	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES IDENTIFICATION NUMBER 155486	(X2) MULTIPLE CC A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/16/2024	
	ROVIDER OR SUPPLIER FOWN NURSING AND REHABILITATION CENTER	131 S 1	ADDRESS, CITY, STATE, ZIP COD OTH ST ETOWN, IN 47356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
E 0000	ALGOLITORY GREEK INC., IN THIS IN CHAMITON			BARE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/16/24	E 0000			
	Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600				
	At this Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.				
	The facility has 45 certified beds. At the time of the survey, the census was 13.				
	Quality Review completed on 12/20/24				
	The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:				
E 0039 SS=F Bldg	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements				
3.	Based on record review and interview, the facility failed to document exercises which tested the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	Tag E 039 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were harmed during the actual fire event. The fire occurred in the kitchen, and all residents were	n	

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

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/16/2024		
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	facility-based function b. If the LTC facility	y experiences an actual natural		evacuated in a timely manner staff that were involved during evacuation did everything exa	g the actly		
	of the emergency pl from engaging its n	ency that requires activation an, the LTC facility is exempt ext required full-scale		right, and no changes to our properties for evacuation was necessary the future whether it is an action	ı. In		
	full-scale functional the onset of the actu	r individual, facility-based l exercise for 1 year following nal event. itional exercise that may		event or just training, the Administrator will conduct a s summary of the experience to ensure there is nothing needi)		
	include, but is not li a. A second full-sca	mited to the following:		be changed. The facility will continue to do annual active shooter training, as well as	ng to		
	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a			tornado drills and table talk fo potential chemical spills especially since we are in a ru			
	a narrated, clinically	des a group discussion, using y-relevant emergency scenario, n statements, directed		area. How other residents having potential to be affected by the	the		
	challenge an emerge (iii) Analyze the LT	C facility's response to and		same deficient practice will identified and what correctivaction(s) will be taken: Any			
	exercises, and emer LTC facility's emer	ation of all drills, tabletop gency events, and revise the gency plan, as needed in		resident could potentially be affected if training was never conducted in the facility. To			
	deficient practice co	CFR 483.73(d)(2). This ould affect all occupants.		ensure no residents are affect training has been done every If there was ever a reason for	year.		
		"Emergency Preparedness		concern with the staff being a to perform their duties to the fullest, the Administrator would	d		
	Administrator and M review from 10:20 a	n dated 07/20/24 with the Maintenance during record a.m. to 1:10 p.m. on 12/16/24,		ensure more training, even ju individualized training is comp What measures will be put in	olete.		
	emergency that requested emergency plan wit	on actual natural or man-made sired activation of the hin the most recent two year		place and what systemic changes will be made to ensure that the deficient			
	actual kitchen fire in	ete. Documentation for the neident which occurred on fire department involvement		practice does not recur: The deficient practice will not recubrief summary of any actual e	r. A		

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

PRINTED: 02/24/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		A. BUILDING B. WING		COMPLETED 12/16/2024	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	131 S 1	ADDRESS, CITY, STATE, ZIP COD OTH ST ETOWN, IN 47356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	interview at the time Administrator stated active shooter training recent twelve month report documentation was not available for emergency prepared was not available for survey.	fter action report. Based on a of record review, the left the facility also performs and but agreed that active go documentation for the most a period along with after action on for the 05/03/23 fire incident ar review and agreed additional liness testing documentation ar review at the time of the described with the diaintenance during the exit		will be conducted by the Administrator. During a table to exercise all staff will be require sign-in to show proof of trainin and if there are any issues with the staff's responses they will quickly identified. The Administrator will contact local department to do a community based exercise in the spring. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pointo place: The Administrator conduct small quarterly audits during QAPI to ensure no "after action reports" are needed as as any actually training needs be conducted. By what date the systemic changes for each deficiency will be completed: Systemic changes for documentation was completed December 17, 2024	ed to g, h be fire fire will er well to
K 0000					
Bldg. 02	Survey was conduct	00343 155486	K 0000		

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Event ID:

