Rachel Downing

PRINTED: 09/05/2023 FORM APPROVED OMB NO. 0938-039

08/25/2023

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2023	
	PROVIDER OR SUPPLIER	1012 P	ADDRESS, CITY, STATE, ZIP COD ARKWAY DR RSON, IN 46012	
(X4) ID PREFIX TAG E 0000	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/07/23 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 At this Emergency Preparedness survey, REM Occazio LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 08/10/23 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0039 Bldg	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d) (2), §491.12(d)(2), §494.62(d)(2).			
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

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

TITLE

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

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Area Director

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/07/2023
	PROVIDER OR SUPPLIER		1012 P	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		6.54, CORFs at §485.68, ons" under §485.727,			
		20, RHCs/FQHCs at			
	-	RD Facilities at §494.62]:			
	(2) Testing The If	acility) must conduct			
	(2) Testing. The [facility] must conduct exercises to test the emergency plan				
		ility] must do all of the			
	following:				
		full-scale exercise that is			
	community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based				
		•			
		e every 2 years; or			
	, , -	lity] experiences an actual ade emergency that requires			
		mergency plan, the [facility]			
		gaging in its next required			
	-	or individual, facility-based			
	1	e following the onset of the			
	actual event.				
		ditional exercise at least			
	` '	posite the year the full-scale			
		cise under paragraph (d)(2)			
		s conducted, that may			
	include, but is not	limited to the following:			
	(A) A second full-s	scale exercise that is			
	community-based	or individual, facility-based			
	functional exercise	e; or			
	(B) A mock disast				
	1 ' '	ercise or workshop that is			
		and includes a group			
	discussion using a				
	I -	emergency scenario, and a			
	set of problem sta				
		pared questions designed			
	to challenge an er	• • •			
		acility's] response to and			
	maintain documer	ntation of all drills, tabletop			

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Event ID:

 $0KW421 \qquad {\tt Facility\ ID:} \quad 000869$

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G353	B. W	ING		08/07	/2023
NAME OF P	ROVIDER OR SUPPLIER	·	_		ADDRESS, CITY, STATE, ZIP COD		
					ARKWAY DR		
REM OC	CAZIO LLC			ANDER	RSON, IN 46012		
(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)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		nergency events, and revise rgency plan, as needed.					
	une flacility of enic	rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					
	(2) Testing for ho	spices that provide care in					
	the patient's home	e. The hospice must					
	conduct exercises to test the emergency						
	plan at least annually. The hospice must do						
	the following: (i) Participate in a full-scale exercise that is						
	(i) Participate in a full-scale exercise that is						
	community based every 2 years; or (A) When a community based exercise is not						
	` '						
	accessible, conduct an individual facility based functional exercise every 2 years; or						
		experiences a natural or					
		ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	_	ctional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	, ,	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		onducted, that may					
		limited to the following:					
		scale exercise that is					
	, ,	or a facility based					
	functional exercise						
	(B) A mock disas						
	, ,	ercise or workshop that is					
	, ,	and includes a group					
	discussion using a	.					
		emergency scenario, and a					
	set of problem sta	•					
		pared questions designed					
	to challenge an er						
	-						
	· , -	spices that provide inpatient					
	Lcare directly. The	hospice must conduct	1		I		I

