CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155400	B. WING		01/14/2025	
	PROVIDER OR SUPPLIEF		4600 E	ADDRESS, CITY, STATE, ZIP COD E JACKSON ST IE, IN 47303		
77.0.7D				, 		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 0000			TAG	BEIGHNOT	DATE	
□ 0000						
Bldg	conducted by the Irraccordance with 42  Survey Date: 01/14  Facility Number: 00  Provider Number: 1002  At this Emergency Care Strategies was Emergency Prepare Medicare and Mediand Suppliers, 42 C capacity of 104 and of this survey.	/25 00269 155400	E 0000	By submitting the following material, we are not admitting truth or accuracy of any specifindings or allegations. We resulted the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests the plan of correction considered our allegation of compliance effective 01/27/20 the state findings of the recent Safety Survey. We are request paper compliance,	fic serve s or cility n be 125 to t Life	
	The requirements o	f 42 CFR, Subpart 483.73 are sed by:				
E 0041 SS=F Bldg		(e), 485.542(e), 485.62 I LTC Emergency Power				
	failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2).  Findings include:  Based on record rev	view and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42  view with the Maintenance 25 at 11:38 a.m., documentation	E 0041	It is the practice of this facility implement the emergency powsystem inspection, testing, and maintenance requirements in Health Care Facilities Code.  1 What corrective actions who be accomplished for those residents found to be affected the deficient practice:  a There were no residents affected by the alleged deficie	wer d the vill by	

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

(X6) DATE

TITLE

Denise Arbuckle RN DON AIT 01/30/2025

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		A. BUILDING COM		(X3) DATE SURVEY COMPLETED 01/14/2025	
	PROVIDER OR SUPPLIER		4600 I	FADDRESS, CITY, STATE, ZIP COD E JACKSON ST CIE, IN 47303	
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	testing did not inclu The Load kW colur Based on interview the Maintenance Di ran under load on a percentage was not This finding was re	nonths of generator under load de the percentage under load. In was blank for every month, at the time of record review, rector confirmed the generator monthly basis but the load documented monthly.  Viewed with the Administrator irector at the exit conference.		practice.  2 - How other residents having potential to be affected by the same deficient practices will identified and what corrective action will be taken:  a. All residents, staff members and visitors have the potential be affected by the alleged depractice.  3 - What measures will be purplace and what systemic chance will be made to ensure that deficient practice does not real. Emergency Generator—Monthly Test Log implement and added to monthly maintenance duties list.  b. The Maintenance Director completed the monthly generous log with load kW on 1/16/2024. How the corrective action be monitored to ensure the deficient practices will not on a. The Maintenance Director added the Emergency Generous Monthly Test Log.  b. The administrator and/or designee shall review weekly inspection checklist and more test log to ensure compliance. This is an ongoing program, should non-compliance be observed, corrective actions a any corrective actions taken be reviewed during Quality. Assurance Meeting and the of action adjusted according needed.	e be be e e e e e e e e e e e e e e e e

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155400		A. BUILDING B. WING	UNSTRUCTION	COMPLETED 01/14/2025			
NAME OF PROVIDER OR SUPPLIER  CARDINAL CARE STRATEGIES		4600 E	STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM.	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION			
K 0000							
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the India Department of Health in accordance with 42 (483.90(a).  Survey Date: 01/14/25  Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720  At this Life Safety Code survey, Cardinal Car Strategies was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(Life Safety from Fire and the 2012 edition of National Fire Protection Association (NFPA) Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm syste with smoke detection in the corridors, areas of to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 104 and had a censur 72 at the time of this survey.  All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.  Quality Review completed on 01/15/25  NFPA 101	cFR  a), the 101, g  of em pen	By submitting the following material, we are not admitt truth or accuracy of any sp findings or allegations. We the right to contest the find allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations. The requests the plan of correct considered our allegation of compliance effective 01/27 the state findings of the red Safety Survey. We are requipaper compliance,	ing the ecific reserve ings or ese facility tion be of //2025 to cent Life			
SS=E	NFPA 101 Hazardous Areas - Enclosure						

