STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING -- B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/12/24 Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100 At this Emergency Preparedness survey, Morning Breeze Retirement Community and Healthcare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 64 certified beds. At the time of the survey, the census was 50. Quality Review completed on 09/13/24	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director on 09/12/24 between 11:20	E 0041	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;¿ Emergency power inspection was completed on 9/23/2024 by the maintenance director. The load percentage was recorded to verify of load placed upon the generator during load test. ¿ ¿	09/26/2024

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

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	a.m. and 12:55 p.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at the time of record review, the Maintenance Director stated he was unaware that he needed to record and keep a record of the percentage of load placed upon the generator during the monthly load tests. In the space provided on the records sheet it indicated "Load Percentage UNK" or "100%." This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive 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 to 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 into place and what systemic changes will be made to ensure that the deficient practice does not recur;¿ The facility electronic life safety record keeping system, TELS, was updated to include a required field to document the load testing percentage. Maintenance Director educated on the newly defined required documentation of load percentage on TELS report. ¿ ¿¿ How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and¿	

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			¿¿ A Performance Improvement Tool has been developed that will monitor compliance of documentation of the generator load percentage. Maintenance Director/Designee will complete PI tool 1x weekly¿for two¿months, then weekly for two months, then monthly going forward, with results being presented at the QAPI committee meeting and if 100% or greater compliance is obtained, the committee will on continuing or discontinuing the audits.¿ ¿¿ By what date the systemic changes for each deficiency will be completed.¿¿ 9/26/2024¿	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/12/24 Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100	K 0000		

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	155675	A. BUILDING 01 B. WING	09/12/2024

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	At this Life Safety Code survey, Morning Breeze Retirement Community and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 50 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 09/13/24			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, Chapter 8. NFPA 110 Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;¿ Emergency power inspection was completed on 9/23/2024 by the maintenance director. The load percentage was recorded to verify of load placed upon the generator during load test. ¿	09/26/2024

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	of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director on 09/12/24 between 11:20 a.m. and 12:55 p.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at the time of record review, the Maintenance Director stated he was unaware that he needed to record and keep a record of the percentage of load placed upon the generator during the monthly load tests. In the space provided on the records sheet it indicated "Load Percentage UNK" or "100%."		¿ 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 to 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 into place and what systemic changes will be made to ensure that the deficient practice does not recur;¿ The facility electronic life safety record keeping system, TELS, was updated to include a required field to document the load testing percentage. Maintenance Director educated on the newly defined required documentation of load percentage on TELS report. ¿ ¿¿ How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and¿	

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		¿¿ A Performance Improvement Tool has been developed that will monitor compliance of documentation of the generator load percentage. Maintenance Director/Designee will complete PI tool 1x weekly¿for two¿months, then weekly for two months, then monthly going forward, with results being presented at the QAPI committee meeting and if 100% or greater compliance is obtained, the committee will on continuing or discontinuing the audits.¿ ¿¿ By what date the systemic changes for each deficiency will be completed.¿¿ 9/26/2024¿	