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	OF CORRECTION	IDENTIFICATION NUMBER 15G353	A. BUILDING B. WING		COME	PLETED 7/2023
	PROVIDER OR SUPPLIER		1012 P	ADDRESS, CITY, STATE, ZIP (ARKWAY DR RSON, IN 46012	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	per year. The hos (i) Participate in a that is community-(A) When a comm accessible, conduct facility-based functions of the emergency exempt from engatull-scale community functional exercise emergency event. (ii) Conduct an additional exercise emergency event. (iii) Conduct an additional exercise (B) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exefacilitator that inclusing a narrated, demergency scenar statements, direct questions designe emergency plan. (iii) Analyze the homaintain document exercises, and emithe hospice's emergency scenarios.) *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [For PRFTs at §4]	unity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the ditional annual exercise out is not limited to the exact exercise that is or a facility based e; or er drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared d to challenge an expected exercise to and tation of all drills, tabletop ergency events and revise rgency plan, as needed.				
	plan twice per yea CAH] must do the	r. The [PRTF, Hospital, following:				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING		COMPLETED	
		15G353	B. W	ING		08/07/	/2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			ARKWAY DR		
DEM OC	CAZIO LLC				SON, IN 46012		
KEW OC	CAZIO LLC			ANDER	3011, 111 40012		
(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
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	, ,	nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the [PRTF, Hospital, CAH] experiences						
	an actual natural or man-made emergency						
	that requires activation of the emergency						
	plan, the [facility] is exempt from engaging in						
		ull-scale community based					
	or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual						
		at may include, but is not					
	limited to the follo	_					
	1 ' '	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	, ,	ock disaster drill; or					
		exercise or workshop that					
	1	or and includes a group					
	discussion, using						
	I -	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		he [facility's] response to					
		umentation of all drills,					
	· ·	s, and emergency events					
	needed.	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	30 84(d)·1					
		ACE organization must					
	l ' '	to test the emergency					
	plan at least annu						
	organization must	-					
	1 -	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	(1) Which a collin	idinty-based exercise is flut					l

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	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 15G353		UILDING	NSTRUCTION	COMPL 08/07/	ETED
	F PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility-based fund (B) If the PACE exor man-made emeractivation of the exist exempt from enfull-scale community-based functional exercise of this section is a but is not limited to the functional exercise of this section is a but is not limited to the functional exercise of this section is a but is not limited to the functional exercise of this section is a but is not limited to the functional exercise based functional exercise based functional exercised by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an enfuil in the pace of the the emergency problem in the emergency problem in a that is community (A) When a community (A) When a community of the pace of the pa	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and entation of all drills, tabletop hergency events and revise gency plan, as needed. Les at §483.73(d):] Let y must conduct exercises ency plan at least twice per announced staff drills using occedures. The [LTC facility, the following: an annual full-scale exercise					

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	AN OF CORRECTION				==	COMPLETED 08/07/2023	
	OF PROVIDER OR SUPPLIED		10	12 PAF	odress, city, state, zip cod RKWAY DR SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	III PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	actual natural or requires activation LTC facility is exercipated a full-scalindividual, facility-following the onse (ii) Conduct an arthat may include, following: (A) A second full-community-based functional (B) A mock disased functional (C) A tabletop extend by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the [response to and rall drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at § (2) Testing. The Idexercises to test to twice per year. The following: (i) Participate in a that is community (A) When a communicy (B) If the ICF/IID of	cility] facility experiences an man-made emergency that an of the emergency plan, the empt from engaging its next alle community-based or based functional exercise et of the emergency event. In the exercise but is not limited to the exercise that is a or an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a extements, directed pared questions designed emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the					

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		15G353	B. WING		08/07/2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
				ARKWAY DR	
KEM OC	CAZIO LLC		ANDER	RSON, IN 46012	
(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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		mergency plan, the ICF/IID			
		ngaging in its next required			
		nity-based or individual,			
		ctional exercise following the			
	onset of the emergency event. (ii) Conduct an additional annual exercise				
	that may include, but is not limited to the				
	following:				
		scale exercise that is			
	community-based				
		ctional exercise; or			
	(B) A mock disaster drill; or				
		ercise or workshop that is			
	· ·	and includes a group			
	discussion, using				
	1	emergency scenario, and a			
	set of problem sta				
		pared questions designed			
	to challenge an er				
	1 ' '	CF/IID's response to and			
		ntation of all drills, tabletop			
		nergency events, and revise			
	the ICF/IID's eme	rgency plan, as needed.			
	 *[For HHAs at §48	34.1021			
		e HHA must conduct			
	' ' ' '	he emergency plan at			
		e HHA must do the			
	following:	· · · · · · · · · · · · · · · · · · ·			
	I -	full-scale exercise that is			
	community-based				
	1	community-based exercise			
	, ,	conduct an annual			
		based functional exercise			
	every 2 years; or.				
	(B) If the HHA experiences an actual				
	, ,	ade emergency that requires			
		mergency plan, the HHA is			
		aging in its next required			