Z52J21

Facility ID: 000343

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED	
		155486	B. WI	NG		12/16	/2024
			<u> </u>	CED FEET	ADDRESS STEV STATE SID SOD		
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
MIDDLET	FOMAL NILIDOINIO A	ND DELIADII ITATION CENTED			OTH ST		
MIDDLE	IOWN NURSING A	AND REHABILITATION CENTER		MIDDL	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	At this Life Safety	Code survey, Middletown					
	Nursing and Rehab	ilitation Center was found not					
	in compliance with	Requirements for Participation					
	in Medicare/Medica	aid, 42 CFR Subpart 483.90(a),					
	Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,						
	Life Safety Code (I	LSC). Bldg. 02 was surveyed					
	under Chapter 19, I	Existing Health Care					
	Occupancies and 41	10 IAC 16.2.					
		fied as Bldg. 02 and Bldg. 03,					
	consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story						
	-	be Type II (222) construction					
		The facility has a fire alarm					
	-	detection in the corridors,					
		corridors, battery operated					
		the twelve resident rooms on					
		ld Hall), and hard-wired smoke					
		een resident rooms on the					
	- '	Hall) which are electrically					
		signal at the nurses' station.					
	•	apacity of 45 and had a census					
	of 13 at the time of	this visit.					
	A 11 ama1	idente have out					
		idents have customary access					
		all areas providing facility					
	were sprinkled.	two detached storage sheds					
	were sprinkled.						
	Quality Paviany ass	mpleted on 12/20/24					
	Quanty Keview cor	inpicted 011 12/20/24					
K 0211	NFPA 101						
SS=E	Means of Egress	- General					1
Bldg. 02	modific of Egross	35.16141					
	Based on observation	on and interview, the facility	K 02	211	Tag K 211		12/16/2024
		f 6 means of egress were	15 02	-11	What corrective action(s) will		12/10/2024
		ained free of all obstructions			be accomplished for those	•	
	-	full instant use in the case of			residents found to have been	n	
	1	.= -=== -=	1			-	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 12/16/2024 155486 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 131 S 10TH ST MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE fire or other emergency. This deficient practice affected by the deficient could affect over 10 residents, staff and visitors if practice: Residents could be needing to exit the facility. affected if that exit was needed and the means of egress was Findings include: blocked substantially. Fortunately, no residents are located on that Based on observations with Maintenance during side of the fire door. The chairs a tour of the facility from 1:10 p.m. to 2:30 p.m. on have been moved just in case of 12/16/24, two chairs were stored up against the such an event in order to continue wall in the exit access vestibule outside resident to provide a safe environment for sleeping Room 12. The chairs were stored in the resident, staff and guests. vestibule opposite an upright piano also stored in How other residents having the the vestibule which restricted the path of egress potential to be affected by the to four feet wide in the vestibule. Based on same deficient practice will be interview at the time of the observations, identified and what corrective Maintenance agreed the storage in the exit access action(s) will be taken: vestibule caused the aforementioned means of Fortunately, this occurred in a egress to not be continually maintained free of all non-occupied resident area. Since obstructions or impediments to full instant use in the area is a very lightly travelled the case of fire or other emergency. corridor, the facility staff under the direction of the Maintenance These findings were reviewed with the Director, will need to ensure such Administrator and Maintenance during the exit areas located throughout the conference. building remain clear. What measures will be put into 3.1-19(b) place and what systemic changes will be made to ensure that the deficient practice does not recur: The areas in the facility that are more highly travelled will be monitored daily to ensure a means of egress. The Maintenance Director Assistant will conduct a weekly walk thru the building to ensure all means of egress are clear. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE (A. BUILDING B. WING	construction 02	(X3) DATE SURVEY COMPLETED 12/16/2024	
NAME OF F	PROVIDER OR SUPPLIER	- L		T ADDRESS, CITY, STATE, ZIP COD 10TH ST	
MIDDLE	TOWN NURSING A	ND REHABILITATION CENTER		LETOWN, IN 47356	
(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 APPROPRIATION OF THE APPROPRIATION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				assurance program will be point place: Monitoring means egress will be done weekly by Maintenance Director Assistan By what date the systemic changes for each deficiency will be completed: The chairs were moved upon exit of the surveyor. December 16, 2024.	of the at.
K 0345	NFPA 101				
SS=F Bldg. 02	Fire Alarm System Maintenance 1. Based on record of facility failed to ensign was maintained in a	review and interview, the sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3.	K 0345	Tag K 345 What corrective action(s) will be accomplished for those residents found to have been	
	installed, tested, and with NFPA 70, Nati 72, National Fire Al 14.2.1.2.2 requires t malfunctions shall b	d maintained in accordance ional Electrical Code and NFPA larm Code. NFPA 72, Section that system defects and be corrected. This deficient t all residents, staff and		affected by the deficient practice: Any resident has the potential to be affected when a system is not functioning properties. As a facility we always keep the safety of our residents first, so systems whether mechanical of written in policy are maintained.	any erly. e all or
	Findings include:			and operational. Batteries in the fire panel have been changed,	ne
	inspection contracto	the fire alarm system or's "Fire Alarm Inspection		by not inspecting them annual there could be some flaws in the	ne
		' documentation dated dministrator and Maintenance		system. Gruneau does all of o	
		w from 10:20 a.m. to 1:10 p.m.		fire system inspections. If there was ever a problem with anyth	
	_	sults of main fire alarm system		they would alert us, and inform	_
		y inspection and testing was		of the specific issue(s).	
		view of the "Deficiency		How other residents having t	he
	Summary" section of	of the 11/26/24 inspection		potential to be affected by the	
	report stated "Batter	ries dated 2019. Due for		same deficient practice will b	
		age". Based on interview at		identified and what corrective	e
	the time of record re	eview, Maintenance stated he		action(s) will be taken: All	
	did not change out t	he main fire alarm system		systems will be monitored by	

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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>			COMPLETED	
		155486	B. W	ING		12/16/	2024
				CTREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OTH ST		
MIDDI E.	TOWN NI IPSING /	AND DEHARII ITATION CENTER			ETOWN, IN 47356		
MIDDLETOWN NURSING AND REHABILITATION CENTER			MIDDEL	= 1 O W 11, 111 47 330			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL					COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		or after 11/26/24 and agreed			IDOH guidelines. Batteries in	the	
	the batteries have n	ot yet been replaced.			fire panel will be checked ann	ually	
					to ensure functionality and		
	_	re reviewed with the			expiration. Gruneau will also b	эе	
	Administrator and	Maintenance during the exit			instructed that our sensitivity		
	conference.				testing needs to be more pred	ise	
	3.1-19(b)				as well as the itemization of		
					everything being inspected. T	his	
					will allow us to better monitor	the	
	2. Based on record review and interview, the				situation if one is ever present	ted.	
	facility failed to maintain 1 of 1 fire alarm systems				What measures will be put ir	nto	
		NFPA 72, National Fire Alarm			place and what systemic		
		y LSC Sections 19.3.4.5.1 and			changes will be made to		
	9.6. NFPA 72, Section 14.3.1 states that unless				ensure that the deficient		
	otherwise permitted by 14.3.2, visual inspections				practice does not recur: As		
	_	in accordance with the			stated previously, batteries wi	ll be	
		14.3.1, or more often if required			checked annually and Grunea	ıu	
	1 -	ving jurisdiction. Table 14.3.1			will be instructed to give more	;	
		wing must be visually			detailed reports. Reports will t	эе	
	inspected semi-ann	-			looked over by the Maintenan	ce	
	a. Control unit trou	_			Director to ensure all tasks ha	ve	
	b. Remote annunci				been met, and if not Gruneau	will	
	_	s (e.g. duct detectors, manual			have to come back out and re	do	
		eat detectors, smoke detectors,			inspections.		
	etc.)				How the corrective action(s)		
	d. Notification app				will be monitored to ensure t	the	
	e. Magnetic hold-o	-			deficient practice will not		
		tice could affect all residents,			recur, i.e., what quality		
	staff and visitors.				assurance program will be p		
					into place: During our quarter	:ly	
	Findings include:				QAPI meetings, all basic		
]				maintenance needs will be		
	Based on review of the fire alarm system				addressed.		
	inspection contractor's "Fire Alarm Inspection				By what date the systemic		
	and Testing Report" documentation dated				changes for each deficiency		
	02/19/24, 05/28/24, 10/23/24 and 11/26/ with the				will be completed: Batteries		
	Administrator and Maintenance during record				were replaced December 30,		
		a.m. to 1:10 p.m. on 12/16/24,			2024, and Gruneau has been		
		arm system inspection			notified of the tags. We are wa	aiting	
	documentation for	visual inspections conducted	1		for them to contact us with a		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLETED			LETED	
		155486	B. WI	NG		12/16	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			OTH ST		
MIDDLET	TOWN NURSING A	AND REHABILITATION CENTER	•		ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ot itemized by location. The			rescheduled inspection.		
		ts" section of the 02/19/24					
		ed "Quarterly inspection.					
	Visually inspected devices". Based on interview						
		d review, Maintenance agreed					
	semi-annual fire alarm system inspection documentation dated 02/19/24 was not itemized by device location.						
	device location.						
	These findings wer	re reviewed with the					
	These findings were reviewed with the Administrator and Maintenance during the exit						
	conference.						
	conference.						
	3.1-19(b)						
	3. Based on record	review and interview, the					
	facility failed to en	sure 1 of 1 fire alarm systems					
	was maintained in	accordance with 9.6.1.3. LSC					
	_	ire alarm system to be installed,					
	· ·	ned in accordance with NFPA					
		ical Code and NFPA 72,					
		m Code. NFPA 72, 2010 Edition,					
	_	nires testing shall be performed					
		Table 14.4.5 Testing					1
	1 -	on 14.4.5.3.1 states sensitivity					1
		ithin 1 year after installation.					1
		states sensitivity shall be					
	1	rnate year thereafter unless					1
	_	d by compliance with 14.4.5.3.3.					1
		noke detectors or smoke alarms asitivity outside the listed and					1
		range shall be cleaned and					1
	I -	eplaced. Section 14.6.2.4 states					
	a record of all inspe	-					
		be provided that includes all					
		tion requested in Figure					
		cient practice could affect all					
	residents, staff and	•					
	Findings include:						

