PRINTED:	02/10/2021
FORM APP	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 01/20/2021
	PROVIDER OR SUPPLIE	R	1012 P	ADDRESS, CITY, STATE, ZIP COD ARKWAY DR	
	1			SON, IN 46012	
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	-	NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMPLETION DATE
E 0000	REGULATORI U	K LSC IDENTIFTING INFORMATION	IAU		DATE
Bldg					
Didg	An Emergency Pre	eparedness Survey was	E 0000		
		ndiana State Department of	E 0000		
		nce with 42 CFR 483.475.			
	Survey Date: 01/2	20/21			
	Facility Number:	000869			
	Provider Number:				
	AIM Number: 10	0244230			
	At this Emergency	Preparedness survey, Rem			
	Occazio Lle was fe	ound not in compliance with			
	Emergency Prepar	edness Requirements for			
	Medicare and Med	licaid Participating Providers			
	and Suppliers, 42	CFR 483.475.			
	The facility has 8 (certified beds. At the time of the			
	survey, the census				
	Quality Review co	ompleted on 01/25/21			
E 0007	403.748(a)(3), 41	16.54(a)(3), 418.113(a)(3),			
		32.15(a)(3), 483.475(a)(3),			
Bldg		4.102(a)(3), 485.625(a)(3),			
	485.68(a)(3), 485	5.727(a)(3), 485.920(a)(3),			
	491.12(a)(3), 494				
	EP Program Pati	-			
		Plan. The [facility] must			
		ntain an emergency			
		an that must be reviewed,			
	must do the follo	east every 2 years. The plan wing:]			
		ent/client] population,			
	-	t limited to, persons at-risk; ses the [facility] has the			
	• •	in an emergency; and			
		in an energency, and			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 B. WING 01/20/2021 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility E 0007 02/19/2021 •The emergency preparedness failed to ensure the emergency preparedness plan plan will be updated to address addressed the special needs of its client the services the facility would be population, including, but not limited to, persons able to provide in an emergency. at-risk; the type of services the ICF/IID facility The emergency preparedness has the ability to provide in an emergency; and plan will be updated to address continuity of operations, including delegations of the continuity of services. authority and succession plans in accordance Staff will be trained on the with 42 CFR 483.475(a)(3). This deficient practice updated emergency preparedness could affect all occupants. plan. The updated plan will be kept in Findings include: the home. Based on record review on 01/20/21 at 11:30 a.m. ·The staff will be trained on with the Program Supervisor (PS) the emergency the plan upon the revision and at preparedness plan (EPP) did not address: least annually. a) What services the facility would be able to ·The Program Director will provide. ensure that the plan is available in b) Continuity of services. the home when they do their Based on interview concurrent with record review weekly supervisory visits. it was acknowledged by the PS the EPP did not address items a and b above. This was discussed UKU721 Event ID: Facility ID: 000869 Page 2 of 27 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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ENTERS FO	R MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-0				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	A. I	MULTIPLE CO BUILDING VING	ONSTRUCTION	CO	(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIEF	λ		1012 P/	address, city, state, zif ARKWAY DR SON, IN 46012	P COD		
	SUMMADY	STATEMENT OF DEFICIENCIE		ID	[(7)5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE	
IAU	with the PS during			IAU			DATE	
0015		8.113(b)(6)(iii), 441.184(b)						
Bldg	(1), 482.15(b)(1), 485.625(b)(1)	483.475(b)(1), 483.73(b)(1),						
Diug		ds for Staff and Patients						
		procedures. [Facilities]						
		implement emergency						
		icies and procedures, based						
		v plan set forth in paragraph						
	(a) of this section,	risk assessment at						
	paragraph (a)(1) o	of this section, and the						
	communication pl	an at paragraph (c) of this						
		cies and procedures must						
		updated every 2 years						
). At a minimum, the						
	following:	edures must address the						
		of subsistence needs for						
		whether they evacuate or						
		nclude, but are not limited						
	to the following:							
	.,	er, medical and						
	pharmaceutical su	• •						
	maintain the follow	sources of energy to						
		peratures to protect patient						
		and for the safe and						
	sanitary storage o							
		rgency lighting.						
		detection, extinguishing, and						
	alarm systems.							
	(D) Sewa	age and waste disposal.						
	*[For Inpatient Ho Policies and proce	spice at §418.113(b)(6)(iii):] edures.						
		are additional requirements						
		ted inpatient care facilities						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 B. WING 01/20/2021 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility E 0015 The emergency preparedness 02/19/2021 failed to ensure emergency preparedness policies plan will be updated to address: and procedures include at a minimum, (1) The ·Food, water, medical and provision of subsistence needs for staff and pharmaceutical supplies clients, whether they evacuate or shelter in place, ·Alternate sources of energy include, but are not limited to the following: (i) ·Emergency lighting Food, water, medical, and pharmaceutical ·Fire detection, supplies. (ii) Alternate sources of energy to extinguishing, and alarm systems maintain - (A) Temperatures to protect resident Proper disposal of sewage health and safety and for the safe and sanitary and waste storage of provisions; (B) Emergency lighting; (C) ·Staff will be trained on the Fire detection, extinguishing, and alarm systems; updated emergency preparedness and (D) Sewage and waste disposal in accordance plan. with 42 CFR 483.475(b)(1). This deficient practice •The updated plan will be kept in could affect all occupants. the home. Findings include: •The staff will be trained on the plan upon the revision and at Based on record review and interview on 01/20/21least annually. at 12:05 p.m. with the Program Supervisor (PS) the ·The Program Director will emergency preparedness plan did not address: ensure that the plan is available in 1. Alternate sources of power and protection of the home when they do their provisions. weekly supervisory visits. Based on interview concurrent with record review UKU721

