	OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155684	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION   ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 11/21/2023
	PROVIDER OR SUPPLIER FIELD VILLAGE	6450 M	IIAMI CIR II BEND, IN 46614	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 11/21/23  Facility Number: 002662 Provider Number: 155684 AIM Number: 200315930  At this Emergency Preparedness survey, Southfield Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 60 certified beds. At the time of the survey, the census was 50.  Quality Review completed on 11/27/23	E 0000	This Plan of Correction constit my written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and feder law.	this ists .
E 0039 SS=F 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).  *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

LABORATOR I DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE S SIGNATURE

Joseph M. Doran

12/10/2023

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

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Administrator

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	OF CORRECTION	IDENTIFICATION NUMBER  155684		UILDING	nstruction 	COMPL 11/21	ETED	
	ROVIDER OR SUPPLIER IELD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	(2) Testing. The [factorises to test the annually. The [factorises to test the annually. The [factorises of the community-based (A) When a community-based (B) If the [factorises of the community-based functional exercises actual event.	acility] must conduct ne emergency plan lity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based		TAG	DEFICIENCY		DATE	
	or functional exerce (i) of this section is include, but is not (A) A second full-scommunity-based functional exercises	•						
	led by a facilitator discussion using a clinically-relevant set of problem sta messages, or prep to challenge an en	rcise or workshop that is and includes a group narrated, emergency scenario, and a tements, directed pared questions designed						
	maintain documer exercises, and em	ntation of all drills, tabletop lergency events, and revise rgency plan, as needed.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155684	B. W	ING		11/21/	2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					IAMI CIR		
2001HF	FIELD VILLAGE			SOUTH	I BEND, IN 46614		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION spices that provide care in	+	TAG			DATE
	, ,	e. The hospice must					
		s to test the emergency					
		ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	community based						
	' '	nunity based exercise is not					
		ict an individual facility exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
		plan, the hospital is					
	exempt from enga	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)					
		conducted, that may					
		limited to the following:					
		scale exercise that is					
	community-based	or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop that is					
	1	and includes a group					
	discussion using a	emergency scenario, and a					
	set of problem sta	•					
	1	pared questions designed					
	to challenge an er	·					
	(O) Tark (						
	` '	spices that provide inpatient					
		hospice must conduct he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155684			UILDING	NSTRUCTION	(X3) DATE COMPL 11/21/	ETED		
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	accessible, condu- facility-based functions of the emergency exempt from enga- full-scale communifunctional exercise emergency event (ii) Conduct an act that may include, following: (A) A second full- community-based functional exercis (B) A mock disas (C) A tabletop extigation from the community-based functional exercis (B) A mock disas (C) A tabletop extigation from the community-based functional exercis (B) A mock disas (C) A tabletop extigation from the community-based functional exercise functional exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the from the hospice's emergency plan. (iii) Analyze the from the hospice's emergency plan. (iii) Analyze the from the hospice's emergency plan. (iii) The plant of the conduct exercises plan twice per year CAH] must do the	dditional annual exercise but is not limited to the  scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem red messages, or prepared ed to challenge an  sospice's response to and entation of all drills, tabletop ergency events and revise ergency plan, as needed.  141.184(d), Hospitals at as at §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency ar. The [PRTF, Hospital, as following:						
	that is community (A) When a comm	an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual,						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<del></del>	COMPL	
		155684	B. WIN	NG		11/21/	/2023
NAME OF T	DROVIDED OF CLIPPI FER			STREET A	DDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIEF	<b>C</b>			AMI CIR		
	TIELD VILLAGE				BEND, IN 46614		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ctional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
	-	ation of the emergency					
		is exempt from engaging in					
	· ·	ull-scale community based					
		ty-based functional exercise					
	_	et of the emergency event.					
	` '	an [additional] annual					
		at may include, but is not					
	limited to the follow	_					
	community-based	scale exercise that is					
		etional exercise; or					
	, ,	ock disaster drill; or					
		o exercise or workshop that or and includes a group					
	-	- · · · · · · · · · · · · · · · · · · ·					
	discussion, using						
	set of problem sta	emergency scenario, and a					
	-	pared questions designed					
	to challenge an er	·					
	_	he [facility's] response to					
	, ,	umentation of all drills,					
		s, and emergency events					
		cility's] emergency plan, as					
	needed.	s, of officiality plan, as					
	*[For PACE at §46	60.84(d):]					
	(2) Testing. The P	ACE organization must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					
	or man-made eme	ergency that requires					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/21/2023
NAME OF P	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP CO	D
SOUTHF	IELD VILLAGE			MIAMI CIR TH BEND, IN 46614	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE
TAG		R LSC IDENTIFYING INFORMATION  mergency plan, the PACE	TAG	DEI ICIENCI I	DATE
		gaging in its next required			
		nity based or individual,			
		tional exercise following the			
	onset of the emer	gency event.			
	(ii) Conduct a	n additional exercise every			
	•	he year the full-scale or			
		e under paragraph (d)(2)(i)			
		onducted that may include,			
	but is not limited to				
	` '	scale exercise that is			
	based functional	or individual, a facility			
	(B) A mock disas				
	` '	ercise or workshop that is			
	. ,	and includes a group			
	discussion, using	<del>-</del> ·			
	_	emergency scenario, and a			
	set of problem sta	tements, directed			
	messages, or pre	pared questions designed			
	to challenge an er				
	, ,	ACE's response to and			
		ntation of all drills, tabletop			
		nergency events and revise			
	ule PACE'S emerç	gency plan, as needed.			
	*[For LTC Facilitie	es at §483.73(d):1			
		ty] must conduct exercises			
		ency plan at least twice per			
	year, including un	announced staff drills using			
		ocedures. The [LTC facility,			
	ICF/IID] must do t	•			
		n annual full-scale exercise			
	that is community				
	, ,	nunity-based exercise is not			
		ct an annual individual,			
	facility-based fund	tional exercise. ility] facility experiences an			
	. , -	nan-made emergency that			
		of the emergency plan the			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	
		155684	B. W	ING		11/21	/2023
NAME OF I	PROVIDER OR SUPPLIER	· ·		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					IAMI CIR		
SOUTHF	TIELD VILLAGE			SOUTH	BEND, IN 46614		
(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	DEFICIENCE		DATE
	1	mpt from engaging its next ale community-based or					
		based functional exercise					
		et of the emergency event.					
	-	dditional annual exercise					
	' '	but is not limited to the					
	following:						
	•	-scale exercise that is					
	community-based	l or an individual, facility					
	based functional	exercise; or					
	(B) A mock disas						
		ercise or workshop that is					
	led by a facilitator						
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
	to challenge an e	pared questions designed					
		LTC facility] facility's					
		naintain documentation of					
		exercises, and emergency					
	-	e the [LTC facility] facility's					
	emergency plan,						
	*[For ICF/IIDs at §	3/83 /75/d\]·					
	_	CF/IID must conduct					
	, ,	he emergency plan at least					
		ne ICF/IID must do the					
	following:						
	•	n annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
		ctional exercise; or.					
	, ,	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
	•	ngaging in its next required					
		nity-based or individual,					
	iacility-based fund	ctional exercise following the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		. 0	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUI	ILDING	<del></del>	COMPL	ETED
		155684		B. WIN	NG		11/21/	/2023
					CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	2				IAMI CIR		
SUITHE	IELD VILLAGE					BEND, IN 46614		
300111	IELD VILLAGE				300111	BEND, IN 40014		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FU	LL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATI	ON		TAG	DEFICIENCY)		DATE
	onset of the emer	gency event.						
	(ii) Conduct an ad	ditional annual exercise						
	that may include,	but is not limited to the						
	following:							
	(A) A second full-s	scale exercise that is						
	community-based	or an individual,						
	facility-based fund	tional exercise; or						
	(B) A mock disast							
	(C) A tabletop exe	ercise or workshop that is						
	led by a facilitator	and includes a group						
	discussion, using	a narrated,						
	•	emergency scenario, and	а					
	set of problem sta	tements, directed						
	messages, or prep	pared questions designed						
	to challenge an er							
	(iii) Analyze the IC	CF/IID's response to and						
		ntation of all drills, tabletop						
		nergency events, and revis	е					
	the ICF/IID's emer	rgency plan, as needed.						
	*[For HHAs at §48	=						
	(d)(2) Testing. The	e HHA must conduct						
	exercises to test the	he emergency plan at						
	-	e HHA must do the						
	following:							
	(i) Participate in a	full-scale exercise that is						
	community-based							
	, ,	ommunity-based exercise						
		conduct an annual						
		based functional exercise						
	every 2 years; or.							
		A experiences an actual						
		ade emergency that require						
		mergency plan, the HHA is	s					
		iging in its next required						
		nity-based or individual,						
	•	tional exercise following th	ie					
	onset of the emer	-						
	, ,	ditional exercise every 2						
	years, opposite th	e year the full-scale	or					