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	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	131 S	ADDRESS, CITY, STATE, ZIP COD 10TH ST LETOWN, IN 47356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	inspection contracted and Testing Report! Administrator and M review from 10:20 a smoke detector sense within the most receavailable for review time of record review alarm system inspect "Fire Alarm Supple to document sensitive recent two year peritesting documentatic sensitivity test point which may have been these findings were Administrator and M conference. 3.1-19(b)				
K 0353 SS=F Bldg. 02	1. Based on record of facility failed to proof other evidence that components had been of 4 quarters. Sprin maintained in accord for the Inspection, Towater-Based Fire P. Edition. NFPA 25, waterflow alarm dequarterly to verify the damage. NFPA 25,	review and interview, the vide written documentation or the sprinkler system en inspected and tested for 1 kler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems, 2011 Section 5.2.5 requires that vices shall be inspected they are free of physical Section 5.3.3.1 requires the ow alarm devices including, but	K 0353	Tag K 353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Any residents has to potential of being affected if systems are not checked properly. Containing smoke in event of a fire is crucial to saft and well-being of everyone. It is smoke can't be detained, residents and staff could suffer	n the fety

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155486	B. W	ING		12/16/2024	1
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IOTH ST		
MIDDLE:	TOWN NURSING A	ND REHABILITATION CENTER			ETOWN, IN 47356		
(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 APPROPRI	ATE CON	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		r motor gongs, shall be tested			smoke inhalation. In the same	e not,	
	quarterly. NFPA 25, Section 4.3.1 requires records				sprinkler systems must be		
		ll inspections, tests, and			checked timely. If the sprinkle		
		system components and shall			system does not work proper	ly fire	
		o the authority having			could spread rapidly making		
		equest. NFPA, 25 Section 4.3.2			evacuation very difficult. Spri		
	_	s shall indicate the procedure			systems will be checked quar	-	
		spection, test, or maintenance),			as well as a weekly walk thru	by	
	_	at performed the work, the			the Assistant Maintenance		
		e. This deficient practice could			Director.		
	affect all residents,	staff and visitors in the facility.			How other residents having		
					potential to be affected by t		
	Findings include:				same deficient practice will		
					identified and what correcti	-	
	Based on review of the sprinkler system				action(s) will be taken: Sprir	nkler	
	_	or's "Dry Sprinkler Inspection			systems will be checked		
	_	tion dated 05/28/24, 10/23/24			quarterly. Any building		
		Maintenance during record			imperfections such as; ceiling		
		a.m. to 1:10 p.m. on 12/16/24, no			tiles, broken outlets, door hin	ges,	
		August, September) 2024			etc. will be correctly upon		
		spection documentation was			notification. All staff are well		
		v. Based on interview at the			trained to point out issues an		
		ew, Maintenance agreed no			inform Maintenance Director	of	
	-	sprinkler system inspection			such flaws.		
		available for review and			What measures will be put i	nto	
		greater than 120 days in			place and what systemic		
		sprinkler system inspection and			changes will be made to		
	testing on 05/28/24	and on 10/23/24.			ensure that the deficient		
	T1 C 1	t grad			practice does not recur: A	.	
	These findings were				weekly building walk-thru will	pe	
		Maintenance during the exit			conducted by the Assistant		
	conference.				Maintenance Director for any		
	2.1.10(1)				obvious flaws to the facility. A		
	3.1-19(b)				staff will continue to notify the		
					Maintenance Director as well		
	2. Based on observation and interview, the facility				ensure this deficient practice	does	
	failed to maintain the ceiling construction in 1 of 1				not recur.		
		PA 13, 2010 edition, Section			How the corrective action(s		
		nooth ceiling as a continuous			will be monitored to ensure	the	
	ceiling free from significant irregularities, lumps, or		1		deficient practice will not		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 12/16/2024	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	131 S 1	ADDRESS, CITY, STATE, ZIP COD 10TH ST ETOWN, IN 47356	
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR indentations. The co around the sprinkler operate at a specifie 8.5.4.1.1 states the of deflector and the ce based on the type of construction. This of over 10 residents, st of the freezer room Findings include: Based on observation a tour of the facility 12/16/24, one suspe in the freezer room One sidewall sprink Based on interview observations, Maint ceiling tile would de room. These findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ciling traps hot air and gases r and causes the sprinkler to d temperature. Section distance between the sprinkler iling above shall be selected r sprinkler and the type of deficient practice could affect raff, and visitors in the vicinity by the Administrator's Office. The section of the sprinkler activation in the enance agreed the missing leave sprinkler activation in the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) recur, i.e., what quality assurance program will be p into place: A quick Maintenar summary will be conducted du our quarterly QAPI meetings t discuss any issues involving the structure of the building. By what date the systemic changes for each deficiency will be completed: The tile was replaced December 20, 2024, quarterly sprinkler inspections continue as normal.	ut nce uring ohe
K 0500 SS=F Bldg. 02	interview; the facili equipment which re from the State of In certificates to ensur operating condition requires all health faconstructed, mainta	- Other riew, observation and ty failed to ensure all quire inspection certificates diana had current inspection e the units were in safe NFPA 101, Section 19.1.1.3.1 acilities to be designed ined and operated to minimize ire emergency requiring the	K 0500	Tag K 500 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Potentially all reside and staff could be affected in the event of an explosion. Inspect in the future will be done time!	nts the ions