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Facility ID: 000869

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 15G353 B. WING 01/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE with the PS it was stated she did not believe this information was in the emergency preparedness plan. This was discussed with the PS during the exit conference. E 0018 403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), Bldg. --483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the UKU721 Event ID: Facility ID: 000869 Page 5 of 27 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	R MEDICARE & MEDIC						OMB NO. 0938-0	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION		(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING		_	1PLETED	
		15G353	В.	WING		01/2	20/2021	
JAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP	COD		
					ARKWAY DR			
KEM OC	CAZIO LLC			ANDER	SON, IN 46012			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
REFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLET	
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		PRTF's, LTC, ICF/IID or						
	-	ment the specific name						
	location.	e receiving facility or other						
	*[For Inpatient Ho	spice at §418.113(b)(6):]						
	Policies and proce							
	· ·	n from the hospice, which						
		ation of care and treatment						
		s; staff responsibilities;						
		ntification of evacuation						
	.,	mary and alternate means						
		with external sources of						
	assistance.	olytha lagation of hearing						
		ack the location of hospice ty and sheltered patients in						
		during an emergency. If						
		yees or sheltered patients						
		ng the emergency, the						
		ument the specific name						
		e receiving facility or other						
	location.							
	*[For CMHCs at §	485.920(b):] Policies and						
	procedures. (2) Sa	afe evacuation from the						
		udes consideration of care						
		eds of evacuees; staff						
		ansportation; identification						
		ition(s); and primary and f communication with						
	external sources of							
	*[For OPOs at § 4	86.360(b):] Policies and						
		system of medical						
		at preserves potential and						
	actual donor inform	-						
		otential and actual donor						
		ecures and maintains the						
	availability of reco	rds.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 B. WING 01/20/2021 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility E 0018 The emergency preparedness 02/19/2021 failed to ensure emergency preparedness policies plan will be updated to include a and procedures include a system to track the system to track the whereabouts location of on-duty staff and sheltered clients in of staff and clients during an the ICF/IID facility's care during and after an emergency evacuation. emergency. If on-duty staff and sheltered clients ·Staff will be trained on the are relocated during the emergency, the ICF/IID updated emergency preparedness facility must document the specific name and plan. location of the receiving facility or other location •The updated plan will be kept in in accordance with 42 CFR 483.475(b)(2). This the home. deficient practice could affect all occupants. The staff will be trained on Findings include: the plan upon the revision and at least annually. Based on record review on 01/20/21 at 11:36 a.m. ·The Program Director will with the Program Supervisor (PS) there was ensure that the plan is available in nothing in the Emergency Preparedness policy the home when they do their which addressed a system to track the weekly supervisory visits. whereabouts of staff and clients during an emergency evacuation. Based on interview concurrent with record review with the PS it was acknowledged the plan did not contain a system to track staff and clients. This was discussed with the PS during the exit conference. E 0022 403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), Bldg. --483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at UKU721 Facility ID: 000869

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 B. WING 01/20/2021 15G353 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility E 0022 02/19/2021 The emergency preparedness failed to ensure emergency preparedness policies plan will be updated to include a and procedures include a means to shelter in place means to include a shelter in for clients, staff, and volunteers who remain in the place for clients, staff, and facility in accordance with 42 CFR 483.475(b)(4). volunteers who remain in the This deficient practice could affect all occupants. facility. Staff will be trained on the Findings include: updated emergency preparedness plan. Based on record review and interview on 01/20/21 The updated plan will be kept in at 11:42 a.m. with the Program Supervisor (PS), a the home. policy and procedure that included a means to shelter in place for clients, staff, and volunteers •The staff will be trained on who remain in the facility was not available for the plan upon the revision and at review. Based on interview at the time of review it least annually. was acknowledged by the PS the Emergency ·The Program Director will Preparedness Plan did not include a means to ensure that the plan is available in shelter in place for clients, staff, and volunteers the home when they do their who remain in the facility. This was discussed weekly supervisory visits. UKU721 Event ID: Facility ID: 000869 Page 8 of 27 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

