PRINTED: 01/13/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLE	TED		
		155198	B. WING		12/07/2	12/07/2022		
NAME OF	PROVIDER OR SUPPLIE	D.	STREET	ADDRESS, CITY, STATE, ZIP COD				
		IX.		OWNSHIP LINE RD				
MARQU	ETTE		INDIAN	NAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
E 0000								
Bldg								
2.49.	An Emergency Pre	eparedness Survey was	E 0000	Preparation and execution of	this			
		ndiana Department of Health in	2000	plan of correction in no way				
	accordance with 42	-		constitutes an admission or				
				agreement by Marquette of the	е			
	Survey Date(s): 12	2/06/22 & 12/07/22		truth of the facts alleged in this				
	statement of deficiency and pl							
	Facility Number: (of correction. In fact, this plan				
	AIM Number: NA			correction is submitted exclus				
	Allyl Number. NA	L		to comply with state and feder law. Marquette reserves the r				
	At this Emergency	Preparedness survey,	· · · · · · · · · · · · · · · · · · ·					
		and not in compliance with		all deficiencies, statements,	19-7			
	_	edness Requirements for		findings, facts and conclusions	s			
	Medicare and Med	licaid Participating Providers		that form the basis of the state	∍d			
	and Suppliers, 42 (CFR 483.73.		deficiency. This plan of correct	ction			
				serves as the allegation of				
		certified beds. At the time of		compliance.				
	the survey, the cen	sus was 56.		A -1-1:4:1				
	Quality Paviany co	mpleted on 12/12/22		Additional supporting documentation will be provide	۵			
	Quanty Review co	impleted on 12/12/22		upon request. Marquette	u			
	The requirement at	t 42 CFR, Subpart 483.73 is NOT		respectfully requests a desk				
	MET as evidenced	-		review.				
E 0006	(/ (/ (/	, 416.54(a)(1)-(2), 418.113(a)						
SS=F	` ' ' '	a)(1)-(2), 482.15(a)(1)-(2),						
Bldg		, 483.73(a)(1)-(2), 484.102(a)						
		a)(1)-(2), 485.68(a)(1)-(2), ı, 485.920(a)(1)-(2),						
		i, 491.12(a)(1)-(2), 494.62(a)						
	(1)-(2)	, +31.12(a)(1)-(2), +34.02(a)						
		ll Hazards Risk Assessment						
		2), §416.54(a)(1)-(2),						
	- ' ' ' ' '	2), §441.184(a)(1)-(2),						
	` ` ` ` ` `), §482.15(a)(1)-(2),						
		8/183 /75(a)(1) ₋ (2)						

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

§484.102(a)(1)-(2), §485.68(a)(1)-(2),

TITLE (X6) DATE

Jeffrey Cox Administrator 01/06/2023

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0TFO21 Facility ID: 000105 If continuation sheet Page 1 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155198	B. W	ING		12/07	/2022	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					OWNSHIP LINE RD			
MARQUE	=11E 			INDIAN	APOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DECLE A TONY OR LOCALITY OF THE PROPERTY OF THE P			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION N 8485 727(a)(1) (2)	+	IAG	DEI TOLENO I I		DATE	
	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2),							
		§494.62(a)(1)-(2)						
	,	lan. The [facility] must						
	1	tain an emergency						
	1	n that must be reviewed,						
	and updated at least every 2 years. The plan must do the following:							
	must do tric follow	/iiig.j						
	(1) Be based on and include a documented,							
	facility-based and community-based risk							
	assessment, utilizing an all-hazards							
	approach.*							
	(2) Include strated	gies for addressing						
	1 ' '	s identified by the risk						
	assessment.	,						
		t §418.113(a):] Emergency						
	•	e must develop and						
		gency preparedness plan ewed, and updated at least						
		e plan must do the						
	following:	•						
	(1) Be based on a	nd include a documented,						
		community-based risk						
		ing an all-hazards						
	approach.	ii						
	' '	gies for addressing						
		s identified by the risk						
	assessment, including the management of the consequences of power failures, natural							
		er emergencies that would						
		's ability to provide care.						
	***************************************	4 0400 70/-):1						
	*[For LTC facilities	. , -						
		The LTC facility must tain an emergency						
	1							
	preparedness plan that must be reviewed,						I	