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024			
	MIDDLET		ND REHABILITATION CENTER	, ,	131 S 10 MIDDLE	DDRESS, CITY, STATE, ZIP COD OTH ST ETOWN, IN 47356		(X5)
	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
	(X4) ID PREFIX TAG	evacuation of occupaffects all residents. Findings include: Based on record revand Maintenance fr 12/16/24, current in State of Indiana for inspection certificat were not available fobservations with Mathe facility from 1:1 the following equip Certificate of Indiana: a. the water heater is b. the boiler identificate of interview observations, Maintaforementioned equal Certificate of Inspections, Maintaforementioned equal Certificate of Inspections. These findings were	view with the Administrator om 10:20 a.m. to 1:10 p.m. on aspection certificates from the all equipment which require tes from the State of Indiana for review. Based on Maintenance during a tour of 10 p.m. to 2:30 p.m. on 12/16/24, ament did not have current ction documentation from the dentified as IN252553. The das IN345854. The time of the tenance agreed the aipment did not have current ction documentation from the dentified as IN252553. The das IN345854 at the time of the tenance agreed the aipment did not have current ction documentation from the deriview of the dentification documentation from the deriview of	PR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ed le a le	(X5) COMPLETION DATE
						2025.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		02	COMP	COMPLETED	
		155486	B. WI	B. WING 12/16/2			6/2024	
				STRFI	ET ADDRESS, CITY, STATE,	ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				S 10TH ST	LII COD		
MIDDLET	TOWN NURSING A	ND REHABILITATION CENTER			DLETOWN, IN 47356		_	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN O		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIEN	CY)	DATE	
K 0511	NFPA 101							
SS=D	Utilities - Gas and	Electric						
Bldg. 02								
		on and interview, the facility	K 05	511	Tag K 511		12/18/2024	
		ectrical receptacles in wall			What corrective a			
		es in 1 of 1 Shenandoah			be accomplished			
	_	cordance with NFPA 70,			residents found to			
		ode. NFPA 70, 2011 Edition, at			affected by the de			
		ntegrity of Electrical Equipment			practice: If there is	•		
		tes internal parts of electrical			it could potentially			
		g busbars, wiring terminals,			person nearest the	-		
	insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or				outlets in residents			
					been replaced in the	•		
					and any rooms ou			
		There shall be no damaged			residents rooms th			
		rsely affect safe operation or			remodeled also ha			
		of the equipment such as			and covers replace			
	-	; bent; cut; or deteriorated by			next on the list to b			
		action, or overheating. In			and has just been			
		requires electrical receptacles			Fortunately, for the	•		
		nded in accordance with			resident's the outle			
		0, 2011 Edition at 406.4 General			Shenandoah Dinin	-	1	
	_	ments states receptacle outlets			1 -	only used as a staff lounge.		
		ranch circuits in accordance			How other resider	_		
		cle 210. General installation			potential to be aff	-		
	*	be in accordance with 406.4(A)			same deficient pr		1	
	through (F).	e. Receptacles installed on 15-			identified and who			
		ch circuits shall be of the			action(s) will be to		1	
	grounding type.	on chounts shall be of the			a faulty outlet in a			
		eptacles shall be installed only			could cause electr			
		ltage class and current for			and the potential for building. The staff			
		l, except as provided in Table			job to inform Maint			
	210.21(B)(2) and Ta				issues especially t	•		
		anding-type receptacles			pertain to the resid			
	installed in accordar				What measures w			
		d. Receptacles and cord			place and what sy	•		
		e equipment grounding			changes will be m			
		shall have those contacts			ensure that the de			
		ipment grounding conductor.			practice does not			
	connected to an equ	ipment grounding conductor.	1		practice does not	iecui. IIIC	i	

02/24/2025 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 12/16/2024 155486 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 131 S 10TH ST MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN, IN 47356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Exception No. 1: Receptacles mounted on portable weekly walk-thru will also include and vehicle-mounted generators in accordance outlets as that is a potential to be with 250.34. hazardous for both residents and Exception No. 2: Replacement receptacles as staff. permitted by 406.4(D). How the corrective action(s) (C) Methods of Grounding. The equipment will be monitored to ensure the grounding conductor contacts of receptacles and deficient practice will not cord connectors shall be grounded by connection recur, i.e., what quality to the equipment grounding conductor of the assurance program will be put circuit supplying the receptacle or cord connector. into place: Any maintenance The branch-circuit wiring method shall include or issues will be discussed during provide an equipment grounding conductor to our quarterly QAPI meetings. This which the equipment grounding conductor will ensure that if something has contacts of the receptacle or cord connector are been missed is resolved in a connected. timely manner. Informational Note No. 1: See 250.118 for By what date the systemic acceptable grounding means. changes for each deficiency Informational Note No. 2: For extensions of will be completed: The outlet existing branch circuits, see 250.130. was fixed December 18, 2024. This deficient practice could affect one resident, staff or visitor in the Shenandoah Dining Room. Findings include: Based on observations with Maintenance during a tour of the facility from 1:10 p.m. to 2:30 p.m. on 12/16/24, the top receptacle in the wall mounted outlet box installed in the support column at the center of the Shenandoah Dining Room was cracked. In addition, the receptacles in the outlet box were found to have an open ground when tested with an Ideal Industries GFCI testing device. Based on interview at the time of the observations, Maintenance agreed the aforementioned receptacles needed replacement. These findings were reviewed with the

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conference.

