STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155719	A. BUILDING -- B. WING	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 EAST STATE RD 16 BROOK, IN 47922

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/13/25 Facility Number: 000559 Provider Number: 155719 AIM Number: 100267170 At this Emergency Preparedness survey, George Ade Memorial Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 70 certified beds. At the time of the survey, the census was 56. Quality Review completed on 02/19/25	E 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott James	HFA	03/10/2025

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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			action was necessary.February 27,2025 Suzanne Williams, Director Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, IN 46204 Re: Survey Event ID 3X9521, for George Ade Memorial Health Care Center February 13,2025 Dear Director: The following is our POC for the above-mentioned survey and is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 2nd of March 2025. At this time, we are requesting a desktop review of the POC, and the additional information be conducted to clear the survey findings, and stop any and all proposed remedies that have been presented to date. If you have any questions or need further information, call (219) 275-2531 or fax (219) 275-7472, and we would be available to assist you in any way	

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			possible. Thank you, Scott James, HFA GAMHCC c: survey file	
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 record review with the Maintenance Lead on 02/13/25 at 1:00 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Lead stated the facility does have a diesel generator and results of the most recent fuel quality testing was not available for review. This finding was reviewed with the Administrator and Maintenance Lead at the exit conference.	E 0041	Desktop review requested No residents were found to be harmed by this finding. The annual fuel sample in question was done for 2023. The annual fuel quality test requirements for diesel generators. The test for 2025 is being processed with results to follow. The environmental supervisor or designee will be responsible to see this is conducted annually to prevent further concerns. See attached fuel sample. Done as of 3/2/2025	03/02/2025

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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: 02/13/25 Facility Number: 000559 Provider Number: 155719 AIM Number: 100267170 At this Life Safety Code survey, George Ade Memorial Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, spaces open to the corridors, and in all resident rooms. The facility has a capacity of 70 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered. Quality Review completed on 02/19/25	K 0000	The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective	

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			possible. Thank you, Scott James, HFA GAMHCC c: survey file	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 02/13/25 from 11:10	K 0291	K291 Desktop review requested No residents were found to be harmed by this finding. The battery-operated emergency light test logs have been updated with all emergency lights being tested and found to be in proper working order. The annual and ongoing testing will be scheduled to prevent further concern. See attached log. This will be maintained by the environmental supervisor and/or designee to maintain compliance. Done as of 3/2/2025	03/02/2025

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	a.m. to 2:15 p.m. Maintenance Lead, the Battery Operated Emergency Light Test Log for 2024 did not include 90 minute annual testing. The most recent 90 minute annual testing was documented on 07/24/23. Based on an interview at the time of record review, the Maintenance Lead indicated the facility has battery operated emergency exit lights throughout the facility, but he was aware of the 90 minute annual requirement. This finding was reviewed with the Administrator and Maintenance Lead at the exit conference. 3.1-19(b)			
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any fuel-fired heating device, other than a central heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room. This deficient practice could affect at least two staff in the Laundry. Findings include: Based on observation with the Administrator and Maintenance Lead on 02/13/25 at 3:00 p.m. during a tour of the facility, the laundry room had fuel-fired dryers with a fresh air intake that was fully covered with a piece of carpet. The carpet was screwed into the frame around the fresh air	K 0522	K522 Desktop review requested No residents were found to be harmed by the finding. The carpet flap has been removed from the fresh air vent in the laundry area. A new fresh air vent system has been installed (see pic) to allow for fresh air venting to the area and allow adequate exchange air for the area. The environmental supervisor and/or designee will be responsible for always seeing this is functioning properly. Done as of 3/2/2025.	03/02/2025

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	intake located behind the dryers. This condition does not allow for fresh air to enter the room. Based on an interview at the time of observation, the Maintenance Lead agreed the air intake was covered. This finding was reviewed with the Administrator and Maintenance Lead at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Lead on 02/13/25 from 11:10 a.m. to 2:15 p.m., there was no documentation for the following shifts and quarters: a) third shift drill for first quarter (January, February, March) of 2024 b) First, second and third shift of the second quarter (April, May, June) of 2024 c) second and third shift fire drills in the third quarter (July, August, September) of 2024 Based on interview at the time of record review, the Maintenance Lead confirmed the missing fire drill reports and stated there are no additional fire drills for review at the time of the survey. This finding was reviewed with the Administrator	K 0712	K712 Desktop review requested. No residents were found to be harmed by this finding. The fire drill schedule is in full effect. Drills are scheduled and conducted once per shift per quarter. (See attached) The required fire drill information is documented on an ongoing basis with three drills per calendar quarter. The environmental supervisor and/or designee will maintain and provide necessary drill information by regulation, to maintain compliance. Done as of 3/2/2025.	03/02/2025

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	and Maintenance Lead at the exit conference. 2. Based on record review and interview, the facility failed to ensure a third shift fire drill included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the fourth quarter. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of "Fire Drill Report" forms with the Maintenance Lead on 02/13/25 at 12:20 p.m., the third shift silent fire drill for 12/20/24 did not include the transmission of the fire alarm signal. That section of the fire drill report was left blank. Additionally, there was not a time of alarm documented, as 'Silent Drill' was wrote in the 'time of alarm' area. Based on interview at the time of record review, the Maintenance Lead confirmed the 12/20/24 third shift drill did not include verification of the transmission of the fire alarm signal and no time of when the drill occured was documented. This finding was reviewed with the Administrator and Maintenance Lead at the exit conference. 3.1-19(b) 3.1-51(c)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility	K 0918	Desktop review requested	03/02/2025

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	failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Lead on 02/13/24 at 1:00 p.m., documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Lead agreed documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator and Maintenance Lead at the exit conference 3.1-19(b)		No residents were found to be harmed by this finding. The annual fuel sample in question was done for 2023. The annual fuel quality test requirements for diesel generators. The test for 2025 is being processed with results to follow. The environmental supervisor or designee will be responsible to see this is conducted annually to prevent further concerns. See attached fuel sample. Done as of 3/2/2025	
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011,	K 0920	K920 Desktop review requested. No residents were found to be	02/14/2025

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	400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect 12 residents, staff and visitors in one smoke compartment. Findings include: Based on observation with the Administrator and Maintenance Lead on 02/13/25 at 2:41 p.m. during a tour of the facility, in resident room 111, an extension cord was in use powering a cell phone charger and table lamp. Based on an interview at the time of observation, the Administrator agreed an extension cord was in use powering a table lamp and removed the extension cord upon observation. This finding was reviewed with the Administrator and the Maintenance Lead during the exit and the conference. 3.1-19(b)		harmed by this finding. The observed cord was removed, residents, staff and families have been reminded not to use these or any extension cords for safety purposes. The environmental supervisor and/or designee will be responsible for maintaining this to prevent further concerns. Done as of 2/14/2025.	