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full-scale community-based or individual,

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CENTERS FOR	R MEDICARE & MEDIC					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		CON	COMPLETED	
		15G353	B. WING		08/	07/2023	
	PROVIDER OR SUPPLIEF	R	1012 P	ADDRESS, CITY, STATE, ZIP CO ARKWAY DR RSON, IN 46012	DD		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE	
		ctional exercise following the					
	onset of the emer	<u> </u>					
		Iditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c						
	· ·	limited to the following:					
	(A) A second	full-scale exercise that is					
	community-based	l or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mock d	isaster drill; or					
	(C) A tabletor	p exercise or workshop that					
	is led by a facilitat	tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	·					
	I -	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	and thinks emerge	sney plan, as needed.					
	*[For OPOs at §48	86.3601					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the						
		er-based, tabletop exercise					
		ast annually. A tabletop					
		ast arridally. A tabletop a facilitator and includes a					
	1						
		using a narrated, clinically					
	_	cy scenario, and a set of					
		nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		nan-made emergency that					
	-	n of the emergency plan, the					
	OPO is exempt from	om engaging in its next					
	required testing ex	xercise following the onset					

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of the emergency event.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		15G353	B. WI	NG _		08/07/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ARKWAY DR		
REM OC	CAZIO LLC				SON, IN 46012		
TKEIN OO				7 (TDEI	10012		
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. , , ,	PO's response to and					
		ntation of all tabletop					
		nergency events, and revise					
	=	OPO's] emergency plan, as					
	needed.						
	*[RNCHIs at §403	=					
	, , , ,	e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th	<u> </u>					
		er-based, tabletop exercise					
	1	A tabletop exercise is a					
	, ·	led by a facilitator, using a					
		r-relevant emergency					
		et of problem statements,					
		s, or prepared questions					
	_	enge an emergency plan.					
	. , , ,	NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise rgency plan, as needed.					
		view and interview, the facility	E 00	020			09/07/2023
		e facility's response to and		139	E0039 EP Testing Requireme	nte	09/07/2023
		ation of all drills, tabletop			1. What corrective action	1113	
		gency events. The ICF/IID			will be accomplished?		
	facility must do the	- -			The drill form utilized wi	II	
	1	annual full-scale exercise that			include a section to indicate th		
	is community-based				success of the drill, analysis of		
		ity-based exercise is not			the drill and if there are change		
		an annual individual,			needed to the response plan.		
	facility-based funct				· The Program		
	· ·	cility experiences an actual			Supervisor/Director will ensure	e that	
		le emergency that requires			the drill forms are completed a		
		nergency plan, the ICF/IID			stated above.		
	facility is exempt fr	om engaging its next required			· The supervisors will ens	sure	
		nunity-based or individual,			this through site observations		
		cale functional exercise for 1	audit of the Safety Book.				
	· ·	onset of the actual event.					
		itional exercise that may			2. How will we identify		
	1 1	imited to the following:	1		other residents having the		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING		COMPL	ETED
		15G353	B. W	'ING		08/07/	2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			ARKWAY DR		
REM OC	CAZIO LLC				RSON, IN 46012		
					1 10012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a. A second full-sca				potential to be affected by the	ne	
	•	or an individual, facility-based			same deficient practice and		
	functional exercise.				what corrective action will b	е	
	b. A mock disaster				taken?		
	_	se or workshop that is led by a			· All residents have the		
		des a group discussion led by			potential to be affected by the	:	
	a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem				same deficient practice.		
		-			· The drill form utilized w		
		l messages, or prepared			include a section to indicate the		
		to challenge an emergency			success of the drill, analysis of		
plan.				the drill and if there are chang			
	(iii) Analyze the ICF/IID facility's response to and				needed to the response plan.		
	maintain documentation of all drills, tabletop				· The Program		
	exercises, and emergency events, and revise the				Supervisor/Director will ensur	e that	
		nergency plan, as needed in			the drill forms are completed	as	
		CFR 483.475(d)(2). This			stated above.		
	deficient practice co	ould affect all occupants.			· The supervisors will en	sure	
					this through site observations	and	
	Findings include:				audit of the Safety Book.		
	Based on review of	the facility's Emergency			3. What measures will be	•	
	Preparedness Progra	am (EPP) with the Program			put into place or what system	mic	
	Supervisor (PS) on	08/07/23 at 11:00 a.m., the			changes will be made to		
	documentation for t	the events on 04/08/23 and			ensure that the deficient		
		mplete. There was no			practice does not recur:		
		ne complete scenario, if facility					
		se, and if any updates were			· The drill form utilized w		
		ased on interview at the time of			include a section to indicate the	ne	
		PS stated the two exercises			success of the drill, analysis of	of	