02/10/2021

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	A. 1	MULTIPLE CO BUILDING WING	DNSTRUCTION	CO	TE SURVEY MPLETED 20/2021
		100000	Б.			_	20/2021
NAME OF	PROVIDER OR SUPPLIER	ξ			ADDRESS, CITY, STATE, ZIP C ARKWAY DR	OD	
REM OC	CCAZIO LLC				RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUIDED/OR AN OF COD	NECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH	IOULD BE	COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
	with the PS during	the exit conference.					
0023	403.748(b)(5), 41	6.54(b)(4), 418.113(b)(3),					
		2.15(b)(5), 483.475(b)(5),					
Bldg		.102(b)(4), 485.625(b)(5),					
0		.727(b)(3), 485.920(b)(4),					
		1.12(b)(3), 494.62(b)(4)					
	Policies/Procedur						
	Documentation						
	[(b) Policies and p	procedures. The [facilities]					
		implement emergency					
	preparedness pol	icies and procedures, based					
	on the emergency	/ plan set forth in paragraph					
	(a) of this section,	risk assessment at					
	paragraph (a)(1) o	of this section, and the					
	communication pl	an at paragraph (c) of this					
	section. The polic	cies and procedures must					
	be reviewed and u	updated at least every 2					
	years (annually fo	r LTC).] At a minimum, the					
	policies and proce	edures must address the					
	following:]						
	[(5) or (3),(4),(6)]	A system of medical					
		at preserves patient					
	information, prote	cts confidentiality of patient					
	information, and s	ecures and maintains					
	availability of reco	ords.					
	*[For RNHCIs at §	403.748(b):] Policies and					
	procedures. (5) A						
		at does the following:					
	(i) Preserves patie	-					
		lentiality of patient					
	information.						
		naintains the availability of					
	records.						
		86.360(b):] Policies and					
	procedures. (2) A	system of medical					

	R MEDICARE & MEDIC						B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
LAN	of conduction	15G353	А. В. В. W.			01/20/	
			STREET ADDRESS, CITY, STATE, ZIP COD				
	PROVIDER OR SUPPLIE	R		1012 PARKWAY DR			
REM OC	CAZIO LLC			ANDEF	RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	actual donor infor						
		potential and actual donor					
		secures and maintains the					
	availability of reco		E	222	The second		00/10/2021
		view and interview, the facility ergency preparedness policies	E 0	523	•The emergency preparedn		02/19/2021
	and procedures inc			plan will be updated to include			
	documentation that			means to include a system of medical documentation that			
	protects confidentiality of client information, and secures and maintains the availability of records				preserves client information, protects confidentiality of clien	ht	
	in accordance with			information, and secures and	п		
		ould affect all occupants.			maintains the availability of		
	deficient practice e	ould uncer un occupants.			records.		
	Findings include:				·Staff will be trained on the		
	i manige meraaer				updated emergency prepared	ness	
	Based on record re	view on 01/20/21 at 12:15 p.m.			plan.		
		with the Program Supervisor (PS) the facility did			•The updated plan will be ke	ept in	
	not address a system to preserve, protect and				the home.		
	secure medical doc	secure medical documentation in the Emergency					
	Preparedness Polic	y (EPP). Based on interview			·The staff will be trained	on	
	concurrent with rec	cord review with the PS, it			the plan upon the revision and	d at	
	should be in the po	licy, but she did not know			least annually.		
	where to locate it.				The Program Director w	rill	
	This was discussed	with the PS during the exit			ensure that the plan is availab	ole in	
	conference.				the home when they do their		
					weekly supervisory visits.		
0024	403 748(b)(6) 41	6.54(b)(5), 418.113(b)(4),					
··		2.15(b)(6), 483.475(b)(6),					
Bldg		.102(b)(5), 485.625(b)(6),					
0		5.727(b)(4), 485.920(b)(5),					
	491.12(b)(4), 494						
		res-Volunteers and Staffing					
		procedures. The [facilities]					
	/	l implement emergency					
		licies and procedures, based					
		y plan set forth in paragraph					
		, risk assessment at					
	paragraph(a)(1)	of this section, and the					

PRINTED: 02/10/2021

MENT OF HEAT TH AND HUMAN SERVIC . . .

