PRINTED: 10/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING		COMPI	X3) DATE SURVEY COMPLETED 09/12/2024	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	-	
MORNIN	IG BREEZE RETIF	REMENT COMMUNITY AND HEA	LTHC		_AKEVIEW DR NSBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg			E 00	000			
	Facility Number: Provider Number: AIM Number: 20	155675					
	Breeze Retirement found not in comp Preparedness Requ	Preparedness survey, Morning Community and Healthcare was liance with Emergency airements for Medicare and tting Providers and Suppliers, 42					
	The facility has 64 the survey, the cer	certified beds. At the time of sus was 50.					
	Quality Review co	mpleted on 09/13/24					
E 0041 SS=F Bldg	Hospital CAH an	3(e), 485.542(e), 485.62 d LTC Emergency Power					
	failed to implement inspection, testing found in the Health 110, and Life Safe CFR 483.73(e)(2). affect all occupant Findings include:  Based on records in	eview and interview, the facility at the emergency power system and maintenance requirements in Care Facilities Code, NFPA ty Code in accordance with 42. This deficient practice could is.	E 00	41	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Emergency power inspection completed on 9/23/2024 by the maintenance director. The lost percentage was recorded to vor load placed upon the general during load test. ¿	ents by the was e e ad eerify	09/26/2024
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE
Holly Witkemper				HFA			09/23/2024

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.

Holly Witkemper

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	OF CORRECTION	IDENTIFICATION NUMBER  155675		UILDING	nstruction 	COMPL 09/12/	ETED
NAME OF PROVIDER OR SUPPLIER  MORNING BREEZE RETIREMENT COMMUNITY AND HEALT			STREET ADDRESS, CITY, STATE, ZIP COD  950 N LAKEVIEW DR  THC GREENSBURG, IN 47240				
(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)	TE	(X5) COMPLETION DATE
	available for review percentage of load puring monthly load at the time of record Director stated he were cord and keep a replaced upon the gen load tests. In the spasheet it indicated "L" "100%."  This finding was ac Maintenance Direct again at the exit control of load to the state of the	, no documentation was to show the available blaced upon the generator It tests. Based on an interview I review, the Maintenance ras unaware that he needed to becord of the percentage of load erator during the monthly nee provided on the records load Percentage UNK" or knowledged by the or at the time of discovery and ference with the Maintenance live Director present.			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ¿  All residents had the potential be affected by the alleged practice, but no residents were identified to be affected by this alleged deficiency after review.  ¿¿  What measures will be put interplace and what systemic chan will be made to ensure that the deficient practice does not recur; ¿  The facility electronic life safet record keeping system, TELS was updated to include a required to document the load test percentage. Maintenance Directly educated on the newly defined required documentation of load percentage on TELS report. ¿  ¿¿  How the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance program will put into place; and ¿	to e s i.; o nges e ty iired ting ector d d	

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	OF CORRECTION	IDENTIFICATION NUMBER  155675	A. BUILDIN B. WING	IG	COMPLETED 09/12/2024
	PROVIDER OR SUPPLIEF	EMENT COMMUNITY AND HEAL	950	EET ADDRESS, CITY, STATE, ZIP COD O N LAKEVIEW DR REENSBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CH DEFICIENCY MIJET DE DRECEDED DY EILLI DREETY (EACH CORRECTIVE ACTION SH		CROSS-REFERENCED TO THE APPROP	E COMPLETION
				A Performance Improvement has been developed that will monitor compliance of documentation of the general load percentage. Maintenant Director/Designee will completed tool 1x weekly¿for two¿monthen weekly for two months, monthly going forward, with being presented at the QAP committee meeting and if 10 greater compliance is obtain the committee will on continuing the audits. ¿¿¿  By what date the systemic changes for each deficiency be completed. ¿¿  9/26/2024¿	ator ace alete PI aths, then results I 00% or aed, uing
K 0000					
Bldg. 01	Licensure Survey w	11039 155675	K 0000		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155675		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/12/2024		
	PROVIDER OR SUPPLIER	EMENT COMMUNITY AND HEAL	950 N	T ADDRESS, CITY, STATE, ZIP COD N LAKEVIEW DR ENSBURG, IN 47240		
(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 APPROPR DEFICIENCY)	IOULD BE COMPLETION	
	Retirement Communot in compliance versity Participation in Mesubpart 483.90(a), 2012 Edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.  This one-story facil Type V (111) const sprinklered. The fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms. The facility census of 50 at the fawith smoke detection open to the corridor rooms.	idents have customary access The facility has one detached facility storage services which				
K 0918 SS=F Bldg. 01	•	s - Essential Electric Syste				
	failed to exercise th to meet the requirer Edition, the Standar Powers Systems. C NFPA 99 requires r generator serving th to be in accordance NFPA 110 Section sets in service shall	riew and interview, the facility e generator for 12 of 12 months ments of NFPA 110, 2010 rd for Emergency and Standby Chapter 6.4.4.1.1.4(a) of 2012 monthly testing of the ne emergency electrical system with NFPA 110, Chapter 8. 8.4.2 states diesel generator be exercised at least once mum of 30 minutes, using one	K 0918	What corrective action(s) will accomplished for those reside found to have been affected deficient practice; ¿ Emergency power inspection completed on 9/23/2024 by the maintenance director. The least percentage was recorded to of load placed upon the general during load test. ¿	lents by the n was he pad verify	