	-	there was no documentation			the drill and if there are chang	ges	
	of an after action pl	an for either event.			needed to the response plan.		
					· The Program		
	_	e reviewed at the exit			Supervisor/Director will ensur		
	conference with the	PS.			the drill forms are completed	as	
					stated above.		
					· The supervisors will en		
					this through site observations	and	
					audit of the Safety Book.		
					4. How will the corrective	•	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u></u>	(X3) DATE SU COMPLET 08/07/20	ED
	ROVIDER OR SUPPLIE	R	1012 P	ADDRESS, CITY, STATE, ZIP CO PARKWAY DR RSON, IN 46012	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				action be monitored to the deficient practice or recur? The drill form util include a section to ind success of the drill, and the drill and if there are needed to the response. The Program Supervisor/Director will the drill forms are compstated above. The supervisors this through site observe audit of the Safety Boolon. The Program Suturn in copies of all drill they are completed to the Program Director during monthly end of the more for review. Copies of the will be maintained by the Director. The Program Suturn that conducted located in the safety boolong with the very supervisory visits competed to the Program Director, For Supervisor and Area Director and emergency prepared plans are in place. What is the date which the systemic chewill be completed? 9/7/2023	ized will icate the alysis of changes e plan. ensure that oleted as will ensure rations and k. pervisor will s when he g their enth process ese drills he Program pervisor will drills are look. and Safety veekly oleted by Program irector safety book uired drills edness	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G353		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/07/2023	
	PROVIDER OR SUPPLIER	1012 P	ADDRESS, CITY, STATE, ZIP COD ARKWAY DR RSON, IN 46012		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0000					
Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/07/23 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 At this Life Safety Code survey, REM Occazio LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.470(j), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. This facility has a fire alarm system with hard wired smoke detectors in client sleeping rooms, the corridors, and common living areas with heat detection in the attic. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of .84	K 0000			
	Quality Review completed on 08/10/23				
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>				
	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are re 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure 1 or continuously in pro 33.2.3.4.1 states a result be provided in accordance with the NFPA 70, National National Fire Alarm is an approved exist permitted to be con National Fire Alarm Edition, Section 14 and malfunctions slipractice could affect Findings include: Based on observation panel (FCP) with the 08/07/23 at 11:50 a correct time and dat FCP was 05/05/200 FCP was 10:21 p.m of observation, the the wrong time and	m is tested and maintained in an approved program a requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. In acceptance, maintenance adily available. In an advantage of the facility of 1 fire alarm systems was per operating condition. LSC manual fire alarm system shall ordance with Section 9.6. LSC alarm system required for life alled, tested, and maintained in the applicable requirements of Electrical Code, and NFPA 72, in and Signaling Code, unless it thing installation, which shall be thinued in use. NFPA 72, in and Signaling Code, 2010 in and Signaling Code, 2010 in and Signaling Code, 2010 in an	K S345	K0345 Fire Alarm System- Testing an Maintenance 2012 Existing (Prompt). A fire alarm system tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NI 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenal and testing are readily availab 1. What corrective action will be accomplished for thes residents found to have been affected by the deficient practice: Koorsens will be made aware that the FCP (fire alarm control panel) has the wrong dand time displayed. Program Supervisor will ensure that this gets complete by Koorsens and complete registered at the accurate date and time are being displayed.	FPA nce le. se l d gular		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/07/2023
	PROVIDER OR SUPPLIEI	₹	1012 P	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012	
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE
				2. How will you identify other residents having the potential to be affected by same deficient practice an what corrective action will taken: All residents have the potential to be affected by the deficient practice. Koorsens will be made aware that the FCP (fire alacontrol panel) has the wrong and time displayed. Program Supervisor we ensure that this gets complete the checks to ensure the accurate date and time are being displayed. 3. What measures will be put into place or what system changes you will make to ensure that the deficient practices does not recur: Koorsens will monitor during their scheduled inspections. Koorsens will be made aware that the FCP (fire alacontrol panel) has the wrong and time displayed. Program Supervisor we ensure that this gets complete the checks to ensure the accurate date and time are being displayed. How will the corrective actions be monitored to ensure the mo	d be be enis enis erm g date will eted regular ate erm g date will ered regular ate erm g date will eted regular ate erm

