PRINTED: 03/13/2025

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	A. BU	A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2025		
			3623 E	AST STATE RD 16			
MORIAL	. HEALTH CARE CENTER		BROOI	K, IN 47922			
CH DEFICIE	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Date: 02/1.  Number: (1)  Number: 100  Emergency  morial Heiliance with ments for 1  atting Providely, the centers are	ndiana Department of Health in 2 CFR 483.73.  3/25  000559 155719 1267170  Preparedness survey, George alth Care Center was found not in Emergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR  1 certified beds. At the time of issus was 56.	E 00	000	this Plan of Correction does not constitute admission or agree by the provider of the truth of facts alleged or the conclusion 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 all deficiencies do not individually collectively jeopardize the heat and safety of its residents, not they of such character as to lithis provider's capacity to remadequate resident care. Furthermore, the operation ar licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers	ot ment the n set  of he eged y or alth r are mit der		
	RE & MEDIO CIENCIES CTION  DR SUPPLIE EMORIAL  SUMMARY CH DEFICIE JLATORY O  regency Proceed by the I nace with 42  Date: 02/12  Number: 0  remergency morial Healiance with ments for 1 ating Providence of the center of the cen	RE & MEDICAID SERVICES CIENCIES X1) PROVIDER/SUPPLIER/CLIA CTION IDENTIFICATION NUMBER	EXE & MEDICAID SERVICES  CIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER A. BU 155719  DR SUPPLIER  EMORIAL HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL DLATORY OR LSC IDENTIFYING INFORMATION  Progency Preparedness Survey was ed by the Indiana Department of Health in new with 42 CFR 483.73.  Date: 02/13/25  Number: 000559 Promber: 155719 Sumber: 100267170  Emergency Preparedness survey, George morial Health Care Center was found not liance with Emergency Preparedness ments for Medicare and Medicaid ating Providers and Suppliers, 42 CFR  lity has 70 certified beds. At the time of ey, the census was 56.	EL & MEDICAID SERVICES  CIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719  COR SUPPLIER  EMORIAL HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL DIATORY OR LSC IDENTIFYING INFORMATION  Tagency Preparedness Survey was end by the Indiana Department of Health in ence with 42 CFR 483.73.  Coate: 02/13/25  Number: 000559  Number: 155719  Immer: 100267170  Emergency Preparedness survey, George morial Health Care Center was found not diance with Emergency Preparedness ments for Medicare and Medicaid ating Providers and Suppliers, 42 CFR  Lity has 70 certified beds. At the time of ey, the census was 56.	TENCIES   X1) PROVIDERSUPPLIER/CLIA   X2) MULTIPLE CONSTRUCTION   A BUILDING   E WING   STREET ADDRESS, CITY, STATE, ZIP COD   3623 EAST STATE RD 16   BROOK, IN 47922   E MORIAL HEALTH CARE CENTER   ID   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PRECEDED BY FULL   TAG   PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG    PREFIX   TAG   PROVIDERS PLAN OF CORRECTION ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX   TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PROVIDED PROVIDE	EXEMPLICATION SERVICES  TENCIES (IN) PROVIDERSUPPLIER (LIA IDENTIFICATION NUMBER (155719)  DOR SUPPLIER  EMORIAL HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (ET.) PREFIX TAGE (SAS-REFERENCE) TO THE APPROPRIATE (DESCRIPTION OF CONSTRUCTION OF CONSTRUCTION OF CONSTRUCTION OF CONSTRUCTION OF CONSTRUCTION OF COMPRIANCE (COMPILIANCE) (COMPILIANCE	

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

TITLE (X6) DATE

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

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3X9521 Facility ID: 000559 If continuation sheet Page 1 of 11