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Facility ID: 000269

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		A. BUILDING <u>01</u> COM		(X3) DATE SURVEY  COMPLETED  01/14/2025		
NAME OF PROVIDER OR SUPPLIER  CARDINAL CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303			
(X4) ID PREFIX TAG Bldg. 01	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE AF	OULD BE COMPLETION	
Diug. U I	failed to ensure 1 of as fuel-fired heater other spaces by smodoors. Doors shall be closing in accordance practice could affect visitors.  Findings include:  Based on observation Director during a to to 2:45 p.m. on 01/1 mechanical room or natural gas fired was positively latch into four times. Based on observation, the Mathe door to the afore failed to latch when	on and interview, the facility fover 5 hazardous areas such rooms were separated from oke resistant partitions and be self closing or automatic ce with 7.2.1.8. This deficient t over 10 residents, staff and  on with the Maintenance ur of the facility from 1:15 p.m. 4/25, the corridor door to the in 100 Hall contained three ter heaters would not the door frame when tested in interview at the time of the intenance Director confirmed ementioned hazardous area the door self-closed.  wiewed with the Administrator irector during the exit	K 0321	It is the practice of this is ensure hazardous area would close completely automatically or provide self-closing device. 1 corrective actions will be accomplished for those found to be affected by deficient practice:a Tono residents affected by alleged deficient practice. How other residents has potential to be affected same deficient practice identified and what correction will be taken:a Alderesidents, staff member visitors have the potent affected by the alleged practice.  3 What measures with place and what systemic will be made to ensure deficient practice does a recur:a The Maintenant adjusted the mechanical door closure to ensure latching into the door from the door from the door from the door from the door sare properly closic self-closure devices.  4 How the corrective will be monitored to ensure the door sare properly closic self-closure devices.	doors and latch ed with a What e residents the here were / the ee. 2 aving the by the s will be ective II rs, and ial to be deficient  iill be put in c changes that not ce Director al room proper ames on  ector will week ensure ing with	

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		IDENTIFICATION NUMBER  155400	A. BUILDING B. WING	01	COMPLETED 01/14/2025	
NAME OF PROVIDER OR SUPPLIER  CARDINAL CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303			
(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)	DATE	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extin Based on record rev interview, the facilit portable fire extingu given maintenance a year apart. NFPA 1 Fire Extinguishers, a that fire extinguishes maintenance at inter at the time of hydros indicated by an insp notification. Section	iew, observation and y failed to ensure 1 of 1 tisher in the laundry room was at periods not more than one 0, the Standard for Portable at Section 7.3.1.1.1 requires rs shall be subjected to rvals of not more than 1 year, static test, or when specifically	K 0355	deficient practices will not occi a The Maintenance Director v check randomly once a week during facility rounds to ensure doors are properly closing with self-closure devices. The monitoring will be an ongoing process and if non-compliance observed, corrective action wil taken immediately.  b Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be upd as needed  It is the practice of this facility ensure fire extinguishers have maintenance at periods of not more than one year apart  1 What corrective actions will accomplished for those reside found to be affected by the deficient practice  a There were no residents affected by the alleged deficie	ur: vill e is l be e ated  to  01/27/2025	
	assurance that a fire effectively and safel damage or condition any repair or replace hydrostatic testing of	entended to give maximum extinguisher will operate y and to determine if physical will prevent its operation, if ement is necessary, and if or internal maintenance is 3.3 states each fire extinguisher		practice  2 How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 01/14/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303				
(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		
	shall have a tag or l indicates the month performed, identifies work, and identifies performing the wor affect staff in the la Findings include:  Based on record rev Maintenance Direct on 01/14/25, docume xtinguisher inspect 01/24/24. Based on the facility with the p.m., a portable fire laundry room had a than 1 year old. Base observation, the Mathe fire extinguisher affixed maintenance not inspected when been completed on the facility.  This finding was re	abel securely attached that and year the maintenance was as the person performing the the name of the agency k. This deficient practice could		![if="">a All residents, staff members, a visitors have the potential to b affected by the alleged deficie practice  3 What measures will be put in place and what systemic char will be made to ensure that deficient practice does not rec a The Maintenance Director scheduled the annual fire extinguisher maintenance for laundry room fire extinguisher Koorsen Fire and Security. Ar inspection of fire extinguisher completed 01/27/2025.  b The Maintenance Director w complete review of the annual maintenance date with his monthly fire extinguisher inspection.  4 How the corrective actions w be monitored to ensure the deficient practices will not occ a The Maintenance Director h added the annual maintenance date to the monthly checklist f the portable fire extinguishers  b This is an ongoing program, should non-compliance be observed, corrective actions an any corrective actions taken w be reviewed during Quality	and e nt n n nges cur:  with anual was vill ur: as e for		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED		
		155400	B. WI	B. WING			2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Assurance Meeting and the pl of action adjusted accordingly needed			
K 0761	NFPA 101							
SS=E Bldg. 01	Maintenance, Insp	pection & Testing - Doors						
		view and interview, the facility	K 0	761	It is the practice of this facility	to	01/16/2025	
		ual inspection and testing of 1			ensure annual inspection and			
		room fire door assemblies accordance with LSC 8.3.3.1			testing of the oxygen storage room fire door assemblies are			
	_	to have a fire protection rating			completed			
		all be protected by approved,			Completed			
	•	oor assemblies and fire			1 What corrective actions will	be		
		and their accompanying			accomplished for those reside			
		gall frames, closing devices,			found to be affected by the			
	anchorage, and sills	in accordance with the			deficient practice:			
		PA 80, Standard for Fire Doors						
		Protectives, except as			a There were no residents affe			
	_	in this Code. NFPA 80 5.2.1			by the alleged deficient practic	e		
		mblies shall be inspected and						
		annually, and a written record			2 How other residents having	the		
		all be signed and kept for			potential to be affected by the			
		HJ. NFPA 80, 5.2.4.1 states fire all be visually inspected from			same deficient practices will be	е		
					identified and what corrective action will be taken:			
	both sides to assess the overall condition of door assembly.							
	NFPA 80 5242 et	tates as a minimum, the			a All residents, staff members and visitors have the potential			
	following items sha				be affected by the alleged defi			
	_	r breaks exist in surfaces of			practice	2.0110		
	either the door or fr							
		light frames, and glazing beads			3 What measures will be put in	ı İ		
		ely fastened in place, if so			place and what systemic chan			
	equipped.				will be made to ensure that			
		, hinges, hardware, and			deficient practice does not rec	ur:		
		eshold are secured, aligned,						
		er with no visible signs of			a The Maintenance Director			
	damage.				completed the Annual Inspecti			
	(4) No parts are mis	ssing or broken.	I		and Testing of Fire and Smoke	Э		