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Event ID:

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Facility ID: 000105

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			ETED	
		155198	B. WI	B. WING			12/07/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEI	₹			OWNSHIP LINE RD			
MARQUI	MARQUETTE				IAPOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	and updated at least annually. The plan must							
	do the following:	and include a documented,						
	· '	community-based risk						
		ring an all-hazards						
		ng missing residents.						
		_						
	(2) Include strategies for addressing emergency events identified by the risk							
	assessment.	o lacinamed by ano non						
	*[For ICF/IIDs at §483.475(a):] Emergency							
	Plan. The ICF/IID must develop and maintain							
	an emergency preparedness plan that must							
	be reviewed, and updated at least every 2							
		nust do the following:						
	'	3						
	(1) Be based on a	and include a documented,						
	facility-based and	community-based risk						
	assessment, utiliz	ring an all-hazards						
		ng missing clients.						
	1 ' '	gies for addressing						
	1 -	s identified by the risk						
	assessment.						00/04/000	
		view and interview, the facility	E 00	006	What corrective action will be	е	02/01/2023	
		n emergency preparedness			accomplished for those	_		
		sed on and includes a y-based and community-based			residents found to have beer	1		
		lizing an all-hazards approach,			affected by the deficient			
		residents and (2) included			practice? No residents were found to be			
	1 0	ssing emergency events			affected by this practice.			
	-				Immediately following the Life			
	identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2).				Safety inspection, an Emergin	a		
	In the Survey & Certification memo QSO:				Infectious Disease (EID) plan			
	19-06-ALL dated 02/01/19, the Centers for				added to the Emergency			
	Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious				Preparedness Program in add	ition		
					to the All-Hazards Risk			
					Assessment. Additionally, EID			
	diseases to the defin	nition of all-hazards approach			has been included in the "Type			
	and stated "Plannin	g for using an all-hazards			Emergencies Covered by This	;		
	approach should also include emerging infectious				Plan" section of the Emergence			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/07/2022			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		ts. Examples of EIDs include ika Virus and others". This		Preparedness binder.			
		ould affect all occupants.		How other residents having	the		
	Findings include:	"Disaster Preparedness		potential to be affected by the same deficient practice will identified and what corrective action will be taken?	he be		
		ation dated 10/01/22 with the		All residents have the potenti	al to		
	Administrator and t	he Building Engineer during		be affected by this practice.			
		9:35 a.m. to 2:00 p.m. on		Immediately following the			
	12/06/22, a documented facility-based and			inspection, an Emerging Infe			
	community-based risk assessment addressing			Disease plan was incorporate	ed		
	emerging infectious disease (EID) threats was not			into the facility's Emergency	-:c-		
	available for review. EID was not included in the			Preparedness Program. Spec			
	current "Types of Emergencies Covered By This Plan" section of emergency preparedness program			language about EIDs has also been included in the facility's			
		he facility. Based on interview		emergency preparedness and			
		d review, the Administrator		infection control documentation			
		preparedness program		and communicated to staff.	511		
		not address emerging		and communicated to stain.			
	infectious diseases			What measures will be put i	nto		
		ommunity-based risk		place or what systemic			
	_	lated by the CMS Survey &		changes will be made to			
	Certification memo	QSO: 19-06-ALL.		ensure that the deficient			
				practice does not recur?			
	_	viewed with the Administrator		Facility management will mai	I		
	and the Building Er	ngineer during the exit		the Emergency Preparedness			
	conference.			Plan that complies with Fede			
				State, and local laws. Addition	-		
				the Emergency Preparedness	S		
				Plan and All-Hazards Risk			
				Assessment will be reviewed			
				updated annually to ensure a			
				required information is included and accurate. Education will lead to the second accurate.			
				provided to staff regarding El			
				Emergency Preparedness.	2 4.14		
				How will the corrective action be monitored to ensure the	on		