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Facility ID: 002662

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155684		A. BUILDING COMPLETED  B. WING 11/21/2023				LETED	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
SOUTHF	FIELD VILLAGE				BEND, IN 46614		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		e under paragraph (d)(2)(i)		IAU			DATE
	of this section is c						
		limited to the following:					
		full-scale exercise that is					
	community-based						
		ctional exercise; or					
		isaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	, , ,	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise ency plan, as needed.					
	l life i i i A s emerge	ericy plan, as needed.					
	*[For OPOs at §48	<del>-</del>					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	<u> </u>					
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a using a narrated, clinically					
		cy scenario, and a set of					
	_	its, directed messages, or					
	I *	ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
		of the emergency plan, the					
		om engaging in its next					
		xercise following the onset					
	of the emergency	event.					
	(ii) Analyze the Of	PO's response to and					
		ntation of all tabletop					
		nergency events, and revise					
	the [RNHCI's and	OPO's] emergency plan, as					

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	T OF HEALTH AND HU R MEDICARE & MEDIO					FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING COMPLET  B. WING 11/21/20				LETED
	PROVIDER OR SUPPLIE	R		6450 N	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			ΓE	(X5) COMPLETION DATE
	exercises to test RNHCI must do to (i) Conduct a papar at least annually, group discussion narrated, clinicall scenario, and a sidirected message designed to chall (ii) Analyze the Right maintain docume exercises, and enthe RNHCI's eme Based on record refailed to conduct explan at least twice unannounced staff procedures. The Lifollowing:  (i) Participate in an is community-based a. When a community-based function man-made emergency of the emer	the emergency plan. The the following: the emergency plan. The the following: the	E 00	39	The facility actually executed a documented its Emergency Preparedness Plan on July 18 2023, due to a planned power outage by the utility company.  A tabletop exercise will be held prior to December 20, 2023, to meet the additional annual test requirement.  To prevent reoccurrence, a ne Chairperson has been appoint to head the Environmental Enrichment Committee, a subcommittee of the facility's QAPI program. The Environment Enrichment Committee will be responsible to meet the annual	d o ting w ed	12/20/2023

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functional exercise.

include, but is not limited to the following:

community-based or an individual, facility-based

a. A second full-scale exercise that is

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testing requirements of the plan