3.1-19(b)

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0						B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155400	B. W	ING		01/14/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				JACKSON ST		
CARDINA	AL CARE STRATE	SIES			E, IN 47303		
OANDINAL GANE OTTATEGIEG				WONO	L, IIV 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	do not exceed clearances			Door Assemblies on 1/16/202	25.	
	listed in 4.8.4 and 6	5.3.1.7.					
	(6) The self-closing	device is operational; that is,			b The Annual Inspection and		
	the active door com	pletely closes when operated			Testing of Fire and Smoke Do	oor	
	from the full open p	oosition.			Assemblies form will be adde	d to	
	(7) If a coordinator	is installed, the inactive leaf			the monthly maintenance duti	ies	
	closes before the ac	tive leaf.			list		
	(8) Latching hardw	are operates and secures the					
	door when it is in th	ne closed position.					
	(9) Auxiliary hardw	vare items that interfere or			4 How the corrective actions	will	
	prohibit operation a	are not installed on the door or		be monitored to ensure the			
	frame.				deficient practices will not occ	cur:	
	(10) No field modif	ications to the door assembly			· ·		
		ed that void the label.			a The Maintenance Director h	nas	
	_	edge seals, where required, are			added the Annual Inspection	and	
		their presence and integrity.			Testing of Fire and Smoke Do		
					Assemblies form to the month		
	This deficient pract	ice could affect 10 residents,			maintenance duties list.	•	
	staff and visitors.	,					
					span="">b This is an ongoing		
	Findings include:				program, should non-complia		
					be observed, corrective action		
	Based on record rev	view and interview with the	shall be taken, the observations				
		tor at 10:20 a.m. on 01/14/25,	and any corrective actions taken				
		d swinging door assembly			will be reviewed during Qualit		
		5/06/24; however, the			Assurance Meeting and the p	-	
	-	ed to include inspection of one			of action adjusted accordingly		
		rage room. Based on interview			needed	, 4.5	
		d review, the Maintenance					
		the fire rated door of the					
		ot inspected annually within			span="">		
		would add it to the annual fire					
	door inspection list						
	mspection list						
	This finding was re	viewed with the Administrator					
		irector at the exit conference.					
		at the entrement.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155400		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/14/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4600 E JACKSON ST MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 0918 SS=F Bldg 01	NFPA 101 Electrical Systems	s - Essential Electric Syste				
Bldg. 01	facility failed to may of monthly generated 12 months. Chapter requires monthly test the emergency elect accordance with NF Emergency and Stat 8. NFPA 110 8.4.2.4 Gas) generator sets once a month with the minutes or until the pressure have stabil 99 requires a writter performance, exercing generator to be regulated for inspection by the jurisdiction. This decupants.  Findings include:  Based on record revelocity Director on 01/14/2 for the last twelve in testing did not included the Maintenance Director and the Maintenance Director	review and interview, the intain a complete written record or load testing for 12 of the last of 6.4.4.1.1.4(a) of 2012 NFPA 99 sting of the generator serving rical system to be in PA 110, the Standard for endby Powers Systems, Chapter 4 states spark-ignited (Natural shall be exercised at least the available EPSS load for 30 water temperature and the oil ized. Chapter 6.4.4.2 of NFPA in record of inspection, sing period, and repairs for the clarly maintained and available authority having efficient practice could affect all riew with the Maintenance 5 at 11:38 a.m., documentation nonths of generator under load de the percentage under load. In was blank for every month, at the time of record review, rector confirmed the generator monthly basis but the load documented monthly.	K 0918	It is the practice of this facility ensure that the weekly inspect of emergency generator is completed and that there is a written record of monthly general load testing.  1 What corrective actions will accomplished for those reside found to be affected by the deficient practice:  a There were no residents affiby the alleged deficient practice  2 How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken:  a All residents, staff members and visitors have the potential be affected by the alleged definition practice  3 What measures will be put in place and what systemic charm will be made to ensure that deficient practice does not recomplete the practice of the practice of the practice does not recomplete the practice of the practice does not recomplete the practice of the practice does not recomplete the practice does not recom	erator be ents ected ce. the ected ce. It to ricient n neges cur: enthly ded	
	3.1-17(0)			completed the monthly genera	ator	