STATEMENT OF DEFICIENCE	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE C A. BUILDING B. WING	- <u>-</u>	(X3) DATE SURVEY COMPLETED 01/20/2021	
NAME OF PROVIDER OR SUP	PLIER	1012 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
section. The be reviewed a years (annua policies and p following:] (6) [or (4), (5) of volunteers emergency st process and p Federally des professionals an emergency *[For RNHCIs procedures. (emergency a strategies to a emergency. *[For Hospice procedures. employees in emergency st professionals an emergency strategies, incl integration of a care profession an emergency	at §403.748(b):] Policies and 6) The use of volunteers in an ad other emergency staffing address surge needs during an at §418.113(b):] Policies and (4) The use of hospice an emergency and other affing strategies, including the ole for integration of State and ignated health care to address surge needs during	E 0024	•The emergency preparedness plan will be updated to address the use of volunteers including to process and role for integration State or Federally designated health care professionals to address surge needs during and emergency. •Staff will be trained on the updated emergency preparedne plan.	he of d	

AND PLAY	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		<u></u>	(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIEF		-	1012 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR		
REM U				ANDER	RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETIO DATE
E 0026 Bldg	with the Program S preparedness plan (of volunteers in an interview at the tim it was confirmed th volunteers. This wa during the exit confi 403.748(b)(8), 410 (iv), 441.184(b)(8), (8), 483.73(b)(8), (7), 494.62(b)(7) Roles Under a Wa [(b) Policies and p must develop and preparedness polition on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The politic be reviewed and the years (annually for policies and proceed following:] (8) [(6), (6)(C)(iv), [facility] under a wa Secretary, in accord of the Act, in the p treatment at an all by emergency ma *[For RNHCIs at § procedures. (8) Th waiver declared b	view on 01/20/21 at 12:06 p.m. upervisor (PS) the emergency EPP) did not address the use emergency. Based on e of record review with the PS e plan did not address use of as discussed with the PS e rence.			the home. •The staff will be trained the plan upon the revision and least annually. •The Program Director ensure that the plan is availed the home when they do their weekly supervisory visits.	nd at will able in	

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G353	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIE	ER	STREET 1012 ANDE			
	1			RSON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 0030 Bldg	provision of care identified by eme officials. Based on record re failed to ensure en and procedures im facility under a wa in accordance with provision of care a care site identified officials in accord This deficient prace Findings include: Based on record re with the Program nothing in the Em (EPP) which addre compliance with t Secretary. Based record review with know where to loc waiver. This was the exit conference 403.748(c)(1), 48 485.68(c)(1), 48 486.360(c)(1), 48 48 486.360(c)(1), 48 48 486.360(c)(1), 48 48 48 48 48 48 48 48 48 48 48 48 48 4	eview on 01/20/20 at 12:17 p.m. Supervisor (PS) there was ergency Preparedness Plan eview on 01/20/20 at 12:17 p.m. Supervisor (PS) there was ergency Preparedness Plan esses the facilities role in the 1135 wither declared by the on interview concurrent with the the PS it was stated she did not ok in the EPP to find the 1135 discussed with the PS during e. 16.54(c)(1), 418.113(c)(1), 82.15(c)(1), 483.475(c)(1), 4.102(c)(1), 494.62(c)(1)	E 0026	 The emergency prepare plan will be updated to inconstruct 1135 waiver. Staff will be trained on a updated emergency prepare plan. The updated plan will be the home. The staff will be trained the plan upon the revisioned least annually. The Program Director ensure that the plan is avan the home when they do the weekly supervisory visits. 	lude the the aredness e kept in ned on and at or will ailable in	02/19/202

	R MEDICARE & MEDIC		OMB NO. 0938-03					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	A. I	MULTIPLE CO BUILDING VING	NSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 01/20/2021	
NAME OF	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP	COD		
		ς τ _α						
REMO	CAZIO LLC			ANDER	SON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	following: (i) Staff. (ii) Entities pr arrangement. (iii) Patients' µ (iv) Other [fac (v) Volunteers *[For Hospitals at §485.625(c)] The include all of the f (1) Names and co following: (i) Staff. (ii) Entities pr arrangement. (iii) Patients' µ	oviding services under ohysicians silities]. s. §482.15(c) and CAHs at communication plan must ollowing: ntact information for the oviding services under ohysicians spitals and CAHs].						
	following: (1) Names and co following: (i) Staff. (ii) Entities pr arrangement. (iii) Next of ki (iv) Other RN (v) Volunteers *[For ASCs at §41 communication pl following: (1) Names and co following: (i) Staff.	an must include all of the ntact information for the oviding services under n, guardian, or custodian. HCIs. s.						