QAPI committee quarterly. Additionally, staff have been

and report their findings to the full

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155684		 JILDING	INSTRUCTION	COMPL 11/21/	ETED	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
SOUTHF	IELD VILLAGE			BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
	facilitator that include a narrated, clinically and a set of problem messages, or prepare challenge an emerge (iii) Analyze the LT maintain documentate exercises, and emerge LTC facility's emerge accordance with 42 deficient practice coeffindings include:  Based on record reveand the Maintenance between 09:39 a.m. documentation of a exercise was available interview at the time Administrator stated participate in a full-community-based with the participate of the pa	see or workshop that is led by a des a group discussion, using relevant emergency scenario, a statements, directed ed questions designed to ency plan.  C facility's response to and attion of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This hald affect all occupants.  iew with the Administrator e Director on 11/21/23 and 11:51 a.m., no community based annual ble for review. Based on e of records review, the lather facility did not scale exercise that is within the last twelve months.		in-services on this requirement. Failure to execute the plan of correction will result in discipling action, up to and including termination.		
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1)				
	( ) ==== () 5 5.	<del>.</del>				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155684	B. W	_		11/21/	2023
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
SOUTHF	TIELD VILLAGE				IAMI CIR I BEND, IN 46614		
(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	§483.73(e), §485.	R LSC IDENTIFYING INFORMATION 625(a)		TAG	DEFCENCT!		DATE
	- , , -	nd standby power systems.					
	. ,	and the CAH] must					
	implement emerg	ency and standby power					
		n the emergency plan set					
	forth in paragraph	(a) of this section.					
	§482.15(e)(1), §4	83.73(e)(1), §485.625(e)(1)					
		rator location. The					
	•	e located in accordance with					
	•	rements found in the Health					
		ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
		and Tentative Interim					
	,	12-1, TIA 12-2, TIA 12-3,					
	and TIA 12-4), an	d NFPA 110, when a new					
		r when an existing					
	structure or building	ng is renovated.					
	482.15(e)(2), §48	3.73(e)(2), §485.625(e)(2)					
	, , , , _	rator inspection and testing.					
		H and LTC facility] must					
		nergency power system					
		g, and [maintenance]					
	-	nd in the Health Care FPA 110, and Life Safety					
	Code.	FFA 110, and the Salety					
	, , , , -	3.73(e)(3), §485.625(e)(3)					
		rator fuel. [Hospitals, CAHs					
	-	that maintain an onsite fuel					
	•	emergency generators must ow it will keep emergency					
	•	perational during the					
	emergency, unles	_					
		§482.15(h), LTC at					
	- 1,	CAHs §485.625(g):]					
	The standards inc	corporated by reference in					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	COM	TE SURVEY  IPLETED  21/2023
	PROVIDER OR SUPPLIEF		6450	TADDRESS, CITY, STATE, ZIP MIAMI CIR TH BEND, IN 46614	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	reference by the I Federal Register is 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information Reson this material at NA go to:  http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characterist (1) National Fire FBatterymarch Par Quincy, MA 0216: 1.617.770.3000.  (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NF 2012.  (iv) TIA 12-4 to NF 2013.  (v) TIA 12-5 to NF 2013.  (vi) TIA 12-6 to NF 2014.  (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to NF 11, 2011.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	155684		B. WING 11/21/2023			
		100001	J			11/21	72020
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
SOUTHF	IELD VILLAGE				H BEND, IN 46614		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN O			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	(x) 11A 12-3 to NF 22, 2013.	PA 101, issued October					
		FPA 101, issued October					
	22, 2013.	177 To 1, Issued Colober					
		tandard for Emergency and					
	1 ' '	ystems, 2010 edition,					
	including TIAs to chapter 7, issued August 6,						
	2009						
		eview and interview, the facility	E 00	041	The three year and monthly		12/20/2023
	failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in				testing of the emergency		
				generator under load ha		n	
		•			completed.		
		CFR 483.73(e)(2). This				_	
	deficient practice co	ould affect all occupants.			To prevent reoccurrence, the to document the monthly testi		
	Findings include:				has been revised to include th	ne	
					load measurements. Addition	•	
		eview with the Administrator			staff have been in-serviced or		
		nce on 11/21/23 between 09:49			requirement and the use of th	е	
		, the documentation for the			form. The Environmental		
		r exercise under load and			Enrichment Committee, a		
	I	g required by LSC and NFPA ble for review. Based on			subcommittee of the facility's QAPI committee will be		
		e of record review, the Lead			responsible to review the		
		wledged the missing			documentation monthly and re	nort	
		te time of the survey.			its findings to the full QAPI	Броге	
	documentation at the	to time of the survey.			committee quarterly. Failure	to	
	The findings were r	reviewed with the			execute the plan of correction		
	_	Lead Maintenance at the exit			result in disciplinary action, up		
	conference.				and including termination.		
K 0000							
Bldg. 01							
	1	Recertification Survey was	K 0	000	This Plan of Correction consti	tutes	
	I	diana Department of Health in			my written allegation of		
	accordance with 42	CFR 483.90(a).			compliance for the deficiencie		
		(2022			cited. However, submission of	f this	
	Survey Date: 11/21	1/2023			Plan of Correction is not an		
	Ī		ı		admission that a deficiency ex	(ISts	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155684	B. WI	NG		11/21/	2023
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					IAMI CIR		
SOUTHF	TELD VILLAGE			SOUTH	I BEND, IN 46614		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	Facility Number: 0 Provider Number:				or that one was cited correctly  This Plan of Correction is	·-	
	AIM Number: 200			submitted to meet requirements			
	7 Mivi ivamoci. 200	313730			established by state and feder		
	At this Life Safety	Code survey, Southfield			law.	ui .	
	· ·	not in compliance with					
	Requirements for P	-					
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),						
	Life Safety from Fire, and the 2012 edition of the						
	National Fire Protection Association (NFPA) 101,						
	Life Safety Code (LSC), Chapter 19, Existing						
	Health Care Occupancies and 410 IAC 16.2. The 2020 Therapy addition, was evaluated under Life						
	Safety Code (LSC), Chapter 18, New Health Care						
	Occupancies	Chapter 16, New Health Care					
	This one-story facil	ity was determined to be of					
	Type V (111) const	ruction, with a 2020 Therapy					
	addition with Type	II (000) construction and was					
		he facility has a fire alarm					
	1 -	detection in the corridors and					
		corridors. The hard-wired					
		the resident sleeping rooms is					
		ne fire alarm system. The I to a three story Assisted					
	1	n which it is separated by a Fire					
		Fire Resistive Rating. The					
		the 2020 addition are					
		Wall with a 1-hour Fire					
		he Healthcare facility is fully					
	_	el powered 200 kW generator.					
	_	certified beds. At the time of					
	the survey, the cens	us was 50.					
	All areas where res	idents have customary access					
	were sprinklered. All areas providing facility services were sprinklered.						
	Onelia P						
	Quanty Keview cor	mpleted on 11/27/23					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/21/2023
	ROVIDER OR SUPPLIER		6450 M	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupant Multiple Occupant Care Facilities Sections of health other occupancies  o They are not in more inpatients fo treatment, or custo o They are sepan care occupancies construction ha fire resistance ratin accordance wit o The entire build by an approved, s automatic sprir with Section 9.7.  Hospital outpatien required to be clast Health Care Occu number of patients 19.1.3.3, 42 CFR Based on observation failed to ensure 2 of limit the spread of fo of smoke. LSC 19. facilities to be main minimize the possib requiring the evacua 8.3.4.1 states every be protected to limit	cies cies - Sections of Health care facilities classified as meet all of the following:  tended to serve four or repurposes of housing, comary access.  cated from areas of health by eving a minimum two houring in the Chapter 8. ding is protected throughout upervised eighter system in accordance to surgical departments are saified as an Ambulatory pancy regardless of the	K 0131	The kitchen and pantry doors been adjusted to assure they close and latch.  The other door located in the two-hour fire wall separation vinspected and functioned proportion of the property of the prevent reoccurrence, with each monthly fire drill, all door	fully vas perly.
		This deficient practice could		the two-hour separation will be inspected to assure they function properly. Staff have been in-serviced on this requirement. The Environmental Enrichment.	e tion nt.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	 JILDING	nstruction 01	(X3) DATE : COMPL 11/21/	ETED
	PROVIDER OR SUPPLIER		6450 M	ADDRESS, CITY, STATE, ZIP COD IAMI CIR BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	facility with the Lea Administrator on 11 2:12 p.m., the set of two-hour fire wall s healthcare sections to the coordinator o closing. There was between the doors, of the door did not l closed. Also, the Pa wall separating the portions of the build when tested. Based observations, the Lea the kitchen doors di latch and would nee	ssed with the Lead		Committee, a subcommittee of facility's QAPI committee will be responsible to review the documentation monthly and relits findings to the full QAPI committee quarterly. Failure to execute the plan of correction result in disciplinary action, up and including termination.	pe port o will	
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing r and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a d readily available. system last checked ————————————————————————————————————				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155684		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/21/2023	
	ROVIDER OR SUPPLIEF		6450 M	ADDRESS, CITY, STATE, ZIP COD NAMI CIR H BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	c) Water system	supply source			
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure 1 or provided with spare cabinet large enough heads, and a sprinkl NFPA 25, Standard and Maintenance of Systems, 2011 Edit supply of spare sprinklers that have any way can be proshall correspond to	and NFPA 25 on and interview, the facility f 1 sprinkler systems were e sprinklers, a spare sprinkler th to fit all spare sprinkler for the Inspection, Testing, f Water-Based Fire Protection ion, Section 5.4.1.4 states a nklers (never fewer than six) on the premises so that any been operated or damaged in mptly replaced. The sprinklers the types and temperature	K 0353	The old, used sprinkler heads were placed on top of the cab have been removed.  All four cabinets were inspect both externally and internally, new, replacement heads are stored properly.  To prevent reoccurrence, the storage cabinets will be inspeed each time the sprinkler contradoes any work on the system	ted, , the all ected actor
	sprinklers shall be keethe temperature in wood no time exceed 100 sprinkler wrench should be used in	clers on the property. The cept in a cabinet located where which they are subjected will at degrees Fahrenheit. A special all be provided and kept in the n the removal and installation deficient practice could affect ff in the facility.		When sprinkler heads are replaced, the old head will be disposed of by the vendor and verified by the Maintenance s. The Environmental Enrichme Committee, a subcommittee of facility's QAPI committee will responsible to assure this pra occurs and report its findings the full QAPI committee quart Failure to execute the plan of	d staff. ent of the be actice to terly.
	and Administrator of and 2:12 p.m., four the riser room. Thre large enough to con prevent damage to to top of three of the fa approximately 10 sp	on with the Lead Maintenance on 11/21/23 between 11:51 a.m. spare sprinkler cabinets were in the of the cabinets were not stain all sprinkler heads and the sprinkler heads. Sitting on four sprinkler cabinets were pare sprinkler heads unsecured tets. Based on interview at the		correction will result in discipl action, up to and including termination.	I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	l í	UILDING	nstruction 01	(X3) DATE COMPL 11/21	ETED
	PROVIDER OR SUPPLIER			6450 MI	DDRESS, CITY, STATE, ZIP COD AMI CIR BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
		w, the Administrator confirmed kler heads and was unaware					
	_	viewed with the Lead dministrator during the exit					
	3.1-19(b)						
K 0363 SS=E Bldg. 01	than required encilexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller land CMS regulation. The apply to auxiliary solid flammable or complying to the doors complying with the door closed with a complete covering is not expected with a complete covering of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2023
	PROVIDER OR SUPPLIER		6450 N	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 1 of doors on the southwan means suitable for no impediment to corresist the passage of practice could affect and staff in Meadow.  Findings include:  Based on observation and 2:12 p.m., the droom next to room frame when tested. had self-latching had closed. Based on in observation, the Leccorridor door would because the latch with the finding was revenue.	fire window assemblies are a sprinklered compartments octions in area or fire is or frames in window.  Parts 403, 418, 460, 482, 483 details of doors such as angs, automatics closing on and interview, the facility if 3 mechanical closet corridor west wing were provided with a keeping the door closed, had losing, latching and would if smoke. This deficient tapproximately 12 residents	K 0363	The Mechanical Room door outside of room M216 was adjusted to assure it fully lated. All other corridor doors have linspected and all fully close a latch.  To prevent reoccurrence, each month during fire drills, all cordoors will be inspected and documented they fully close a latch. The Maintenance staff been in-serviced on this requirement. The Environme Enrichment Committee, a subcommittee of the facility's QAPI committee will be responsible to review the documentation monthly and roits findings to the full QAPI committee quarterly. Failure execute the plan of correction result in disciplinary action, up and including termination.	been ind  th tridor and have intal eport to i will