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		15G353	B. W	ING		08/07	/2023
	PROVIDER OR SUPPLIER	2	<u> </u>	1012 P	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROGRAMMENT OF CONTROL OF			(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\IE	DATE
					the deficient practice will no	t	
					recur, i.e., what quality		
					assurance program will be p	out	
					into place:		
					The Program Superviso	or will	
					ensure that the deficiencies for	ound	
					during inspections are followed	ed up	
					on.		
					 Koorsen's Fire and 		
					Security will monitor.		
					· The Program Supervise	or	
					and/or Program Director will		
					complete quarterly health and	l	
					safety forms that monitor the		
					safety needs of the home.		
					5. What is the date by wh the systemic changes will be completed: 9/7/2023		
K S511	NFPA 101						
	Utilities - Gas and	l Electric					
Bldg. 01	Utilities - Gas and	l Electric					
-		gas or related gas piping					
		PA 54, National Fuel Gas					
	· ·	riring and equipment					
	complies with NP	FA 70, National Electric					
	Code.						
	32.2.5.1, 33.2.5.1	, 9.1.1, 9.1.2					
		ation and interview, the facility	KS	511	K0511 Utilities- Gas and Elec	ctric	09/07/2023
	failed to ensure 1 o	f 3 wet locations were provided			Equipment using gas o relate	d	
	with ground fault c	ircuit interrupter (GFCI)			gas piping complies with NFP		
	-	electric shock. NFPA 70, NEC			54, National Fuel Gas Code,		
	2011 Edition at 210	0.8 Ground-Fault			electrical wiring and equipme	nt	
	Circuit-Interrupter	Protection for Personnel,			complies with NFPS 70, Natio		
	_	circuit-interruption for			Electric Code.		
	-	provided as required in					

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210.8(A) through (C). The ground-fault

circuit-interrupter shall be installed in a readily

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What corrective action

will be accomplished?