NTERS FOR MEDICARE & MEDICAID					IB NO. 0938-0			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì,		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING			COMPLETED 01/20/2021	
		15G353	B. WIN	G		01/20	/2021	
NAME OF	PROVIDER OR SUPPLIEF	ι			DDRESS, CITY, STATE, ZIP COD ARKWAY DR			
REM OC	CAZIO LLC				SON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE	
	(iii) Patients' (iv) Volunteer	-						
	*[For Hospices at	§418.113(c):] The						
		an must include all of the						
	following:							
	•	ntact information for the						
	(i) Hospice er (ii) Entities pr	nployees. oviding services under						
	arrangement.							
	(iii) Patients'	-						
	(iv) Other hos	spices.						
	*[For HHAs at §48	84.102(c):] The						
	communication pl	an must include all of the						
	following:							
	• •	ntact information for the						
	following:							
	(i) Staff.							
		oviding services under						
	arrangement.							
	(iii) Patients' (iv) Volunteer	-						
	*[For OPOs at §48	86.360(c):] The						
	communication pl	an must include all of the						
	following:							
	(2) Names and co	ntact information for the						
	following:							
	(i) Staff.							
	(ii) Entities pr	oviding services under						
	arrangement.							
	(iii) Volunteer							
	(iv) Other OP							
		t and donor hospitals in the						
		Service Area (DSA).						
		view and interview, the facility	E 00	30	The emergency preparedr		02/19/2	
		emergency preparedness			plan will be updated to includ			
	communication pla	n includes (1) Names and			names and contact information	on for		

PRINTED: 02/10/2021 ORM APPROV

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIE	ER	1012 F	ADDRESS, CITY, STATE, ZIP COD PARKWAY DR RSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION on for the following: (i) Staff (ii)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY) the staff, clients physicians	D BE DPRIATE	(X5) COMPLETION DATE	
E 0033 Bldg	Entities providing Clients' physicians Volunteers in acco (1). This deficient occupants. Findings include: Based on record rawith the Program Preparedness Plan information on cli Based on interview with the PS it was portion of the EPF information for cli discussed with the 403.748(c)(4)-(6) (4)-(6), 441.184(483.475(c)(4)-(6) (4)-(5), 485.625(485.727(c)(4), 48 494.62(c)(4)-(6) Methods for Sha [(c) The [facility] an emergency pup plan that complie local laws and m at least every 2 y The communicat the following: (4) A method for medical docume [facility's] care, a	services under arrangement (iii) s (iv) Other ICF/IID facilities (v) ordance with 42 CFR 483.475(c) practice could affect all eview on 01/19/21 at 12:18 p.m. Supervisor (PS) the Emergency (EPP) did not have contact ent physicians. w concurrent with record review confirmed the communication P did not include contact ent physicians. This was PS during the exit conference.), 416.54(c)(4)-(6), 418.113(c) c)(4)-(6), 482.15(c)(4)-(6),), 483.73(c)(4)-(6), 491.12(c)(4), 35.920(c)(4)-(6), 491.12(c)(4),		the staff, clients physicians ICF/IID facilities and volun •Staff will be trained on t updated emergency prepa- plan. •The updated plan will be the home. •The staff will be train the plan upon the revision least annually. •The Program Directo ensure that the plan is ava the home when they do th weekly supervisory visits.	teers. he iredness e kept in eed on and at or will illable in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/20/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR				
REMOC			AND	ERSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETIO DATE	
	release patient ir under 45 CFR 16 provision is not re §484.102(c), CO (6) [(4) or (5)]A m about the general patients under th permitted under 4 *[For RNHCIs at for sharing inform documentation for care, as necessal maintain the cont written election s patient or his or h *[For RHCs/FQH means of providi general condition under the facility' CFR 164.510(b)() Based on record re failed to ensure the communication pl sharing information for clients under th necessary, with oth maintain the contin the event of an eva information as per (1)(ii); (6) A mean the general condition the facility's care a 164.510(b)(4) in a	or patients under the RNHCI's ry, with care providers to tinuity of care, based on the tatement made by the her legal representative. Cs at §491.12(c):] (4) A ng information about the and location of patients s care as permitted under 45	E 0033	•The emergency prepared communication plan will be updated to include a method sharing information and med documentation for patients u the facility's care, as necessa with other health providers to maintain the continuity of car means, in the event of an evacuation, to release client information as permitted; and means for providing informat about the general condition a location of clients under the facility's care as permitted. •Staff will be trained on the	for iical nder ary, o re; a d a iion and	02/19/202	