Administrator and Maintenance during the exit

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024		
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	<u> </u>	131 S 1	ADDRESS, CITY, STATE, ZIP COD 0TH ST ETOWN, IN 47356		
(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)	ЛЕ	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 02	failed to conduct questimes under varying for 4 of 4 quarters. affect all residents, and the time of precord residents are as a many conducted at a many and the time of record residents and the time of record residents. These findings were affected at unexpected at unexpected at the residents and the time of record residents.	the Administrator and record review from 10:20 a.m. 6/24, third shift fire drills e most recent twelve month 03/29/24, 06/28/24 and 09/18/24 respectively, 6:15 a.m., 6:00 6:00 a.m. Based on interview at eview, Maintenance stated the ee shifts per day, additional documentation was not and agreed the d shift fire drills were not exted times under varying	K 0'	712	Tag K 712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All personnel could affected in an actual event if pevacuation procedures are not followed. This includes all staff be knowledgeable of procedure for any event as well as how to actual execute. Fire drills are a common training done by the tot ensure proper execution in event of a fire. The facility prefire drills on a quarterly basis possift as directed by Indiana Guidelines. This has been noticeably effective knowing the May of 2024 the facility experienced an actual fire, and everyone evacuated out of the building safely. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: It is he to say how the fire drills are not unexpected when 2 of 4 were different times and 2 drills happened to be the same time. The regulation states unexpected and expected times varying conditions. All staff are still trains.	be proper t ff to res o a staff the forms oer hat in d e the e ard ot cted	12/16/2024

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155486		A. BUILDING B. WING	02	COMPLETED 12/16/2024			
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				properly per their quarterly fire drills. Resident could only be affected if no training is ever conducted, or staff are simply unaware of procedure. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will try a not do a fire drill within 30 min of the previous drill in order for be more unexpected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be provided in necessary during quarterly QAPI meetings. By what date the systemic changes for each deficiency will be completed: Systemic changes have been established following the exit survey; December 16, 2024.	ind utes r it to he ut		
K 0918 SS=F Bldg. 02	-	s - Essential Electric Syste					
	failed to ensure an a performed for the fa generator. NFPA 99 2012 Edition Sectio (Essential Electrical be inspected and tes	iew and interview, the facility innual fuel quality test was acility's diesel powered 9, Health Care Facilities Code, in 6.5.4.1.1.2 states Type 2 EES System) generator sets shall ted in accordance with Section 6.4.4.1.1.3 states	K 0918	Tag K 918 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: In the event of an emergency the generator will operate the entire building. It is	n		

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Facility ID: 000343

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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	UILDING	02	COMPLETED	
		155486	B. W	ING		12/16/2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
MIDDI E		ND DELIABII ITATION CENTED			OTH ST		
MIDDLE	IOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintenance shall b	be performed in accordance			imperative that everything is ir	1	
	with NFPA 110, Sta	andard for Emergency and			working order because loss of	:	
	Standby Power Sys	tems, 2010 Edition, Chapter 8.			power in Middletown can happ	oen	
	NFPA 110, Section	8.3.8 states a fuel quality test			on the nicest of days. We		
	shall be performed	at least annually using tests			understand the simplest of iss	ues	
	approved by ASTM	I standards. This deficient			to avoid in bad fuel. Bad fuel o	ould	
	practice could affec	et all residents.			keep the generator from runni	ng	
					properly or run at all, which co	uld	
	Findings include:				cause a major issue in the eve	ent	
					of power loss.		
	Based on record rev	view with the Administrator			How other residents having	the	
	and Maintenance fr	om 10:20 a.m. to 1:10 p.m. on			potential to be affected by th	е	
	12/16/24, document	tation of an annual fuel quality			same deficient practice will b	е	
	test for the facility's	s diesel fuel fired emergency			identified and what correctiv	е	
	generator within the	e most recent twelve month			action(s) will be taken: The		
	period was not avai	lable for review. Based on			generator fuel will be tested		
	interview at the tim	e of record review,			annually per the Indiana		
	Maintenance agreed	d documentation of an annual			guidelines. This will ensure pro	oper	
	fuel quality test for	the facility's diesel fuel fired			functionality of the generator a	and	
	emergency generate	or within the most recent			keep all residents safe in the	event	
	twelve month perio	d was not available for review.			of power loss.		
					What measures will be put in	ito	
	These findings were	e reviewed with the			place and what systemic		
	Administrator and I	Maintenance during the exit			changes will be made to		
	conference				ensure that the deficient		
					practice does not recur: The		
	3.1-19(b)				generator fuel will be tested		
					annually per the Indiana		
					guidelines. This will ensure pro	oper	
					functionality of the generator a	and	
					keep all residents safe in the	event	
					of power loss. Starting in the f	all of	
					2025 the Administrator will sta	y in	
					touch with the Maintenance		
					Director to ensure fuel is teste	_	
					because with winter coming u	р	
					fuel is more likely to gel espec	ially	
					if it is bad fuel.		
					How the corrective action(s)		
					will be monitored to ensure t	he	