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/07/2023	
	PROVIDER OR SUPPLIER		1012 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012	
(X4) ID PREFIX		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.	(X5) COMPLETION
TAG	REGULATORY OF accessible location.	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		: See 215.9 for ground-fault		 Power strip was dangli from the television cord. Prog 	_
		rotection for personnel on		supervisor will secure the pov	
	feeders.	rotection for personner on		strip to ensure no damage co	
		relling Units. All 125-volt,		to the power strip or tv cord.	
	1 1	nd 20-ampere receptacles			
		tions specified in 210.8(B)(1)		2. How will we identify	
	through (8) shall ha			other residents having the	
	- ' '	protection for personnel.		potential to be affected by the	ne
	(1) Bathrooms	•		same deficient practice and	
	(2) Kitchens			what corrective action will b	е
	(3) Rooftops			taken?	
	(4) Outdoors			· All residents have the	
	Exception No. 1 to	(3) and (4): Receptacles that are		potential to be affected by the	:
	not readily accessib	le and are supplied by a		same deficient practice.	
		eated to electric snow-melting,		· Power strip was dangli	ng
		and vessel heating equipment		from the television cord. Prog	ram
	_	o be installed in accordance		supervisor will secure the pov	ver
	with 426.28 or 427.			strip to ensure no damage co	mes
	_	(4): In industrial establishments		to the power strip or tv cord.	
	1 -	ditions of maintenance and			
	_	that only qualified personnel		3. What measures will be	
		sured equipment grounding		put into place or what syste	mic
		as specified in 590.6(B)(2)		changes will be made to	
	_	or only those receptacle		ensure that the deficient	
		oly equipment that would		practice does not recur:	
	_	ard if power is interrupted or		Power strip was dangli	-
	T. T.	t is not compatible with GFCI		from the television cord. Prog	
	protection.	santaalag one installad within		supervisor will secure the pov	
	1 1	eceptacles are installed within butside edge of the sink.		strip to ensure no damage co	mes
		(5): In industrial laboratories,		to the power strip or tv cord.	
	^	supply equipment where			
	_	vould introduce a greater		4. How will the corrective	
	_	nitted to be installed without		action be monitored to ensu	
	GFCI protection.	made to be mistaned without		the deficient practice will no	-
	_	(5): For receptacles located in		recur?	
	_	s of general care or critical		The Program Supervis	or
		care facilities other than those		and Program Director will mo	
	covered under	with the sale with these		as they complete their	1.11.01
ı	1		I	1,	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	G <u>01</u>	COMPLETED			
15G353		B. WING		08/07/2023				
NAME OF BROWIDER OR CURNITER			STRE	EET ADDRESS, CITY, STATE, ZIP CO	D			
NAME OF PROVIDER OR SUPPLIER				2 PARKWAY DR				
REM OC	CAZIO LLC		ANI	ANDERSON, IN 46012				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)			
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE API	ULD BE COMPLETION PROPRIATE			
TAG		R LSC IDENTIFYING INFORMATION	TAG		BATE			
	(6) Indoor wet locat	protection shall not be required.		observations in the hom				
	` /	vith associated showering		 Quarterly Health a assessments will be con 	- I			
	facilities	thi associated showering		quarterly by the Progran	•			
		e bays, and similar areas where		Supervisor or Program [
		e equipment, electrical hand		ensure that there are no				
	tools.	'		environmental concerns				
	NFPA 70, 517-20 V	Vet Locations, requires all		home and that safety ne	eds are			
	receptacles and fixe	ed equipment within the area of		being addressed.				
		have ground-fault circuit						
		protection. Note: Moisture can						
		esistance of the body, and						
		is more subject to failure.		5. What is the date	-			
	1	ice could affect all clients and		which the systemic cha	anges			
	staff.			will be completed?				
	F' 1' ' 1 1			9/7/2023				
	Findings include:							
	Based on observation	on on 08/07/23 at 11:55 a.m.						
	during a tour of the	facility with the Program						
	Supervisor (PS), the	ere was one electric receptacle						
		the laundry sink that was not						
	1 ^	I protection. When tested with						
		ch receptacle it did not break						
		t. Based on interview at the						
		, the Program Manager agreed						
	_	ele by the laundry sink was not						
	provided with GFC	I protection.						
	This finding was re	viewed with the PS at the exit						
	conference.							
		ar a						
		ation and interview, the facility						
		f 1 flexible cords were installed						
		n a safe manor. NFPA 99,						
		tes adapters and extension						
	_	equirements of 10.2.4.2.1						
	_	shall be permitted. Section						
		e cabling shall comply with						
1	r ro.∠.∋. Section 10.2	states cota stiatii ieliei		•	ı			

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012				
NAME OF PROVIDER OR SUPPLIER			PRI	EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	

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