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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 09/12/2024 155675 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 950 N LAKEVIEW DR MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC GREENSBURG, IN 47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the How other residents having the manufacturer potential to be affected by the (2) Under operating temperature conditions and at same deficient practice will be not less than 30 percent of the EPS (Emergency identified and what corrective Power Supply) nameplate kW rating. action(s) will be taken;¿ Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of All residents had the potential to 8.4.2 shall be exercised monthly with the available be affected by the alleged EPSS (Emergency Power Supply System) load and practice, but no residents were shall be exercised annually with supplemental identified to be affected by this loads at not less than 50 percent of the EPS alleged deficiency after review.¿ nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS 55 nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous What measures will be put into hours Chapter 6.4.4.2 of NFPA 99 requires a place and what systemic changes written record of inspection, performance, will be made to ensure that the exercising period, and repairs for the generator to deficient practice does not be regularly maintained and available for recur;¿ inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: The facility electronic life safety record keeping system, TELS, Based on records review and interview with the was updated to include a required Maintenance Director on 09/12/24 between 11:20 field to document the load testing a.m. and 12:55 p.m., no documentation was percentage. Maintenance Director available for review to show the available educated on the newly defined percentage of load placed upon the generator required documentation of load during monthly load tests. Based on an interview percentage on TELS report. ¿ at the time of record review, the Maintenance Director stated he was unaware that he needed to نن record and keep a record of the percentage of load placed upon the generator during the monthly How the corrective action(s) will be load tests. In the space provided on the records monitored to ensure the deficient sheet it indicated "Load Percentage UNK" or practice will not recur, i.e., what "100%." quality assurance program will be

put into place; and ¿

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CTATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII TIDI E C	ONETRICTION	(V2) DATE	CLIDVEY	
			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPL		
		155675	B. WING		09/12/	2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIEF	R					
MODNIN	C RDEE7E DETIDI	EMENT COMMUNITY AND HEALT	950 N LAKEVIEW DR FHC GREENSBURG, IN 47240				
MONIM	G DIVELZE IVETIIVI	EMENT COMMONTT AND TIEACT	TIC GIVE				
(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	.TE (	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPROPE		DATE	DATE	
	This finding was ac	knowledged by the					
	Maintenance Direct	tor at the time of discovery and		55			
	again at the exit con	nference with the Maintenance					
	Director and Execu	tive Director present.		A Performance Improvement	Tool		
				has been developed that will			
	3.1-19(b)			monitor compliance of			
				documentation of the generate	or		
				load percentage. Maintenance	;		
				Director/Designee will complete			
				tool 1x weekly; for two; month	s.		
				then weekly for two months, the			
				monthly going forward, with re			
				being presented at the QAPI			
				committee meeting and if 100	% or		
				greater compliance is obtained			
				the committee will on continuing			
				or discontinuing the audits.¿	.a		
				or alcoording the addits.			
				33			
				Dy what data the evets ::			
				By what date the systemic	.:11		
				changes for each deficiency w	/III		
				be completed.¿¿			
				9/26/2024¿			
						i	

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