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155684	B. WI	NG		11/21	/2023
NAME OF P	PROVIDER OR SUPPLIER	• {			ADDRESS, CITY, STATE, ZIP COD		
	IELD VILLAGE				IAMI CIR I BEND, IN 46614		
							T
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K 0712			1	1110			BITE
SS=F	NFPA 101 Fire Drills						
Bldg. 01	Fire Drills Fire Drills						
Diag. 01		the transmission of a fire					
		simulation of emergency fire					
	_	rills are held at expected					
		· · · · · · · · · · · · · · · · · · ·					
	and unexpected times under varying conditions, at least quarterly on each shift.						
		ar with procedures and is					
		re part of established					
	routine. Where drills are conducted between						
	9:00 PM and 6:00	9:00 PM and 6:00 AM, a coded					
	announcement ma	ay be used instead of					
	audible alarms.						
	19.7.1.4 through 19.7.1.7						
		view and interview, the facility	K 0'	712	Fire Drills for the last two quar	ters	12/20/2023
		re drills on each shift for 2 of 4			were conducted timely.		
	_	1.6 states drills shall be					
		on each shift to familiarize			A new fire drill schedule for		
		nurses, interns, maintenance			calendar year 2024 has been		
	_	inistrative staff) with the			completed.		
		ncy action required under This deficient practice affects					
	all staff and residen	-			To prevent reoccurrence,  Maintenance staff have been		
	an stan and residen	its.			in-serviced on this requiremen	.+	
	Findings include:				The Environmental Enrichmer		
					Committee, a subcommittee o		
	Based on records re	eview with the Lead			facility's QAPI committee will b		
	Maintenance and th	ne Administrator on 11/21/23			responsible to review the fire of		
		and 11:51 a.m., the following			documentation monthly and re	port	
		documentation of a completed			its findings to the full QAPI		
	fire drill:				committee quarterly. Failure t		
		nd third shift fire drills in the	execute the plan of correction will				
	first quarter of 2023				result in disciplinary action, up	to	
	· ·	nd third shift fire drills in the			and including termination.		
	second quarter of 20						
	Based on interview at the time of record review						
		tated the drills were completed,					
		had been lost due to the					
1	cnanging of position	ns with the Maintenance					1