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G353		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ	(X3) DATE SURVEY COMPLETED 01/20/2021	
	NAME OF PROVIDER OR SUPPLIER			t address, city, state, zip cc PARKWAY DR	DD		
REM OC	CAZIO LLC		AND	ERSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
	with the Program 3 Preparedness Plan a) A method for sh documentation for facility's care, as n providers to maint b) A means, in the release client infor CFR 164.510(b)(1 information about location of clients permitted under 45 accordance with 4 Based on interview the PS began search EPP but was unab	eview on 01/20/21 at 12:37 p.m. Supervisor (PS) the Emergency (EPP) did not include: naring information and medical clients under the ICF/IID ecessary, with other health care ain the continuity of care; event of an evacuation, to mation as permitted under 45)(ii); c. c) A means of providing the general condition and under the facility's care as 5 CFR 164.510(b)(4) in 2 CFR 483.475(c)(4). v concurrent with record review thing for this information in the le to find it. The Program the time stated this would		updated emergency preplan. The updated plan will be the home. •The staff will be trained plan upon the revision at annually. •The Program Directo ensure that the plan is at the home when they do weekly supervisory visit	e kept in ed on the and at least r will available in their		
K 0000							
Bldg. 01	conducted by the I accordance with 4		K 0000				
	Survey Date: 01/2 Facility Number: Provider Number: AIM Number: 10	000869 15G353					
	was found not in c for Participation ir 483.470(j), Life Sa	Code survey, Rem Occazio Llc ompliance with Requirements Medicaid, 42 CFR Subpart afety from Fire and the 2012 onal Fire Protection Association					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 01/20/2021			
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR				
REM OCCAZIO LLC			ANDE	RSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	(NFPA) 101, Life	Safety Code (LSC), Chapter 33, al Board and Care Occupancies.						
K S100 Bldg. 01	has a fire alarm sy the corridors comm smoke detectors in attic was not used fuel-fired equipmed detection system t The facility has a of 8 at the time of Calculation of the (E-Score) using N Approaches to Lif facility Prompt wi Quality Review co NFPA 101 General Require 2012 EXISTING List in the REMA Section 33.1 or 3 that are not addr K-tags, but are d along with the ap NFPA standard of on Form CMS-28 1. Based on obset	Evacuation Difficulty Score FPA 101A, Alternative e Safety, Chapter 6, rated the th an E-Score of 0.52. ompleted on 01/25/21 ments - Other ments - Other RKS section any LSC 03.2 General Requirements essed by the provided eficient. This information, oplicable Life Safety Code or citation, should be included	K \$100	•The fire extinguisher in the laundry room will be lowered to	02/19/202			
	extinguishers were NFPA 10. LSC 4. equipment, system of protection, fire- other feature requi inspection, or open	e installed in accordance with 6.12.4 requires any device, h, condition, arrangement, level resistive construction, or any ring periodic testing, ration to ensure its maintenance pected, or operated as specified		ensure that the top of the extinguisher is no taller than 5 from the ground. •The fire extinguisher in the kitchen will be remounted and ensure that the top of the extinguisher is no taller than 5	feet			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 01/20/2021		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR			
REM OC	REM OCCAZIO LLC		ANDE	RSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETIC DATE	
	 in applicable NFP. Standard for Porta Edition, Section 6. having a gross were be installed so that is not more than fi deficient practice of visitors. Findings include: Based on observatt Supervisor (PS) at portable fire exting was mounted on the extinguisher 69 in- interview at the tire the portable fire exting uisher 69 in- interview at the tire the portable fire exting uisher was real above the floor. Based on observer failed to ensure 1 of Kitchen was prote Portable Fire Exting portable fire exting secured on a hang the manufacturer (for such purpose (This deficient prace Findings include: Based on observatt Supervisor on 01/2 extinguisher was sunsupported in the the time of observent 	A standards. NFPA 10, ble Fire Extinguishers, 2010 .1.3.8.1 states fire extinguishers ight not exceeding 40 lb. shall t the top of the fire extinguisher ve feet above the floor. This could affect all clients, staff and ion with the Program 1:15 p.m. on 01/20/21, the guisher located in the Laundry ne wall with the top of the ches above the floor. Based on ne of observation, the PS stated attinguisher has been mounted years and the PS agreed the fire nounted more than five feet vation and interview, the facility of 1 fire extinguishers in the cted. NFPA 10, Standard for nguishers, 6.1.3.4 requires that guishers types shall be (1) er (2) in the bracket supplied by (3) in a listed bracket approved 4) in cabinets or wall recesses. ctice could affect all occupants.		from the ground. •The Program Super Koorsens will monitor to end new extinguishers are non higher than 5 feet from the •Quarterly Health and assessments will be com- quarterly by the Program Densure that there are non- environmental concerns in home and that safety need being addressed.	ensure t hung e ground. d Safety pleted irector to n the	DAIE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIE	ËR	STREE 1012 ANDE			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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	
< S222	NFPA 101					
Bldg. 01	Egress Doors Egress Doors 2012 EXISTING Doors and paths escape shall not Bathroom doors inches. Doors and closet door latch the inside in case bathroom door st opening from the emergency when means of escape egress when the Delayed egress I 7.2.1.6.1 shall be only. Access-corr complying with 7 Forces to open of 7.2.1.4.5. Door-latching de 7.2.1.5.10. Corric positive latching are prohibited. Door assemblies required to swing travel shall be ins than annually in 33.2.2.5.1 throug 483.470(j)(1)(ii) Based on observat failed to ensure 1 provided with only release the door an 7.2.1.5.10 which s device on a door late	of travel to a means of be less than 28 inches. shall not be less than 24 e swinging or sliding. Every shall be readily opened from e of an emergency. Every hall be designed to allow e outside during an n locked. No door in any e shall be locked against building is occupied. ocks complying with e permitted on exterior doors not cled egress locks .2.1.6.2 shall be permitted. loors shall comply with dor doors are provided with hardware, and roller latches for which the door leaf is g in the direction of egress spected and tested not less accordance with 7.2.1.15. gh 33.2.2.5.7, 33.7.7, 42 CFR ion and interview, the facility of 1 staff office doors was y one latching mechanism to ad open. 33.2.2.5.7 refers to tates a latch or other fastening eaf shall be provided with a	K S222	•The regular door knob with turn lock on the Program Supervisor office has been removed and replaced with a regular door knob with no loc	k.	
	operation and that	hat has an obvious method of is readily operated under all s. 7.2.1.5.10.4 states the		•The Program Supervise ensure that double locks are present on the doors of egres	not	