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i '		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED B. WING 12/16/2024				
		155486	B. WI			12/16/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD OTH ST		
MIDDLET	TOWN NURSING A	ND REHABILITATION CENTER	MIDDLETOWN, IN 47356				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0000	REGUELITORI GR				deficient practice will not recur, i.e., what quality assurance program will be pinto place: Any Maintenance issues will be discussed during quarterly QAPI meetings. By what date the systemic changes for each deficiency will be completed: The fuel sample was pulled December 2024 by Shaeffer Oil.	g	
Bldg. 03	Survey was conduct of Health in accordal Survey Date: 12/16/2 Facility Number: 00 Provider Number: 1002 At this Life Safety Onursing and Rehabi in compliance with in Medicare/Medical Life Safety from Fit National Fire Protect Life Safety Code (Lunder Chapter 18, Nand 410 IAC 16.2.	289600 Code survey, Middletown Code survey,	K 00	000			
	consisted of the sou determined to be of fully sprinkled, and	fied as Bldg 02 and Bldg 03, th wing, a one-story wing Type V (111) construction and the north wing, a one story be Type II (222) construction					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03			(X3) DATE SURVEY COMPLETED		
11.212111		155486	B. WI			12/16	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	•	131 S 1	ADDRESS, CITY, STATE, ZIP COD OTH ST ETOWN, IN 47356		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TF	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	system with smoke spaces open to the commoke detectors in the North Wing (Ol detectors in the fifte South Wing (New Fwired to an audible Bldg 03 consisted of adjoining support at 03 was determined construction and ful has a capacity of 45 time of this visit. All areas where resist were sprinkled and services except for the were sprinkled.	The facility has a fire alarm detection in the corridors, corridors, battery operated the twelve resident rooms on d Hall), and hard-wired smoke the resident rooms on the Hall) which are electrically signal at the nurses' station. If the north dining room and the reas constructed in 2018. Bldg to be of Type V (111) and had a census of 13 at the didents have customary access all areas providing facility two detached storage sheds					
K 0161 SS=E Bldg. 03	NFPA 101 Building Construct	tion Type and Height					
	failed to maintain the for new construction. This deficient practice residents, staff and new dining room. Findings include: Based on review of information dated 0 and Maintenance dua.m. to 1:10 p.m. or add a new dining ar	on and interview, the facility the building construction type in in the new dining room. tice could affect over 10 visitors in the vicinity of the "Project Data" application 18/23/17 with the Administrator uring record review from 10:20 at 12/16/24, construction plans to the teed to the Indiana Department	K 0	161	Tag K 161 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Any resident has the potential to be affected in not a fire procedures are in place. Froulk is an easy fix to stop such devastating event. Keeping the residents safe is top priority for facility. The deficient area has been fire caulked and other potential areas have been chesto ensure the deficiency does	n e all iire ch a e e or the	01/02/2025

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>03</u>	_	ESURVEY LETED 5/2024
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	131 S	ADDRESS, CITY, STATE, ZIP CO 10TH ST .ETOWN, IN 47356)D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
IAG	of Health by the fad documentation for adjoining areas was Department of Health and III/20/18. Bate record review, the stated the new dinition were added to the form observations with In the facility from 1: the annular space is separate black metanew dining room we ceiling above the centrance to the new hall was not firesto corridor door set at room was equipped resistance rating labellatching hardware with the door frame when of the annular space study of the load be at the time of the of agreed the aforement maintain the buildid.	cility. New construction plan the new dining room and a approved by the Indiana Ith in a letter to the facility ased on interview at the time of Administrator and Maintenance and room and adjoining areas facility in 2018. Based on Maintenance during a tour of 10 p.m. to 2:30 p.m. on 12/16/24, aurrounding each of three all pipes which penetrated the rall above the suspended forridor door set serving as the rall door in the the entrance to the new dining I with a 90-minute fire bel and was equipped with which latched each door into the tested to close. The opening the exposed the wood frame the earing wall. Based on interview the entrance of the maintenance and openings did not and construction type. The reviewed with the Maintenance during the exit	IAG	occur elsewhere. How other residents had potential to be affected same deficient practice identified and what con action(s) will be taken: Fortunately, no new corn has occurred, so fire can complete. It is odd that construction that it was noticed for the past few the future if there is any construction are proced safety will be completed to Indiana Guidelines. What measures will be place and what system changes will be made to ensure that the deficie practice does not recure deficiency will most likely recur due to the fact that construction is coming in future. Simple quarterly will solve the issue of an old imperfections to be thow the corrective act will be monitored to endeficient practice will recur, i.e., what quality assurance program with into place: Any Mainter issues will be discussed quarterly QAPI meeting caulk should not be a fusince there is not new construction in the work. By what date the system changes for each deficient in the work in the completed: The will be completed: The	aving the d by the e will be rrective instruction ulking is being new not be years. In r new lures for fire d according e put into nic to nt ir: This ly not at no new in the near checks ny new or fixed. ition(s) nsure the not rill be put nance d during is. Fire uture issue	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED	
		155486	B. W	ING		12/16	/2024
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356				
(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 CROSS-REFERENCED TO THE APPROX		TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					was completed January 2, 202	24.	
K 0221	NEDA 404						
K 0321 SS=E	NFPA 101	Engloque					
Bldg. 03	Hazardous Areas	- Enclosure					
Diag. 00	Based on record rev	view, observation and	K 0	221	Tag K 321		12/16/2025
		ty failed to ensure 2 of 2	I K U	321	What corrective action(s) wil	ı	12/10/2023
		the new dining room such as			be accomplished for those	•	
		oms were enclosed with a			residents found to have been	1	
		rrier with a 3/4-hour fire-rated			affected by the deficient	-	
		e self-closing or automatic			practice: Any explosion or fire	<u> </u>	
		ce with 7.2.1.8. This deficient			could potentially affect resider		
	_	t over 10 residents, staff and			Safety is top priority for the		
	visitors in the new of				facility. We will continue to train	in	
					for fire evacuation emergencie		
	Findings include:				ensure the safety of our reside		
					and staff. We are not sure how		
	Based on review of	"Project Data" application			these doors will be fixed yet		
	information dated 0	8/23/17 with the Administrator			because it is a part of our new	1	
	and Maintenance du	uring record review from 10:20			addition that was approved by		
	a.m. to 1:10 p.m. or	12/16/24, construction plans to			IDOH and Life Safety. Bluepri	nts	
	add a new dining ar	rea to the north end of the			even indicated the type of doc	rs	
	facility was submitt	ed to the Indiana Department			being used, and the past befo	re	
	1	eility. New construction plan			the construction of the new		
		he new dining room and			addition. The blueprints were		
		approved by the Indiana			available during the time of ex		
	-	th in a letter to the facility			interview, but the surveyor ref		
		sed on interview at the time of			to look at them because it wou		
		Administrator and Maintenance			be difficult to read; or it would	add	
		ng room and adjoining areas			more time to the survey.	ula a	
		acility in 2018. Based on Maintenance during a tour of			How other residents having		
		10 p.m. to 2:30 p.m. on 12/16/24,			potential to be affected by the		
	I -	two separate natural gas fired			same deficient practice will be identified and what corrective		
		e new dining room in Bldg. 03			action(s) will be taken: In the	-	
		a self-closing device which			future if there is any new		
		hed the door into the door			construction we will work with	an	
		to close but each of the doors			architect again and have IDO		
		furnace rooms were not			look over the plans to ensure		