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	PROVIDER OR SUPPLIER FIELD VILLAGE			6450 MI	DDRESS, CITY, STATE, ZIP COD AMI CIR BEND, IN 46614		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Director and any do produced at the time	ocumentation was unable to be e of the survey.					
	Findings were discu Maintenance and A conference.						
	3.1-19(b) 3.1-51(c)						
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro annually confirm t safety and critical and testing of the switches are perfo NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu loads, and are cor personnel. Mainte	other alternate power iated equipment is capable ce within 10 seconds. If the in is not met during the cess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, coad 30 minutes 12 times a intervals, and exercised onths for 4 continuous hours. Indeed to the continuous include					
	accordance with N circuit breakers ar program for period components is est manufacturer requ	NFPA 111. Main and feeder re inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155684		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/21/2023	
	PROVIDER OR SUPPLIER FIELD VILLAGE	6450 M	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)  1. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.  Findings include:  During records review with the Lead Maintenance and Administrator on 11/21/23 between 09:49 a.m. and 11:51 a.m., documentation of a four hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Administrator stated they were unsure if a 4-hour load exercise had been conducted within the past 36 months.  This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.	K 0918	Both the 36 month and month testings under load have beer completed. Documentation includes the specific transfer to the monthly testing form has revised to include the specific transfer time and load documentation.  To prevent reoccurrence, maintenance personnel have in-serviced on this requirement. The Environmental Enrichment Committee, a subcommittee of facility's QAPI committee will be responsible to review the generated documentation monthly and resits findings to the full QAPI committee quarterly. Failure to execute the plan of correction result in disciplinary action, up and including termination.	been  been  t.  t f the  beer  erator  eport  o  will	

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	LAN OF CORRECTION IDENTIFICATION NUMBER  155684  A. BUILDING  B. WING		COMPLETED 11/21/2023			
NAME (	F PROVIDER OR SUPPLIE	3		ADDRESS, CITY, STATE, ZIP COD IAMI CIR		
SOUT	HFIELD VILLAGE		SOUTH	BEND, IN 46614		
(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
	2. Based on record facility failed to exemonths to meet the 2010 Edition, the S Standby Powers Sy 8.4.2 states diesel g be exercised at least of 30 minutes, usin methods:  (1) Loading that magas temperatures as manufacturer  (2) Under operating not less than 30 per Power Supply) nan Section 8.4.2.3 stat installations that do 8.4.2 shall be exercised a loads at not less than nameplate kW ratin and at not less than nameplate kW ratin total test duration of hours. This deficien occupants.  Findings include:  Based on review of documentation with 09:49 a.m. to 11:51 information to show the diesel powered documented. Based record review, the assertion of the second review revi	es diesel-powered EPS o not meet the requirements of ised monthly with the available Power Supply System) load and unnually with supplemental un 50 percent of the EPS ng for 30 continuous minutes 75 percent of the EPS ng for 1 continuous hour for a of not less than 1.5 continuous nt practice could affect all  Segenerator load testing on the Lead Maintenance from a.m. on 11/21/23, the load we the actual load percentage for				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155684			JILDING	01	COMPL 11/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>			DDRESS, CITY, STATE, ZIP COD		
SOUTHF	FIELD VILLAGE				BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	_	revious maintenance ded a load percentage.					
	This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.						
	facility failed to do alternate power sou for 12 of the past 12 alternate power sup service within 10 se	review and interview, the cument the transfer time to the rece on the monthly load tests 2 months to ensure the ply was capable of supplying econds. This deficient practice dents, staff and visitors.					
	a.m. and 11:51 a.m. and Administrator, Monthly Test Log" year and lacked the normal power to en documentation, it st "<30 second". It was the generator was a 10 second requirem time of record reviet that the transfer time	with the Lead Maintenance the "Emergency Generator - was reviewed over the past detailed transfer time from nergency power. On the ated that the transfer time was as unable to be determined if ble to transfer over within the ent. Based on interview at the w, the Administrator agreed es were not properly able to verify if the generator within the 10 second					

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	OF CORRECTION	IDENTIFICATION NUMBER  155684	A. BUILDING B. WING	01	COMPLETED 11/21/2023
	ROVIDER OR SUPPLIER IELD VILLAGE		6450 M	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0920	12 months. Chapter requires monthly test the emergency elect accordance with NF Emergency and Star 8. NFPA 110 8.4.2 is service to be exercise minimum of 30 min 99 requires a writter performance, exercing generator to be regulator inspection by the jurisdiction. This decocupants.  Findings include:  Based on records remaintenance and the between 09:49 a.m. documentation for the 2023 were available generator set in servat least once monthly minutes. Based on a records review, the monthly load tests for could have been condocumentation could the survey.  The finding was reversed.	PA 110, the Standard for andby Powers Systems, Chapter requires diesel generator sets in sed at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA a record of inspection, sing period, and repairs for the clarly maintained and available and authority having reficient practice could affect all view with the Lead e Administrator on 11/21/23			
SS=E Bldg. 01		ent - Power Cords and			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2023
	ROVIDER OR SUPPLIER		6450 M	ADDRESS, CITY, STATE, ZIP COD IAMI CIR I BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Electrical Equipmed Extension Cords Power strips in a pused for componer patient-care-related (PCREE) assembly assembled by quarthe conditions of the patient care vinon-PCREE (e.g., except in long-terredo not use PCREI meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 1. Based on observativated in the cords and consumer 1 of as a substitute for financial form of the substitute for financial form of the cords and consumer 1 of as a substitute for financial form of the substitute for financial form of the cords and consumer form of the substitute for financial form of the cords and consumer form of the cords and c	ent - Power Cords and patient care vicinity are only	K 0920	The resident's extension cord removed and the power strip properly aligned.  Room inspections were completed, no other extension cords or inappropriately used power strips were discovered.  To prevent reoccurrence, education will be provided to residents, families, and staff regarding the appropriate use electrical equipment.  Maintenance staff will inspect	was 12/20/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155684	B. W	ING		11/21/	2023
				CTREET	DDDFGG CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
COLITUE					IAMI CIR		
SOUTHE	IELD VILLAGE			SOUTH	BEND, IN 46614		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(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	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
	ready to be used in	resident room M201. Based on			rooms two times per year for tl	ne	
	interview at the tim	e of observation, the Lead			inappropriate use of electrical		
		that they were unaware of the			equipment. The Environmenta	al	
	extension cord and removed it upon observation.				Enrichment Committee, a		
					subcommittee of the facility's		
	The finding was rev	viewed with the Lead			QAPI committee will be		
	_	ne Administrator during the			responsible to review the room	1	
	exit conference.	<del></del>			inspection documentation twic		
					per year and report its findings		
	3.1-19(b)				the full QAPI committee quarte		
	3.1 17(0)				Failure to execute the plan of	211y.	
	2 Based on observa	ation and interview, the facility			correction will result in discipling	narv	
	failed to ensure 1 of 1 flexible cords were installed				action, up to and including	iai y	
	properly and used in a safe manor. NFPA 99,				termination.		
		ites adapters and extension			terrimation.		
		equirements of 10.2.4.2.1					
	_	shall be permitted. Section					
	_	e cabling shall comply with					
		2.3.5.1 states cord strain relief					
		t the attachment of the power					
	_	ce so that mechanical stress,					
		bend, is not transmitted to					
	_	s. This deficient practice could					
		y 2 staff and an unknown					
	number of residents	-					
	number of residents	S.					
	Findings include:						
	rindings include.						
	Rosed on observative	on with the Lead Maintenance					
		on 11/21/23 between 11:51 a.m.					
		e Shift Supervisors office a					
		power equipment, was not					
	_	wer cord was wrapped around					
		sulted in the power strip					
		outlet on the wall. This					
	_	stress on the power cord					
		the power cord. Based on					
		e of observation, the Lead					
		d the power strip was					
	dangling, not secure	ed, and stated the power strip					

