07 S JA	DDRESS, CITY, STATE, ZIP COD ACKSON PARK DR UR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E .	(X5) COMPLETION DATE
	the Maintenance Din Maintenance Superv conference.	rector and the Field visor during the exit					
K 0920 SS=E Bldg. 01	Extens Electrical Equipment Extension Cords Power strips in a pused for component patient-care-relate (PCREE) assembled by quanthe conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care reother UL standard used with general	ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE T UL 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet ls. All power strips are precautions. Extension					
	wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Based on observation failed to ensure 1 of power strips were no fixed wiring. LSC 1 comply with Section	d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility f 1 extension cords including to tused as a substitute for 19.5.1 requires utilities to n 9.1. LSC 9.1.2 requires d equipment to comply with	K 0920		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient prac The extension cord has been removed, no residents were	l	01/31/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet

Page 30 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPI			ETED
1		155377	B. WING			01/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
05,4401	ID 00000110				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWING DE ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	NFPA 70, National	Electrical Code, 2011 Edition.			affected by alleged deficient		
	·	00.8 requires that, unless			practice		
	·	ed, flexible cords and cables			How will you identify other		
		a substitute for fixed wiring of			residents having the potentia	al	
		ection 4.5.7 states any building			to be affected by the same		
		or safeguard provided for life			deficient practice and what		
		gned, installed and approved			corrective action will be take	n?	
		all applicable NFPA standards.			A 100% audit of all resident ro		
		for Health Care Facilities, 2012			along with all offices was		
	·	ient care areas as any portion			completed identifying those po	wer	
	-	lity wherein patients are			cords which were deficient, all		
		nined or treated. Patient care			identified power cords were		
		as a space, within a location			replaced.		
		amination and treatment of			What measures will be put in	to	
		6 ft (1.8 m) beyond the normal			place or what systemic		
	-	chair, table, treadmill, or other			changes you will make to		
	device that supports				ensure that the deficient		
		eatment. A patient care vicinity			practice does not recur?		
		o 7 ft 6 in. (2.3 m) above the			Maintenance director to inspec	ct all	
	-	ection 10.4.2.3 states household			power cords brought into build		
		not commonly equipped with			before usage, additionally	5	
		ors in their power cords shall			Maintenance director to compl	ete	
		led they are not located within			monthly inspection of all room		
	the patient care vici	nity. This deficient practice			ensure no extension cords have		
	could affect over 8	residents, staff and visitors in			been brought in.		
	the vicinity of resid	ent sleeping Room 701.			How the corrective action(s)		
					will be monitored to ensure t	he	
	Findings include:				deficient practice will not		
					recur, i.e., what quality		
	Based on observation	ons with the Maintenance			assurance program will be p	ut	
	Director and the Fie	eld Maintenance Supervisor			into place?		
	during a tour of the	facility from 12:30 p.m. to 2:30			To ensure compliance, the		
	p.m. on 01/09/23, a	sleep apnea machine and a			Maintenance Director will bring	3	
	television were plug	gged into a power strip on the			results of audit to monthly QA		
	floor one foot from	the upholstered chair in which			meeting for review and		
	a resident was sittin	ng in resident sleeping Room			recommendation monthly for a	1	
		g of the power strip was 1363A.			period of not less than 12		
	Based on interview				months. Executive Director to		
	observations, the M	laintenance Director and the			complete random checks of po	ower	
	Field Maintenance	Supervisor agreed a power			cords and audit reports, report		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VNMX21 Facility ID: 000272

If continuation sheet Page 31 of 32

PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
	155377 B. WING			01/09/2023				
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP COD 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	strip was being used	l in the patient care vicinity			findings to QA meeting for a po	eriod		
	for PCREE and non-PCREE at the aforementioned				of not less than six months			
	location.							
	3.1-19(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VNMX21 Facility ID: 000272 If continuation sheet Page 32 of 32