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0TFO21 Facility ID: 000105

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DEPARTMENT CENTERS FOR	FORM APPROVED OMB NO. 0938-039						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/07/2022	
NAME OF P	PROVIDER OR SUPPLIER			8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					deficient practice will not recur, i.e. what quality assurance program will be printo place? Annual review of the Emergen Preparedness Plan will be completed by Plant Director or designee to ensure that all required information is include the program. Additionally, in-servicing on the requirement the Emergency Preparedness Plan will be completed with fact staff. The results of the annual reviews of the Emergency Preparedness Plan will be shawith the facility's Quality Assurance Performance Improvement Committee for additional recommendations a necessary. Compliance Date: February 1 2023	cy d in ts of cility red	
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0	000	Preparation and execution of t plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and pla of correction. In fact, this plan	e s an	

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Facility Number: 000105

Provider Number: 155198

At this Life Safety Code survey, Marquette was

AIM Number: NA

Event ID:

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Facility ID: 000105

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correction is submitted exclusively

law. Marquette reserves the right to challenge in legal proceedings,

to comply with state and federal

all deficiencies, statements,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155198	B. WING 12/07/2022			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	Participation in Med 483.90(a), Life Safe edition of the Nation (NFPA) 101, Life S Existing Health Car 16.2. This two story build determined to be of was fully sprinklere system with smoke all areas open to the smoke detectors har system installed in a The facility has a car of 56 at the time of All areas where resi were sprinklered. A services were sprinklered.	dents have customary access all areas providing facility clered.		findings, facts and conclusions that form the basis of the state deficiency. This plan of correct serves as the allegation of compliance. Additional supporting documentation will be provide upon request. Marquette respectfully requests a desk review.	ed etion	
	Quality Review con	npleted on 12/12/22				
K 0100 SS=E Bldg. 01	Section 18.1 and of that are not address. K-tags, but are designed along with the app NFPA standard cition Form CMS-256. Based on observation failed to ensure 1 of second floor dining latch into the door frequires existing life.	tents - Other IKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, licable Life Safety Code or tation, should be included	K 0100	What corrective action will b accomplished for those residents found to have been affected by the deficient practice? No residents were found to be	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/07/2022			
NAME OF E	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
	practice could affect visitors in the vicinit room. Findings include: Based on observation and the Building Erracility from 2:00 p west door in the confloor dining room was position with a port Based on interview observations, the Dethe west door in the and would not fully door frame. This finding was recommended.	ons with the Administrator regimeer during a tour of the second gioner during a tour of the second vas propped in the fully open able hand sanitizer stand. The time of the frector of Maintenance agreed door set was propped open self close and latch into the viewed with the Administrator Maintenance during the exit		affected by this practice. The facility's Director of Plant Operations has contracted of approved vendor to inspect supply the necessary self-closing/latching equipment the second-floor dining room that were observed during the survey. Additionally, the porsanitizer stand in front of the has been removed and educe will be provided to staff regardoor safety and proper usage. How other residents having potential to be affected by same deficient practice will identified and what correct action will be taken? This alleged deficient practice the potential to affect over 1 residents, staff, and visitors vicinity of the 2nd Floor dinit room. To ensure that the idea doors self-close and latch unobstructed, the facility has contracted with an approved vendor to inspect and supple necessary self-closing/latch equipment. Additionally, instraining/education will be protested to staff regarding door safet proper usage and a door safe	with an and ent for in doors he table door cation arding ge. g the the ii be tive ce has 0 in the higher entified in the higher entificient entification entificatio		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155198	B. WING 12/07/2022				/2022
			•	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	K		8140 T	OWNSHIP LINE RD		
MARQUE	ETTE			INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	changes will be made to		DATE
					ensure that the deficient		
					practice does not recur?		
					Contracted vendor will comple	ete	
					initial door inspection of the		
					identified door set and install t	he	
					required equipment needed for	r	
					self-closing/latching. Specific		
					in-service training/education w		
					provided to staff regarding dod		
					safety and proper usage and a		
					door safety audit will be condu		
					by the Plant Director or design	iee	
					to ensure that doors are	0	
					functioning and unobstructed.	See	
					below for audit details.		
					How will the corrective actio	n	
					be monitored to ensure the		
					deficient practice will not recur, i.e. what quality		
					assurance program will be p		
					into place?	ut	
					The facility Director of Plant		
					Operations or designee will		
					oversee the vendor		
					inspection/installation process	and	
					maintain documentation of		
					equipment installation. A door		
					safety audit will be conducted	-	
					the Plant Director or designee		
					ensure that doors are correctly	-	
					functioning and unobstructed.		
					will occur weekly for 8 weeks,		
					then bi-weekly for 8 weeks, th		
					monthly for a total duration of months. The results of the aud		
					will be shared with the facility's		
					Quality Assurance Performance		
					Improvement Committee for		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155198		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/07/2022	
NAME OF I	PROVIDER OR SUPPLIER	. {		ADDRESS, CITY, STATE, ZIP COD	
MARQUI				OWNSHIP LINE RD NAPOLIS, IN 46260	
	1			1/11 OLIO, IIN 70200	T
(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 APPROPRI DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE
				additional recommendations necessary.	as
				Compliance Date: February 2023	1,
K 0222	NFPA 101				
SS=E	Egress Doors				
Bldg. 01	Egress Doors				
	•	ed means of egress shall not			
	1	a latch or a lock that			
	requires the use of	of a tool or key from the			
	egress side unles	s using one of the following			
	special locking an	rangements:			
		S OR SECURITY THREAT			
	LOCKING				
		king arrangements for the			
		eeds of the patient are			
		cking device shall be			
	1 '	n door and provisions shall			
		apid removal of occupants			
	1 -	l of locks; keying of all			
	· ·	ied by staff at all times; or e means available to the			
	staff at all times.	e illealis avallable to tile			
		.2.2.6, 19.2.2.2.5.1,			
	19.2.2.2.6	.2.2.0, 19.2.2.2.1,			
	SPECIAL NEEDS	LOCKING			
	ARRANGEMENT				
		king arrangements for the			
	•	e patient are used, all of			
		curity Locking requirements			
		addition, the locks must be			
	I -	at fail safely so as to			
	release upon loss	of power to the device; the			
	building is protect	ed by a supervised			
	automatic sprinkle	er system and the locked			
	space is protected	d by a complete smoke			
	detection system	(or is constantly monitored			
	at an attended loc	ation within the locked			