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/21/2023
	ROVIDER OR SUPPLIER ELD VILLAGE		6450 M	ADDRESS, CITY, STATE, ZIP COD MAMI CIR H BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5)  BE COMPLETION  DATE
	This finding was rev	nted or set on the floor. viewed with the Lead dministrator during the exit			
K 0000					
Bldg. 03	conducted by the In accordance with 42  Survey Date: 11/21  Facility Number: 00  Provider Number: 1  AIM Number: 2003  At this Life Safety C  Village, was found a  Requirements for Pa  Medicare/Medicaid,  Life Safety from Fin  National Fire Protect  Life Safety Code (L  Health Care Occupa 2020 Therapy additi  Safety Code (LSC),  Occupancies  This one-story facili  Type V (111) constraddition with Type if  fully sprinklered. The	/2023 02662 155684 315930 Code survey, Southfield not in compliance with	K 0000	This Plan of Correction cormy written allegation of compliance for the deficiencited. However, submission Plan of Correction is not an admission that a deficiency or that one was cited correction is Plan of Correction is submitted to meet requiremestablished by state and felaw.	cies n of this v exists ctly.
	spaces open to the c	orridors. The hard-wired the resident sleeping rooms is			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684		ILDING	nstruction  03	(X3) DATE : COMPL 11/21/	ETED
	ROVIDER OR SUPPLIER IELD VILLAGE			6450 MI	DDRESS, CITY, STATE, ZIP COD AMI CIR BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 03	not supervised by the facility is connected. Living facility, from Wall with a 2-Hour original facility and separated by a Fire Resistive Rating. The protected by a diese The facility has 60 of the survey, the cens.  All areas where resist were sprinklered. Asservices were sprinklered. Asservices were sprinklered. As services were spr	the fire alarm system. The story Assisted in which it is separated by a Fire Fire Resistive Rating. The the 2020 addition are Wall with a 1-hour Fire the Healthcare facility is fully all powered 200 kW generator. Sertified beds. At the time of the swas 50.  Idents have customary access all areas providing facility allered.  Impleted on 11/27/23  The providing facility areas of Egress and of Egress are of egress, including exitinged in accordance with 7.8 are continuously in operation matic operation without form.  The and interview, the facility the timuity of egress lighting for 2 purposes of this requirement, and go to an exit. For the purposes exit discharge shall include	K 02		It has been determined that the current lighting at the emergency exits is connected to the emergency generator.  All other exits have been inspected and those lights are		12/20/2023
	escalators, walkway leading to a public v	rs, aisles, corridors, ramps, s and exit passageways vay. This deficient practice oproximately 10 residents and			connected to the emergency generator as well.  Bids will be received by Decen 20, 2023, to install additional lighting to illuminate the entire means of egress at all emerge		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155684			ILDING	03	COMPL 11/21/	ETED
	ROVIDER OR SUPPLIER		6450 MI	ADDRESS, CITY, STATE, ZIP COD IAMI CIR BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETION DATE
K 0351	with the Lead Maint 11/21/23 between 1 discharge sidewalks gym on the west and poles to illuminate t However, it was una adequate lighting course the public way. Furt determined or confulight the exit dischargemergency generator time of observations Administrator could was adequate or confuling the maintenance and Administrator could was adequate or conful this finding was reversely maintenance and Administrator could conference.	ons during a tour of the facility tenance and Administrator on 1:51 a.m. and 2:12 p.m., the exit from the physical therapy deast ends did have light the sidewalk towards the end. able to be determined if evered the sidewalk leading to thermore, it was unable to be the rmed if the lighting used to trace was connected to the extra damage. The Lead Maintenance and a not confirm if the lighting unected to the generator.		exits where necessary. Lightir will be installed no later than January 20, 2024. The Environmental Enrichment Committee, a subcommittee of facility's QAPI committee will be responsible to review the bids authorize the work to be performed. The discovery of the egress lighting will be reported the full QAPI committee. Failut to execute the plan of correction will result in disciplinary actions to and including termination.	f the pe and he to re	
K 0351 SS=E Bldg. 03	an approved autor accordance with N Installation of Sprii In Type I and II corprotection measure substituted for sprii areas where state prohibit sprinklers. Listed quick-resposprinklers are used compartments with	Installation  e protected throughout by matic sprinkler system in IFPA 13, Standard for the nkler Systems.  Instruction, alternative es are permitted to be inkler protection in specific and local regulations				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE A. BUILDING B. WING	e construction  9 03	COMI	E SURVEY PLETED 1/2023
	PROVIDER OR SUPPLIEF		6450	ET ADDRESS, CITY, STATE, ZIP COD O MIAMI CIR JTH BEND, IN 46614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
	where the area of six square feet an the closet footprin Standard for Insta Systems. 18.3.5.1, 18.3.5.4 9.7.1.1(1), 18.3.5. Based on observation	on and interview, the facility	K 0351	The escutcheon was adju		12/20/2023
	mechanical room in Standard for the Ins NFPA 13, 2010 edi plates, escutcheons, cover the annular sp be metallic, or shall sprinkler. This definand up to 10 staff a	ne ceiling construction in 1 of 1 accordance with NFPA 13, stallation of Sprinkler Systems. tion, Section 6.2.7.1 states or other devices used to bace around a sprinkler shall be listed for use around a cient practice could affect staff and residents in the Physical		assure full coverage by th sprinkler head.  All other escutcheons wer inspected and all are instaproperly to allow the sprinhead full coverage of their designated areas.	e alled kler	
	and Administrator of and 2:12 p.m., the r therapy gym had an leaving annular spa and the wall Based observation, the Leaving	on with the Lead Maintenance on 11/21/23 between 11:51 a.m. nechanical room in the physical a escutcheon plate dislodged, ce between the sprinkler head d on interview at the time of ad Maintenance and armed the escutcheon was		Escutcheons will be insperand documented at the tine each fire drill. The results inspections will be monito the Environmental Enricht Committee, a subcommitte facility's QAPI Committee results reported to the QA Committee quarterly. Fail execute the plan of correct result in disciplinary action and including termination.	ne of of these red by ment ee of the and the PI ure to tion will n, up to	
		viewed with the Administrator nce at the exit conference.				
K 0353 SS=F Bldg. 03	Sprinkler System	- Maintenance and Testing - Maintenance and Testing er and standpipe systems				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155684		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURV  COMPLETED  11/21/2023			ETED		
	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR 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
	accordance with Inspection, Testii Water-based Fire Records of syste inspection and tesecure location a a) Date sprinkle b) Who provide c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observat failed to ensure 1 provided with span cabinet large enougheads, and a sprinkle large enougheads, and a sprinkle systems, 2011 Edsupply of spare specially be maintaine sprinklers that have any way can be preshall correspond to ratings of the sprinklers shall be the temperature in no time exceed 10 sprinkler wrench scabinet to be used	n supply source  ARKS information on non-required or partial ler system. B, and NFPA 25 ion and interview, the facility of 1 sprinkler systems were re sprinklers, a spare sprinkler gh to fit all spare sprinkler scler wrench on the premises. d for the Inspection, Testing, of Water-Based Fire Protection ition, Section 5.4.1.4 states a rinklers (never fewer than six) d on the premises so that any the been operated or damaged in comptly replaced. The sprinklers of the types and temperature taklers on the property. The kept in a cabinet located where which they are subjected will at 0 degrees Fahrenheit. A special thall be provided and kept in the in the removal and installation as deficient practice could affect	K 03	353	The old, used sprinkler heads were placed on top of the cabi have been removed.  All four cabinets were inspected both externally and internally, new, replacement heads are a stored properly.  To prevent reoccurrence, the storage cabinets will be inspece each time the sprinkler contract does any work on the system. When sprinkler heads are replaced, the old head will be disposed of by the vendor and verified by the Maintenance storage the modern of the Environmental Enrichmer Committee, a subcommittee of facility's QAPI committee will be responsible to assure this practice.	ed, the all cted ctor  aff. at f the pe ctice	12/20/2023