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/13/2025 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPL	ETED
		155719	B. WI	NG		02/13/	/2025
	ROVIDER OR SUPPLIE	R HEALTH CARE CENTER	•	3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					action was necessary.Februar 27,2025	гу	
					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, George Ade Memorial Health Center February 13,2025		
					Dear Director:		
					The following is our POC for the above-mentioned survey and is being submitted as our allegate of substantial compliance. We further submit that this facility 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 presented to date.	is is in he ne,	
					If you have any questions or n further information, call (219) 275-2531 or fax (219) 275-7472, and we would be	need	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

available to assist you in any way

If continuation sheet

Page 2 of 11

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155719	A. BUILDING B. WING	ONSTRUCTION	COMPLETED 02/13/2025
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE RD 16 K, IN 47922	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
E 0041 SS=F Bldg	Based on record reversal failed to implement inspection, testing, a found in the Health 110, and Life Safety CFR 483.73(e)(2). The affect all occupants.  Findings include:  Based on record reversal Lead on 02/13/25 at of an annual fuel quere generator was available interview at the time Maintenance Lead selected generator and fuel quality testing with the selected selected generator and fuel quality testing with the selected selected generator and fuel quality testing with the selected generator and the selected generator gener	(e), 485.542(e), 485.62 LTC Emergency Power  iew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA (Code in accordance with 42) This deficient practice could  iew with the Maintenance 1:00 p.m., no documentation ality test for the diesel able for review. Based on (e) of records review, the tated the facility does have a results of the most recent was not available for review.  Viewed with the Administrator and at the exit conference.	E 0041	Thank you,  Scott James, HFA GAMHCC  C: survey file  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 diesel generators. The test for 2025 is being processed with results to follow. The environmental supervisor or designee will be responsible see this is conducted annuall prevent further concerns. Se attached fuel sample.  Done as of 3/2/2025	n ual for or to y to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

If continuation sheet

Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED		
		155719	B. W	B. WING 02/13/2025				
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	L			AST STATE RD 16			
GEORG	E ADE MEMORIAI	HEALTH CARE CENTER		BROOK, IN 47922				
	- ADE IVILIVIONAL	TIEVE III OAKE OF MILIT		Bittoor	1, 11 71 322			
(X4) ID		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	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
K 0000								
Bldg. 01								
		Recertification and State	K 0	000	The preparation and execution			
	_	ras conducted by the Indiana			this Plan of Correction does n			
	_	th in accordance with 42 CFR			constitute admission or agree			
	483.90(a).				by the provider of the truth of			
		(O.5			facts alleged or the conclusion	n set		
	Survey Date: 02/13	/25			forth in the Statement of			
	F 11: 37 1 0	20550			Deficiencies rendered by the	_		
	Facility Number: 00				reviewing agency. The Plan of	)†		
	Provider Number: 155719 AIM Number: 100267170  At this Life Safety Code survey, George Ade				Correction is prepared and			
					executed solely because it is			
					required by the provisions of t	ne		
					federal and state law. This			
		are Center was found not in equirements for Participation in			provider maintains that the all	-		
	_	, 42 CFR Subpart 483.70(a),			deficiencies do not individually			
		re and the 2012 edition of the			collectively jeopardize the hea and safety of its residents, no			
	-	etion Association (NFPA) 101,			they of such character as to li			
		LSC), Chapter 19, Existing			this provider's capacity to rend			
		ancies and 410 IAC 16.2.			adequate resident care.	aC1		
	Trouver care courp				Furthermore, the operation an	nd		
	This one-story facil	ity was determined to be of			licensor of the long-term care	ıu		
		ruction and was fully			facilities, and this plan of			
	• • • • • •	cility has a fire alarm system			correction in its entirety,			
		oke detection in corridors,			constitutes this providers			
		corridors, and in all resident			allegation of			
		has a capacity of 70 and had a			compliance. Completion date	S		
	census of 56 at the t				are provided for the procedura			
					preceding purposes to comply			
	All areas where resi	dents have customary access			with state and federal regulation			
	were sprinklered. A	reas providing facility services			and correlate with the most re	cent		
	were sprinklered.				contemplated or accomplished	d		
					corrective action. These date	s do		
	Quality Review cor	npleted on 02/19/25			not necessarily correspond			
					chronologically to the date the	:		
					provider is under the opinion i	t was		
					in with requirements of			
l	I				narticination or that the correct	tivo	I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC	AID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01	COM			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155719		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/13/2025	
	ROVIDER OR SUPPLIE	R HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE RD 16 K, IN 47922	
(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
				action was necessary.Februa 27,2025	ry
				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, George Ade Memorial Health Center February 13,2025	
				Dear Director:	
				The following is our POC for tabove-mentioned survey and being submitted as our allega of substantial compliance. We further submit that this facility substantial compliance as of tand 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 presented to date.	is tion e is in he ne,
				If you have any questions or r further information, call (219) 275-2531 or fax (219) 275-7472, and we would be available to assist you in any	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