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0TFO21 Facility ID: 000105

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155198	B. WING 12/07/2022				
NAME OF E	PROVIDER OR SUPPLIER		8140 T	ADDRESS, CITY, STATE, ZIP COD TOWNSHIP LINE RD NAPOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDENCE BLANCE CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRE: ARRANGEMENT: Approved, listed d systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, super detection system automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controllectinstalled in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an automatic fire dete approved, supervisystem.	ss LOCKING s lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an sed automatic sprinkler					
	failed to ensure the 3 second floor exits residents without a specialized security required means of e with a latch or lock or key from the egre	on and interview, the facility means of egress through 1 of were readily accessible for clinical diagnosis requiring measures. Doors within a egress shall not be equipped that requires the use of a tool ess side unless otherwise section 19.2.2.2.4. Door-locking	K 0222	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by this practice. Immediately following the inspection, a laminated postin	n		

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Event ID: 0TFO21 Facility ID: 000105 If continuation sheet Page 10 of 21

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ED	
		155198	B. WING 12/07/2022			22	
		l .	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			OWNSHIP LINE RD		
MARQUE	TTF				APOLIS, IN 46260		
IVII (I (QUL	- 1 1 -		_		7.1 OLIO, III 70200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT		OMPLETION
TAG		LISC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)		DATE
	_	be permitted in accordance			was added to the keypad that	lists	
		This deficient practice could			the code for exiting the area.		
		ents, staff and visitors if					
	-	facility using the stairwell exit			How other residents having t		
	on the second floor	Uy KOOIII 227.			potential to be affected by th		
	Findings include:				same deficient practice will be identified and what corrective	I	
	i manigs include:				action will be taken?	E	
	Based on observations with the Administrator				This alleged deficient practice		
	and the Building Engineer during a tour of the				could affect over 10 residents,		
	facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the				and visitors if needing to exit the		
	stairwell exit door on the second floor by Room				facility using the stairwell exit		
	227 was marked as a facility exit with an exit sign				the second floor by Room 227		
	and could be opened by entering a code into a				Immediately following the	•	
	keypad at the door. However, the code was not				inspection, a laminated posting	g	
		oor. Based on interview at the			was added to the keypad that	-	
	-	tions, the Administrator stated			the code for exiting the area.		
	residents who have	a clinical diagnosis to be in a					
	secure wing are hou	ised in a secure wing on the			What measures will be put in	to	
		l residents in the smoke			place or what systemic		
	_	he second floor exit door by			changes will be made to		
		linical diagnosis to be in a			ensure that the deficient		
		reed the keypad code to			practice does not recur?		
		r to open was not posted at the			Facility management will main		
	keypad.				egress doors that are complian		
	TE1 : C 1:	t deal Attend			with federal, state, and local la	IWS	
	-	viewed with the Administrator			by implementing the following		
		ngineer during the exit			systemic changes.	.:u	
	conference.				Education/in-service training w	/111	
	3.1-19(b)				be provided to facility staff highlighting the requirements t	ior	
	J.1-17(U)				Egress Doors. Additionally, an		
					audit of all egress doors on the		
					second floor will be completed		
					Plant Director or designee to	~ y	
					ensure compliance (see below	, for	
					details).		
					22.3.10).		
					How will the corrective action	n	
					be monitored to ensure the		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/07/2022			
NAME OF I	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