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	OF CORRECTION	IDENTIFICATION NUMBER  155684	A. BUILDING B. WING	03	COMPLETED  11/21/2023
	ROVIDER OR SUPPLIER		6450 M	ADDRESS, CITY, STATE, ZIP COD IIAMI CIR I BEND, IN 46614	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 03	and Administrator of and 2:12 p.m., four the riser room. Thre large enough to comprevent damage to to top of three of the fe approximately 10 sp and not in the cabinetime of record reviethe unsecured sprint of the issue.  This finding was rev. Maintenance and Adconference.  3.1-19(b)  NFPA 101  Fire Drills  Fire Drills  Fire drills include to alarm signal and so conditions. Fire drills arm signal and so conditions. Fire drills are that drills are routine. Where dreat 9:00 PM and 6:00 announcement maintains and the staff is familial aware that drills are routine. Where dreat 9:00 PM and 6:00 announcement maintains.  18.7.1.4 through 1 Based on record reversible to conduct quarters. LSC 18.7. conducted quarterly	t quarterly on each shift.  r with procedures and is re part of established  ills are conducted between  AM, a coded  ay be used instead of	K 0712	Failure to execute the plan of correction will result in disciplinaction, up to and including termination.  Fire Drills for the last two quarwere conducted timely.  A new fire drill schedule for calendar year 2024 has been	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155684	B. WI	NG		11/21/	2023
				CTDEET A	DDDEGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
00117115	IELD VIII AOE				IAMI CIR		
SOUTHE	IELD VILLAGE			SOUTH	BEND, IN 46614		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	and residents.				completed.		
					•		
	Findings include:				To prevent reoccurrence,		
					Maintenance staff have been		
	Based on records re	view with the Lead			in-serviced on this requiremen	t.	
		e Administrator on 11/21/23			The Environmental Enrichmen		
		and 11:51 a.m., the following			Committee, a subcommittee of		
		documentation of a completed			facility's QAPI committee will b		
	fire drill:	<b>F</b>			responsible to review the fire of		
		nd third shift fire drills in the			documentation monthly and re		
	first quarter of 2023				its findings to the full QAPI		
		nd third shift fire drills in the			committee quarterly. Failure to	2	
	second quarter of 20				execute the plan of correction		
	_	at the time of record review,			result in disciplinary action, up		
		ated the drills were completed,			and including termination.	.0	
		and been lost due to the			and moldding termination.		
		ns with the Maintenance					
		cumentation was unable to be					
	produced at the time						
	produced at the time	e of the survey.					
	Findings were discu	used with the Lead					
	Maintenance and A						
	conference.	diffillistrator at exit					
	conference.						
	2 1 10/1-)						
	3.1-19(b) 3.1-51(c)						
	3.1-31(c)						
K 0918	NFPA 101						l l
SS=F		- Facential Floatric Syste					
	-	s - Essential Electric Syste					
Bldg. 03	•	s - Essential Electric					
	System Maintenar						
	-	other alternate power					
		ated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	•	his capability for the life					
	-	branches. Maintenance					
	_	generator and transfer					
	switches are perfo	ormed in accordance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155684	B. W.	ING		11/21/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IAMI CIR		
SOUTHE	IELD VILLAGE				BEND, IN 46614		
			-				
(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 1		DATE
	NFPA 110.	a imama ata di sua aldu.					
		e inspected weekly,					
		oad 30 minutes 12 times a					
	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours.						
	Scheduled test under load conditions include						
	a complete simulated cold start and automatic or manual transfer of all EES						
		nducted by competent					
		enance and testing of stored					
		rces (Type 3 EES) are in					
	accordance with NFPA 111. Main and feeder						
	circuit breakers are inspected annually, and a						
		dically exercising the					
		tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	and readily availal	ble. EES electrical panels					
	and circuits are m	arked, readily identifiable,					
	and separate from	n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
		review and interview, the	K 0	918	Both the 36 month and monthl	•	12/20/2023
	•	intain 1 of 1 Emergency Power			testings under load have been		
		accordance with NFPA 110,			completed. Documentation		
	_	gency and Standby Power 4.9, as required by NFPA 99			includes the specific transfer ti	me.	
		ies Code, Section 6.4.1.1.6.1.			The monthly testing form has I		
		8.4.9 states that all Level 1			, ,	been	
		Systems shall be tested at least			revised to include the specific transfer time and load		
		hree years. Where the			documentation.		
	•	eater than 4 hours, it shall be			documentation.		
		ate the test after 4 hours.			To prevent reoccurrence,		
		6.4.1.1.6.1 states that Type 1 and			maintenance personnel have b	neen	
		ectrical system power sources			in-serviced on this requiremen		
		t Type 10, Class X, Level 1			The Environmental Enrichmen		
		s deficient practice could			Committee, a subcommittee or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING	03	COMPLETED		
AND PLAN OF CORRECTION		155684	B. WING	<u></u>	COMPLETED 11/21/2023		
155084			_				
NAME OF P	ROVIDER OR SUPPLIER			TADDRESS, CITY, STATE, ZIP COD			
				MIAMI CIR			
SOUTHF	IELD VILLAGE		SOUT	'H BEND, IN 46614			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE		
	affect all building o	eccupants.		facility's QAPI committee will	be		
	Findings include:			responsible to review the ger			
				documentation monthly and	report		
				its findings to the full QAPI			
	_	ew with the Lead Maintenance		committee quarterly. Failure			
		on 11/21/23 between 09:49 a.m.		execute the plan of correctio			
		rumentation of a four hour run		result in disciplinary action, u	ıp to		
	test for the emergency generator conducted			and including termination.			
	within the last 36 months was not provided for						
	review. Based on interview at the time of records						
	review, the Administrator stated they were unsure						
	if a 4-hour load exercise had been conducted						
	within the past 36 months.						
	This finding was reviewed with the Administrator						
	and Lead Maintenance at the exit conference.						
	3.1-19(b)						
	2. Based on record	review and interview. the					
	2. Based on record review and interview, the facility failed to exercise the generator for 12 of 12						
	•	requirements of NFPA 110,					
		tandard for Emergency and					
	Standby Powers Systems, Chapter 8.4.2.						
	8.4.2 states diesel generator sets in service shall						
	be exercised at least once monthly, for a minimum						
	of 30 minutes, using one of the following						
	methods:						
	(1) Loading that maintains the minimum exhaust						
	gas temperatures as recommended by the						
	manufacturer						
	(2) Under operating temperature conditions and at						
	not less than 30 percent of the EPS (Emergency						
	Power Supply) nameplate kW rating.						
	Section 8.4.2.3 states diesel-powered EPS						
	installations that do not meet the requirements of						
	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS						