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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> COME		COMPLETED	
		155400	B. WING		01/14/2025	
			-			
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
OADDINI	V OADE OTDATE			E JACKSON ST		
CARDINA	AL CARE STRATEO	SIES .	MUN	CIE, IN 47303		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	2. Based on record	review and interview, the		log with load kW on 1/16/2025	5	
		ure a written record of weekly				
	-	emergency generator was		c Emergency Generator – We	eklv	
	-	f 52 weeks. NFPA 99, 6.4.4.1.3		Inspection Checklist implemen	- I	
		erators shall be maintained in		and added to monthly		
		FPA 110, Standard for		maintenance duties list		
		ndby Power Systems. NFPA				
		an Emergency Power Supply		d The Maintenance Director		
		uding all appurtenant		completed the weekly inspect	ion	
	• • •	e inspected weekly and		checklist on 1/20/2025		
	-	NFPA 99, 6.4.4.2 requires a				
	-	spection, performance,		4 How the corrective actions v	vill	
		nd repairs for the generator to		be monitored to ensure the		
		ined and available for		deficient practices will not occur:		
		thority having jurisdiction.		acinoicini pracacco iniii net coc		
		ice could affect all residents,		a The Maintenance Director h	as	
	staff and visitors.	,		added the Emergency Genera		
				Monthly Test Log which include		
	Findings include:			the kW% and Weekly Inspection		
	8			Checklist to the monthly		
	Based on review of	Emergency Generator testing		maintenance duties list		
		the Maintenance Director,				
		w from 10:10 a.m. to 1:15 p.m.		b The Administrator and/or		
	-	y generator inspection		designee shall review weekly		
	-	he last 52 weeks was not		inspection checklist and mont	hlv	
		. Based on interview at the		test log to ensure compliance	•	
		w, the Maintenance Director		This is an ongoing program,		
		ned records for weekly		should non-compliance be		
		n documentation and could		observed, corrective action sh	nall	
		there was not any available		be taken. the observations an		
	for the last 12 month	-		any corrective actions taken w		
				be reviewed during Quality		
	These findings were	e reviewed with the		Assurance Meeting and the pl	lan	
	_	Maintenance Director during		of action adjusted accordingly		
	the exit conference.	——————————————————————————————————————		needed.		
	3.1-19(b)					
			1	1	1	

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