		x1) provider/supplier/clia identification number 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 01/20/2021	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012			
	I					1
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON ID BE OPRIATE	(X5) COMPLETION DATE
< S351 Bldg. 01	releasing mechanis not more than one states the releasing be located not less than 48 inches, abd deficient practice of facility. Findings include: Based on observat with the Program 3 door had a knob lo require more than This was acknowle observation. This during the exit cor NFPA 101 Sprinkler System Sprinkler System Where an autom installed, for eithe building coverage accordance with shall initiate the f accordance with modified below. Supply shall be d In Prompt Evacu sprinkler System with NFPA 13D, of Sprinkler System with NFPA 13D, of Sprinkler System with NFPA 13D, of Sprinkler System and two Family D Homes, shall be Automatic sprink	sm shall open the door leaf with releasing operation. 7.2.1.5.10.1 g mechanism for any latch shall than 34 inches, and not more ove the finished floor. This could affect all staff in the ion on 01/20/21 at 12:10 p.m. Supervisor (PS) the staff office ock and a deadbolt which would one motion to open the door. edged by the PS at the time of was discussed with the PS iference. - Installation - Installation atic sprinkler system is er total or partial e, the system shall be in Section 9.7 and ire alarm system in Section 9.6, as The adequacy of the water ocumented. ation facilities, an automatic in accordance Standard for the Installation ems in One Dwellings and Manufactured permitted. lers shall not be required in eding 24 square pooms not exceeding 55		•The Program Super Program Director will com monthly observations to e double locks are not prese the doors of egress. •The Program Super and/or Program Director w complete quarterly health safety forms that monitor to safety needs of the home.	plete nsure ent on visor vill and the	

	R MEDICARE & MEDI		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION					
						(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		U	01	- 1		
		15G353	B. WING			01/	20/2021	
NAME OF	PROVIDER OR SUPPLI	ĒR			DRESS, CITY, STATE, ZIP CO	DD		
NAME OF PROVIDER OR SUPPLIER				RKWAY DR				
REM OC	CAZIO LLC		AN	IDERS	ON, IN 46012			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	COMPLETIC	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAC	G	DEFICIENCY)		DATE	
	materials providi	ng a 15-minute						
	thermal barrier.							
	In Prompt Evacu	ation Capability facilities						
	where an automa	atic sprinkler						
	system is in acco	ordance with NFPA 13,						
	Standard for the	Installation of						
	Sprinkler System	ns, automatic sprinklers shall						
	not be required i	n closets not						
	exceeding 24 sq	uare feet and in bathrooms						
	not exceeding 58	5 square feet,						
	provided that suc	ch spaces are finished with						
	lath and plaster of	or material						
	providing a 15-m	inute thermal barrier.						
	In Prompt Evacu	ation Capability facilities in						
	buildings four or	fewer stories						
		ne, systems in accordance						
	with NFPA 13R,							
		rinkler Systems in						
		ipancies up to and						
	including Four S	tories in Height, shall be						
	permitted.							
		re alarm system shall not be						
	required for exist							
		ccordance with 33.2.3.5.6.						
		atic sprinkler is installed,						
	attics used for liv							
	-	ired equipment are sprinkler						
		5, 2019. Attics not used for						
	- · ·	storage, or fuel-fired						
		one of the following:						
		neat detection system to						
	activate the fire a	-						
	according to 9.6.							
		automatic sprinkler system						
	according to 9.7.							
		f noncombustible or						
		ble construction; or						
		f fire-retardant-treated wood						
	according to NFI							
	1 33 2 3 5 3 33 2	3.5.3.1, 33.2.3.5.3.3,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01 15G353 B. WING 01/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7 Based on observation and interview, the facility K S351 ·The two low voltage wires 02/19/2021 failed to ensure a 1 of 1 complete automatic strapped to a 2 $\frac{1}{2}$ inch diameter sprinkler system was installed in accordance with metal sprinkler pipe located at the NFPA 13, 2010 Edition, Standard for the ceiling have been moved so they Installation of Sprinkler Systems, Section 9.1.1.7, are no longer attached to the Support of Non-System Components, requires sprinkler pipe. sprinkler piping or hangers shall not be used to support non-system components. This deficient ·The Program Supervisor will practice could affect all clients, staff and visitors. ensure that wires are not connected to the sprinkler pipes. Findings include: ·Koorsens will also ensure that wires are not connected to Based on observation with the Program the sprinkler pipes. Supervisor (PS) on 01/20/21 at 12:53 p.m., in the Riser utility room there were two low voltage wires •The Program Supervisor strapped to a 2 1/2 inch diameter metal sprinkler and/or Program Director will pipe located at the ceiling. Based on interview at complete monthly observations to the time of observation, the PS acknowledged the ensure that wires are not attached pipe and was unaware this was not connected to the sprinkler pipes. allowed.. This was discussed with the PS during the exit conference. ·Koorsens will monitor when they complete their inspections. •The Program Supervisor and/or Program Director will complete quarterly health and safety forms that monitor the safety needs of the home. K S363 **NFPA 101** Corridor - Doors Bldg. 01 Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. UKU721