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PRINTED: 02/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	03	COMPL	ETED
		155486	B. W	ING		12/16/	2024
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	<u>C</u>		131 S 1	0TH ST		
MIDDLE	TOWN NURSING A	ND REHABILITATION CENTER		MIDDLE	ETOWN, IN 47356		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG			DATE
		e resistance rating label. Based time of the observations,			codes are met per any new		
		no changes have been made			standard.	***	
		e rooms were constructed and			What measures will be put in place and what systemic	ito	
		ere not equipped with fire			changes will be made to		
	_	pels. Maintenance also stated			ensure that the deficient		
	facility blueprints o				practice does not recur: In the	ne	
		ht be available but was not			future if there is any new	. =	
		at the time of the survey.			construction we will work with	an	
		-			architect again and have IDOI		
	These findings were	e reviewed with the			look over the plans to ensure		
	Administrator and I	Maintenance during the exit			codes are met per any new		
	conference.				standard. The codes that were	9	
					used in the blueprints were		
	3.1-19(b)				created in 2017, with final app	roval	
					in 2018 are as followed:		
					1 Building: 2012 Internation		
					building code effective Decem		
					1, 2014 w/ Indiana amendents		
					2 Electrical: 2009 I.E.C ba	sed	
					on 2008 N.E.C with Indiana		
					Amendments 3 Mechanical: 2012		
					3 Mechanical: 2012 International building code efforts	active	
					December 1, 2014 w/ Indiana	COUVE	
					amendents		
					4 Plumbing: 2006 I.P.C., v	v/	
					2012 Indiana amendments		
					5 Energy: ASHRAE 90.1 2	2007	
					effective 2010 w/ Indiana		
					Amendments		
					6 Fire Code: 2012		
					International building code effe	ective	
					December 1, 2014 w/ Indiana		
					amendents		
					How the corrective action(s)		
					will be monitored to ensure t	the	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 03	COMP	E SURVEY LETED 5/2024
	PROVIDER OR SUPPLIEI	ND REHABILITATION CENTER	131 S	ADDRESS, CITY, STATE, ZIP CO 10TH ST LETOWN, IN 47356	DD	
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE
				into place: Any new co will be discussed during with the owner to continensure compliance. By what date the syste changes for each defice will be completed: It is construction with blueprinal structure approval and Life Safety. The conseemed to have change other older structural lay should all be grandfathed am asking that you look codes that were used. We to stay in compliance, be an oversight by Life Safenearly had to change exponstruction with extrent financial costs because misinterpretation of a responsible to the construction was approved to stay in compliance of a responsible to the construction was approved to such that built the second architect that b	g QAPI and nue to semic siency newer rints and by IDOH des ed, so like y-outs this ered in. I at the We strive nut this is fety. We kterior nely high of a egulation, g any more DR of this final yed in r and tructure contractor, luated and re doors per are steel here is no stact door me	
K 0761 SS=E	NFPA 101 Maintenance, Ins	pection & Testing - Doors				

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPLETED	
		155486	B. WI	NG		12/16/	2024
NAME OF D	DOLUDED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	-		131 S 1	IOTH ST		
MIDDLET	TOWN NURSING A	ND REHABILITATION CENTER		MIDDLI	ETOWN, IN 47356		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 03							
		riew, observation and	K 0'	761	Tag K 761		12/16/2025
		ty failed to ensure the proper			What corrective action(s) wil	I	
	-	tained for 1 of 1 rolling steel			be accomplished for those		
		ance with NFPA 80, the			residents found to have beer	ו	
		oors and Other Opening			affected by the deficient		
		5.8 requires any device,			practice: Any explosion or fire		
	* *	condition, arrangement, level			could potentially affect residen	its.	
		other feature is required for			Safety is top priority for the		
	•	e provision of this Code, such			facility. We will continue to trai		
	device, equipment,	-			for fire evacuation emergencie		
	-	of protection, or other feature			ensure the safety of our reside		
		naintained unless the Code		and staff. To ensure the sa			
	•	enance. NFPA 80, 2010		our residents, the overhead		or is	
	Edition, Section 11.	-			always in the closed position		
	_	evice shall be installed on		unless in use. It remains closed			
		oor. Section 11.4.1.2 states			even if residents are in the din	-	
		hall close automatically upon			room, and meals have not yet		
		of a fusible link or detector.			started. The blueprints were	.,	
		tates that after the automatic			available during the time of ex		
		the door shall remain in the			interview, but the surveyor refu		
	_	the automatic-closing device			to look at them because it wou		
		s deficient practice could			be difficult to read; or it would	add	
		ents, staff and visitors in the			more time to the survey.		
	new dining room.				How other residents having t		
	Findings include:				potential to be affected by th		
	rindings include.				same deficient practice will be		
	Rosed on review of	"Project Data" application			identified and what corrective action(s) will be taken: In the		
		8/23/17 with the Administrator			future if there is any new		
		ring record review from 10:20			construction we will work with	an l	
		12/16/24, construction plans to			architect again and have IDOF		
	•	ea to the north end of the					
	_	ed to the Indiana Department			look over the plans to ensure a codes are met per any new	ali	
	•	ility. New construction plan			standard.		
	-	he new dining room and			What measures will be put in	_{to}	
		approved by the Indiana			place and what systemic		
		th in a letter to the facility			changes will be made to		
		sed on interview at the time of			ensure that the deficient		
		Administrator and Maintenance			practice does not recur: In th	۔ ا	