K 0361	NEDA 101			deficient practice will not recur, i.e. what quality assurance program will be printo place? In-service training regarding the requirements for egress doors be provided to facility staff. An audit of all egress doors on the second floor will be completed ensure compliance. This audit occur weekly for 8 weeks, then monthly for a total duration of months. The results of the audit will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations a necessary. Compliance Date: February 12023	ne s will e I to s will n 12 dits s ce			
SS=E Bldg. 01	Corridors - Areas Spaces (other that treatment rooms waiting areas, nursed and cooking facilitin accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1. Based on observating failed to ensure 1 of separated from the of resisting the passing sprinklered buildin 19.3.6.1(7). LSC 1	Open to Corridor Open to Corridor an patient sleeping rooms, and hazardous areas), rse's stations, gift shops, ties, open to the corridor are the the criteria under 18.3.6.1 on and interview, the facility of 1 therapy rooms was corridor by a partition capable sage of smoke as required in a g, or met an Exception per 9.3.6.1(7) states that spaces leeping rooms, treatment	K 0361	What corrective action will be accomplished for those residents found to have beer affected by the deficient practice? No residents were found to be	1			

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		A. BUILDING	01	COMPL		
		B. WING		12/07/2022		
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
MARQUI	ETTE			OWNSHIP LINE RD		
MARQUI			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	· ·	ous areas shall be open to the		affected by this practice.		
		ted in area, provided: (a) The		Immediately following the Life		
	space and corridors	which the space opens onto		Safety inspection, the wedge		
		compartment are protected by		doorstops were removed from		
		rvised automatic smoke		under both sets of Therapy Gy	/m	
	I	accordance with 19.3.4, and		doors.		
		rotected by an automatic				
	-	The space does not to obstruct		How other residents having t	:he	
	_	exits. This deficient practice		potential to be affected by the	е	
		residents, staff and visitors in		same deficient practice will b	е	
	the vicinity of the b	pasement Therapy Room.		identified and what corrective	е	
				action will be taken?		
	Findings include:			This alleged deficient practice		
				could affect over 5 residents, s		
		ons with the Administrator		and visitors in the vicinity of the	е	
	_	ngineer during a tour of the		basement Therapy Gym.		
		o.m. to 1:50 p.m. on 12/07/22, two		Corrective action – the wedge		
	_	oor sets serve as entrances to		doorstops were immediately		
		py Room. Each door in the		removed from under both sets	of	
	-	ce door sets was self closing		doors listed.		
		g but each door was propped				
		sition with a wedge placed		What measures will be put in	to	
		sed on interview at the time of		place or what systemic		
	· ·	e Administrator stated		changes will be made to		
	_	e residents have customary		ensure that the deficient		
		nent Therapy Room and agreed		practice does not recur?		
	_	trance door sets were propped		Facility management will main	tain	
		osition with a wedge placed		a Life Safety procedure that		
		ch did not ensure the Therapy		complies with Federal, State, a		
	-	ed from the corridor by a		local laws. Education/in-servic		
		Fresisting the passage of		training will be provided to faci	-	
	smoke.			staff highlighting the requirement		
		e e e e e e e e e e e e e e e e e e e		for areas that open to corridors		
	_	viewed with the Administrator		and door safety. Additionally, a		
		ngineer during the exit		audit of all doors on the secon		
	conference.			floor will be completed by Plan		
				Director or designee to ensure		
	3.1-19(b)			compliance (see below for deta	ails).	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198	(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE : COMPL 12/07/	ETED
NAME OF P	PROVIDER OR SUPPLIER			8140 TC	DDRESS, CITY, STATE, ZIP COD DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be printo place? In-service training regarding the requirements for areas that operate to corridors and door safety we provided to facility staff. An autofiall doors in the basement we completed to ensure compliant. This audit will occur weekly for weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The result of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessare. Compliance Date: February 12023	ut ne pen ill be idit ill be ice. r 8 il sults th	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall/2-hour fire resist barriers shall be patrium wall. Smoke in duct penetration systems where an	rall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.					