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01 15G353 B. WING 01/20/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1012 PARKWAY DR **REM OCCAZIO LLC** ANDERSON, IN 46012 (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 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4. 33.7.7 Based on observation and interview, the facility K S363 •The bedroom door for room #1 02/19/2021 failed to ensure 1 of 5 client sleeping rooms were will be repaired to ensure that it provided with a door which would latch securely latches into the door frame in the door frame. This deficient practice could properly. affect 2 client. ·All of the bedroom doors will be checked to ensure that they Findings include: latch properly into the door frame. Based on observation on 01/20/21 at 12:02 p.m. with the Program Supervisor (PS), bedroom door #1 did not latch securely into its respective frame. ·Quarterly Health and Safety Based on interview the PS was asked to view assessments will be completed client bedroom door #1 to observe it did not latch quarterly by the Program into its frame and she confirmed the observation. Supervisor or Program Director to This was discussed with the PS during the exit ensure that there are no conference. environmental concerns in the home and that safety needs are being addressed. ·The Program Supervisor will utilize a monthly maintenance report to track maintenance needs for the home. •The maintenance tracking forms will be completed and submitted monthly. These will be turned into the Program Director and Area Director to monitor for concerns that need to be addressed. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UKU721 Facility ID: 000869 Page 25 of 27 If continuation sheet

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ENTERS FO	TO DE			CONCEPTION	L	au puese
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01		PLETED
		15G353	B. WING		01/20	0/2021
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COI)	
				PARKWAY DR		
REM OC	CAZIO LLC		ANDE	ERSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	JLD BE PROPRIATE	COMPLETION
TAG	REGULATORY C	DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
(S511	NFPA 101					
0011	Utilities - Gas an	d Electric				
Bldg. 01	Utilities - Gas an					
Elag. 01						
	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas					
		wiring and equipment				
		PFA 70, National Electric				
	Code.					
	32.2.5.1, 33.2.5.	1.9.1.1.9.1.2				
		ion and interview, the facility	K S511	•The outlet to the left o	f the	02/19/202
		of 4 ground fault circuit	K 5511	kitchen sink has been re		02/17/202
		tested worked properly to		with a working GFCI.	placea	
		le protection against electric shock. LSC		The outlet in the main ba	throom	
		nires all electrical wiring and		was replaced with a work		
	-	e in accordance with NFPA 70,		was replaced with a work		
		l Code. NFPA 70, Article 210.8				
		cuit-Interrupter Protection for				
		8(A), Dwelling Units, requires		·The Program Supervis	sor and	
		it-interrupter (GFCI) protection		Program Director will mo		
		h bathrooms and kitchens where		they complete their obse		
	-	intended to serve the		in the home.	i valiono	
	-	es. Moisture can reduce the				
	· ·	of the body, and electrical		·Quarterly Health and	Safetv	
		subject to failure. This deficient		assessments will be com	-	
	practice could affe	e de la construcción de la const		quarterly by the Program		
	1			Supervisor or Program E		
	Findings include:			ensure that there are no		
				environmental concerns	in the	
	Based on observat	ions on 01/20/21 during the		home and that safety ne		
		0 p.m. and 2:15 p.m. with the		being addressed.		
		or (PS) there was one GFCI				
		eft of the Kitchen sink which				
	-	ed "open ground" and did not				
		CI in the Main bathroom was				
	-	on interview at the time of				
	-	ests with the PS it was				
		GFCI's needed to be replaced.				
		r				1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G353	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 01/20/2021		
	NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP COD 1012 PARKWAY DR ANDERSON, IN 46012			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	This was discussed with the PS during the exit conference.							

UKU721 Facility ID: 000869