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AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	ľ í	UILDING	ONSTRUCTION         (X3) DATE SUR           03         COMPLETE           11/21/20		ETED		
NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	CRUSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE		
	and at not less than nameplate kW ratin total test duration o	ng for 30 continuous minutes 75 percent of the EPS ng for 1 continuous hour for a f not less than 1.5 continuous nt practice could affect all							
	documentation with 09:49 a.m. to 11:51 information to show the diesel powered documented. Based record review, the and was unsure if p	regenerator load testing In the Lead Maintenance from In the Lead Maintena							
		viewed with the Administrator nce at the exit conference.							
	3. Based on record facility failed to do alternate power sou for 12 of the past 12 alternate power sup service within 10 so	review and interview, the cument the transfer time to the cure on the monthly load tests 2 months to ensure the apply was capable of supplying econds. This deficient practice dents, staff and visitors.							
	Findings include:								
	a.m. and 11:51 a.m and Administrator, Monthly Test Log"	wiew on 11/21/23 between 09:49 with the Lead Maintenance the "Emergency Generator - was reviewed over the past detailed transfer time from							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155684		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  03	(X3) DATE SURVEY COMPLETED 11/21/2023				
NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDERS PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
	normal power to endocumentation, it stored and second requirement time of record reviet that the transfer time documented and untransferred power was requirement.  Findings were discumented and Aconference.  3.1-19(b)  4. Based on record facility failed to man of monthly generated 12 months. Chapter requires monthly tender the emergency election accordance with NFE Emergency and Stars. NFPA 110 8.4.2 service to be exercised in the exercise minimum of 30 min 199 requires a written performance, exercised for inspection by the	rergency power. On the ated that the transfer time was as unable to be determined if able to transfer over within the ent. Based on interview at the aw, the Administrator agreed es were not properly able to verify if the generator within the 10 second assed with the Lead doministrator at exit  review and interview, the intain a complete written record or load testing for 4 of the last ar 6.4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving trical system to be in a serving trical system to be in a serving trical system to be in a serving trical system to the in seed at least once monthly, for a serving trical system to the serving trical system to the in seed at least once monthly, for a serving trical system to the serving trical system to the serving trical system to be in the serving trical system to be in seed at least once monthly, for a serving trical system to the serving trical system to the serving trical system to the serving trical system to be in the serving trical system to be in the serving trical system to be in the serving trical system to be in the serving trical system to the serving trical system trical						
		e Administrator on 11/21/23						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155684	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/21/2023			
NAME OF PROVIDER OR SUPPLIER SOUTHFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 6450 MIAMI CIR SOUTH BEND, IN 46614					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	documentation for the months of July-October of 2023 were available for review to show the diesel generator set in service was exercised under load at least once monthly, for a minimum of 30 minutes. Based on an interview at the time of records review, the Administrator stated the monthly load tests for the aforementioned months could have been conducted, however no documentation could be produced at the time of the survey.  The finding was reviewed with the Administrator and Lead Maintenance during the exit conference.							

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