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Event ID:

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Facility ID: 000105

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
155198		B. WING 12/07/2022			12/07/2022		
NAME OF PROVIDER OR SUPPLIER			-		ADDRESS, CITY, STATE, ZIP COD		
					OWNSHIP LINE RD		
MARQUE	=11E			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Describe any med system in REMAR	chanical smoke control					
		on and interview, the facility	K 0	272	What corrective action will b	e 02/01/2023	
		f 4 smoke barrier walls on the	K 0	314	accomplished for those	02/01/2023	
		protected to maintain the fire			residents found to have been	,	
	_	oke barrier. LSC Section			affected by the deficient		
		noke barriers to be constructed			practice?		
	_	LSC Section 8.5 and shall have			No specific resident was found	d to	
		fire resistive rating. This			be affected by this practice.		
		ould affect over 20 residents,			Following the inspection, the h	noles	
	staff and visitors on	the second floor.			noted in the smoke barrier wa		
					above the suspended ceilings		
	Findings include:				above the corridor door sets b		
					Rooms 201, 215, and 228 we	re	
		ons with the Administrator			firestopped with an approved		
		ngineer during a tour of the			commercial firestop material to	l l	
		.m. to 3:50 p.m. on 12/06/22, the			maintain the fire resistance of		
	following was noted				smoke barriers in compliance	with	
		re noted in the smoke barrier			Life Safety code.		
	_	ended ceiling above the					
		Room 201 which were not			How other residents having		
	firestopped.	. 1 1 6 4			potential to be affected by the	l l	
		meter hole for the passage of			same deficient practice will I		
		nit was noted in the smoke			identified and what corrective	e	
		he suspended ceiling above			action will be taken?	haa	
	the corridor door se	t by Room 215. surrounding two separate			The alleged deficient practice	nas	
		er conduits which penetrated			the potential to affect over 20 residents, visitors, and staff or	, the	
		vall above the suspended			second floor. The holes noted		
		orridor door set by Room 228			the smoke barrier walls above		
		d. In addition, a one inch in			suspended ceilings above the		
		e passage of an electrical			corridor door sets by Rooms 2		
		oted in the smoke barrier wall.			215, and 228 were firestopped		
	Based on interview at the time of the				maintain the fire resistance of		
		uilding Engineer agreed the			smoke barriers in compliance		
		enings in the second floor			Life Safety code.		
		were not firestopped to			,		
		sistance of the smoke barrier.			What measures will be put in	nto	
					place or what systemic		
	This finding was re	viewed with the Administrator			changes will be made to		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF P	PROVIDER OR SUPPLIER		8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD JAPOLIS, IN 46260	
	SUMMARY SUMMARY (EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION agineer during the exit	8140 T	OWNSHIP LINE RD JAPOLIS, IN 46260 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure that the deficient practice does not recur? The following systemic chang will be implemented to ensure the alleged deficient practice of not recur. Facility management will maintain a Life Safety procedure that complies with Federal, State, and local laws Education/in-service training of be provided to facility staff highlighting the requirements Subdivision of Building Space and Smoke Barriers. Addition an audit of all door set smoke barriers will be completed by lob Director or designee to ensure compliance (see below for designee) How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be p into place? An audit of all door set smoke barriers will be completed by	es that does nt
				Director or designee to ensure compliance. This audit will occure weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of months. The results of the audit will be shared with the facility Quality Assurance Performan Improvement Committee for additional recommendations and necessary.	ecur 12 dits s ce