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

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155486	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>03</u>	COMP	(X3) DATE SURVEY COMPLETED 12/16/2024	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	13 ⁻	REET ADDRESS, CITY, STATE, ZIP COE 1 S 10TH ST DDLETOWN, IN 47356	_		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APP	TION LD BE ROPRIATE	(X5) COMPLETION DATE	
	stated the new dinir were added to the fa observations with M the facility from 1:1 the metal rolling fir new dining room w link and was not sel Based on interview observations, Maint the metal rolling fir new dining room ha was installed and ag equipped with a fus self-closing or autor These findings were	groom and adjoining areas acility in 2018. Based on faintenance during a tour of 0 p.m. to 2:30 p.m. on 12/16/24, as door between the kitchen and as not equipped with a fusible f-closing or automatic closing. at the time of the enance stated no changes to a door between the kitchen and the enance stated no changes to be door between the kitchen and the been made since the door greed the rolling door was not lible link and was not matic closing.		future if there is any new construction we will work architect again and have look over the plans to en codes are met per any not standard. The codes that used in the blueprints we created in 2017, with fina in 2018 are as followed: 1 Building: 2012 Interbuilding code effective D 1, 2014 w/ Indiana amen 2 Electrical: 2009 I.E on 2008 N.E.C with India Amendments 3 Mechanical: 2012 International building code December 1, 2014 w/ Indiana amendents 4 Plumbing: 2006 I.P 2012 Indiana amendments 5 Energy: ASHRAE 9 effective 2010 w/ Indiana Amendments 6 Fire Code: 2012 International building code December 1, 2014 w/ Indiana Amendments How the corrective action will be monitored to ensideficient practice will not recur, i.e., what quality assurance program will into place: Any new conwill be discussed during with the owner to continue ensure compliance. By what date the system changes for each deficientil it is not becompleted: It is not standard.	with an IDOH sure all sew were all approval mational ecember dents. C based na le effective diana le effecti		

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

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NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP COD 131 S 10TH ST MIDDLETOWN, IN 47356 MIDDLETOW	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY				
MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN, IN 47356 IX4) ID SUMMARY STATEMENT OF DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION CONSTRUCTION With Diseptinits and final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfared in. I am asking that you look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs because of a misinterpretation of a regulation, so we will not be making any more changes. The facility is continuing to IDR this tag since no changes or modifications were made since we got approval to use the diring room in 2022. However, we contacted A and R Garage Door on Thursday, January 9 about adding a fusible link. They did not give us a day of service, but said they would be out to look at the issue. We are requesting a 12 month waiver since we do not have a timetable, and per the actual fire event our method was proven to work and keep everyone safe. Waiver end date is requested for	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED		
MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN NURSING AND REHABILITATION CENTER MIDDLETOWN, IN 47356			155486	B. WING		12/16/2024		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG COMPLETION CONSTRUCTION WITH DIVERSITY AND ADDRESS AFFERENCED TO THE APPROPRIATE DATE OF THE				131 S 10TH ST				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CONSPRIENCE CONSTRUCTION WITH BURDEPINATE ORDER CONSTRUCTION With blueprints and final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfathered in. I am asking that yo look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs ecause of a misinterpretation of a regulation, so we will not be making any more changes. The facility is continuing to IDR this tag since no changes or modifications were made since we got approval to use the dining room in 2022. However, we contacted A and R Garage Door on Thursday, January 9 about adding a fusible link. They did not give us a day of service, but said they would be out to look at the issue. We are requesting a 12 month waiver since we do not have a timetable, and per the actual fire event our method was proven to work and keep everyone safe. Waiver end date is requested for	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWDERIC N. LV OF CORRECTION	(X5)		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CONSTRUCTION with Diluterprints and final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfathered in. I am asking that you look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs because of a misinterpretation of a regulation, so we will not be making any more changes. The facility is continuing to IDR this tag since no changes or modifications were made since we got approval to use the dining room in 2022. However, we contacted A and R Garage Door on Thursday, January 9 about adding a fusible link. They did not give us a day of service, but said they would be out to look at the issue. We are requesting a 12 month waitver since we do not have a timetable, and per the actual fire event our method was proven to work and keep everyone safe.					(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
final structure approval by IDOH and Life Safety. The codes seemed to have changed, so like other older structural lay-outs this should all be grandfathered in. I am asking that you look at the codes that were used. We strive to stay in compliance, but this is an oversight by Life Safety. We nearly had to change exterior construction with extremely high financial costs because of a misinterpretation of a regulation, so we will not be making any more changes. The facility is continuing to IDR this tag since no changes or modifications were made since we got approval to use the dining room in 2022. However, we contacted A and R Garage Door on Thursday, January 9 about adding a fusible link. They did not give us a day of service, but said they would be out to look at the issue. We are requesting a 12 month waiver since we do not have a timetable, and per the actual fire event our method was proven to work and keep everyone safe. Waiver end date is requested for	TAG				DEFICIENCY)			
					final structure approval by IDC and Life Safety. The codes seemed to have changed, so other older structural lay-outs should all be grandfathered in am asking that you look at the codes that were used. We strit to stay in compliance, but this an oversight by Life Safety. We nearly had to change exterior construction with extremely his financial costs because of a misinterpretation of a regulation so we will not be making any rechanges. The facility is continuing to IDI this tag since no changes or modifications were made since got approval to use the dining room in 2022. However, we contacted A and R Garage Doon Thursday, January 9 about adding a fusible link. They did give us a day of service, but so they would be out to look at the issue. We are requesting a 12 month waiver since we do not a timetable, and per the actual event our method was proven work and keep everyone safe. Waiver end date is requested	nd DH like this . I ve is de gh on, more R e we or inot aid aid ae have I fire to		

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