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Facility ID: 000105

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF I	PROVIDER OR SUPPLIER	8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD JAPOLIS, IN 46260	
(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
			Compliance Date: February 1 2023	,
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012	K 0521	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by this practice. Immediately following the inspection, the facility's Director Plant Operations contracted w	oz, or, zozo
	Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped		an approved vendor to complethe fire damper maintenance a inspection in accordance with NFPA 80 – Standard for Fire Doors and Other Opening Protectives.	ete and
	with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all		How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken? This alleged deficient practice the potential to affect all reside staff, and visitors. Facility has contracted with approved vendomplete required maintenance and inspection of all Fire Dam within the facility.	e pe e has ents,

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155198		B. WING 12/07/2022			2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			OWNSHIP LINE RD		
MARQUE	TTE				APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SECONDS - CROSS-REFERENCED TO THE A		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	residents, staff and	visitors.					
	E' 1' ' 1 1				What measures will be put in	ito	
	Findings include:				place or what systemic		
	D 1 ' C				changes will be made to		
		the fire damper inspection			ensure that the deficient		
		e" documentation dated			practice does not recur?	ıto.	
		Administrator and the Building cord review from 9:35 a.m. to			Contracted vendor will comple		
		22, documentation of fire			initial inspections/maintenance		
	•	conducted within the most			verify that all facility fire dampe	ers	
		riod was not available for			are in compliance with NFPA	aro	
		, the 01/18/22 fire damper		regulations – all fire dampers are scheduled for immediate		are	
		ntation was also not itemized		inspection. Additionally, Faci		7/	
	•	tion. Based on observations		Plant Operations personnel will		•	
		ator and the Building Engineer		receive in-service		111	
		facility from 1:00 p.m. to 1:50			education/training on proper		
	-	wo fire dampers were noted in			maintenance, inspection, and		
	-	er room inside the basement			documentation of Fire Dampe	rs.	
		ch fire damper had an affixed					
		pected 01/17/18". Based on			How will the corrective action	n	
		e of record review and of the			be monitored to ensure the		
	observations, the B	uilding Engineer stated he			deficient practice will not		
	thought the fire dan	nper maintenance schedule			recur, i.e. what quality		
	was every five year	s and agreed documentation of			assurance program will be p	ut	
	fire damper inspect	ions conducted within the			into place?		
	most recent four ye	ar period was not available for			The facility Director of Plant		
	review.				Operations or designee will		
					oversee the inspection proces	s	
	_	viewed with the Administrator			and maintain compliant		
and the Building Engineer during the exit		ngineer during the exit			documentation of each inspection.		
	conference.				The results of the inspections		
					the fire dampers will be shared	b	
	3.1-19(b)				with the facility's Quality		
					Assurance Performance		
					Improvement Committee for		
					additional recommendations a	S	
					necessary.		
					Compliance Date: February 1	Ι,	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198	(X2) MULTIPLE C A. BUILDING B. WING	01	COME	E SURVEY PLETED 7/2022
NAME OF P	ROVIDER OR SUPPLIER		8140	TADDRESS, CITY, STATE, ZIP COD TOWNSHIP LINE RD NAPOLIS, IN 46260)	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LLD BE ROPRIATE	(X5) COMPLETION DATE
K 0923 SS=E Bldg. 01	Storage Gas Equipment - O Storage Greater than or eo Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 o Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enc noncombustible or minimum 1/2 hr. fi Less than or equa In a single smoke cylinders available patient care areas of less than or equ required to be stor Cylinders must be as specified in 11. A precautionary si on each door or groom, where the s a minimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with inter threshold pressure	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. I to 300 cubic feet compartment, individual a for immediate use in with an aggregate volume and to 300 cubic feet are not red in an enclosure. handled with precautions 6.2. gn readable from 5 feet is ate of a cylinder storage ign includes the wording as ION: OXIDIZING GAS(ES)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/07/2022 155198 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8140 TOWNSHIP LINE RD **MARQUETTE** INDIANAPOLIS, IN 46260 (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 avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 02/01/2023 Based on observation and interview, the facility K 0923 What corrective action will be failed to ensure 1 of 2 indoor oxygen storage areas accomplished for those was in accordance with NFPA 99 Health Care residents found to have been Facilities Code. NFPA 99, 2012 Edition, Section affected by the deficient 11.3.1 states storage for nonflammable gases practice? equal to or greater than 3000 cubic feet shall No specific resident was found to comply with 5.1.3.3.2 and 5.1.3.3.3. Section be affected by this practice. 5.1.3.3.2 states, if indoors, storage locations of Immediately following the positive-pressure gases shall be constructed and inspection, the entry door to the use interior finishes of noncombustible or limited oxygen storage and transfilling combustible materials such that all walls, floor, room on the second floor near the ceilings, and doors are of minimum 1-hour fire stairwell door by Room 227 was resistant rating. This deficient practice could equipped with self-closing affect over 10 residents, staff and visitors in the hardware - compliant with NFPA vicinity of the oxygen storage and transfilling 101 requirements. room on the second floor near the stairwell door by Room 227. How other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on observations with the Administrator action will be taken? and the Building Engineer during a tour of the The alleged deficient practice has facility from 2:00 p.m. to 3:50 p.m. on 12/06/22, the the potential to affect over 10 entry door to the oxygen storage and transfilling residents, staff, and visitors in the room on the second floor near the stairwell door vicinity of the oxygen storage and by Room 227 was not self closing or automatic transfilling room on the second closing. A 90-minute fire resistance rating label floor near the stairwell door by was affixed to the hinge side of the door. Three Room 227. The referenced door liquid oxygen containers and nine 'E' type oxygen has been equipped with cylinders were observed stored in the room. self-closing hardware – compliant Based on interview at the time of the with NFPA 101 requirements. observations, the Administrator and the Building Engineer agreed the entry door to the second What measures will be put into floor oxygen storage and transfilling room was not place or what systemic self closing or automatic closing which did not changes will be made to ensure the room was constructed of a minimum ensure that the deficient

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NAME OF PROVIDER OR SUPPLIER MARQUETTE STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 1-hour fire resistant rating. 1-hour fire resistant rating. This finding was reviewed with the Administrator and the Building Engineer during the exit B. WING STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT Practice does not recur? In-service education highlighting the requirements for gas equipment — cylinder and	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED	
MARQUETTE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X4) ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION This finding was reviewed with the Administrator and the Building Engineer during the exit 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Practice does not recur? In-service education highlighting the requirements for gas equipment — cylinder and				
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION 1-hour fire resistant rating. This finding was reviewed with the Administrator and the Building Engineer during the exit TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Practice does not recur? In-service education highlighting the requirements for gas equipment — cylinder and	PROVIDER'S I	ID SUMMARY STATEMENT OF DEFICIENCIE	(X5)	
1-hour fire resistant rating. Practice does not recur? In-service education highlighting the requirements for gas and the Building Engineer during the exit practice does not recur? In-service education highlighting the requirements for gas equipment – cylinder and	CROSS-REFERENC	` ·		
This finding was reviewed with the Administrator and the Building Engineer during the exit In-service education highlighting the requirements for gas equipment – cylinder and	IAG		DATE	
conference. container storage – NFPA 101 will be provided to staff. Additionally, an audit will be completed for all oxygen storage and transfilling rooms to ensure compliance (see below for additional details). How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Corrective actions will be monitored as follows. An audit of all oxygen storage and transfilling rooms will be completed by Plant Director or designee to ensure compliance. This audit will occur weekly for 8 weeks, then bi-weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for a total duration of 12 months. The results of the audits will be shared with the facility's Quality Assurance Performance Improvement Committee for additional recommendations as necessary. Compliance Date: February 1, 2023	In-service edu the requirement equipment – container stora be provided to an audit will be oxygen storag rooms to ensu below for addit How will the content prace recur, i.e. what assurance pro into place? Corrective acti monitored as f all oxygen stor rooms will be content prace compliance. The weekly for 8 w bi-weekly for 8 w bi-weekly for 8 w monthly for a t months. The re will be shared Quality Assura Improvement of additional reconnecessary. Compliance D	This finding was reviewed with the Administrator and the Building Engineer during the exit conference.	I will Illy, all g see n ut t of Illing ant ecur 12 dits s ce	

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