If continuation sheet

Page 5 of 11

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025 FORM APPROVED OMB NO. 0938-039

	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155719)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/13/2025	
	PROVIDER OR SUPPLIER  E ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3623 EAST STATE RD 16 BROOK, IN 47922			
(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	
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	Thank you,  Scott James, HFA GAMHCC  c: survey file  K291 Desktop review requested No residents were found to be harmed by this finding. The battery-operated emergency I test logs have been updated all emergency lights being test and found to be in proper wor order. The annual and ongoin testing will be scheduled to prevent further concern. See attached log. This will be maintained by the environmental supervisor and designee to maintain compliant Done as of 3/2/2025	ight with sted king ng	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

If continuation sheet

Page 6 of 11

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719		JILDING	onstruction  01	(X3) DATE SURVEY COMPLETED 02/13/2025	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E	ADDRESS, CITY, STATE, ZIP COD AST STATE RD 16 K, IN 47922		
(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)	ΓE	(X5) COMPLETION DATE
K 0522 SS=D Bldg. 01	Operated Emergence not include 90 minute and on 07/24/23. Based record review, the Mathe facility has batter lights throughout the facility has batter lights throughout the 90 minute annual. This finding was read Maintenance Lead 3.1-19(b)  NFPA 101  HVAC - Any Heating Based on observation failed to ensure 1 of provided with intak outside for rooms on NFPA 101, Section fuel-fired heating deheating plant, shall they shall take air for outside. This deficie atmosphere rich with could cause physical laundry room. This at least two staff in Findings include:  Based on observation Maintenance Lead of a tour of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully covered with a staff of the facility fuel-fired dryers with fully cover	or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed so or combustion directly from the designed and installed and directly from the designed and directly fro	K 0	522	K522 Desktop review requested No residents were found to be harmed by the finding. The caflap has been removed from the fresh air vent in the laundry and A new fresh air vent system habeen installed (see pic) to allow fresh air venting to the area an allow adequate exchange air for the area. The environmental supervisor and/or designee will responsible for always seeing is functioning properly.  Done as of 3/2/2025.	rrpet ne ea. as w for nd or	03/02/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

If continuation sheet Page 7 of 11

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155719	(X2) MULTIPLE ( A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  02/13/2025
	PROVIDER OR SUPPLIER E ADE MEMORIAL	HEALTH CARE CENTER	3623	r address, city, state, zip cod EAST STATE RD 16 DK, IN 47922	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 0712 SS=F Bldg. 01	does not allow for f Based on an intervi- the Maintenance Le covered.  This finding was re and Maintenance Le 3.1-19(b)  NFPA 101 Fire Drills  1. Based on record facility failed to cor of 4 quarters. LSC conducted quarterly conditions. This det and residents.  Findings include:  Based on record rev forms with the Main from 11:10 a.m. to documentation for t quarters: a) third shift drill fo February, March) o b) First, second and quarter (April, May c) second and third quarter (July, Augu Based on interview the Maintenance Le drill reports and sta drills for review at the	third shift of the second	K 0712	K712 Desktop review requested. No residents were found to be harmed by this finding. The fit drill schedule is in full effect. It are scheduled and conducted once per shift per quarter. (Seattached) The required fire drill informati documented on an ongoing bawith three drills per calendar quarter. The environmental supervisor and/or designee wimaintain and provide necessary drill information by regulation, maintain compliance. Done as of 3/2/2025.	re Drills ee on is asis

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3X9521

Facility ID: 000559

If continuation sheet Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED 02/13/2025			
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	3623 E	ADDRESS, CITY, STATE, ZIP COD EAST STATE RD 16 K, IN 47922	
(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 APPROPR DEFICIENCY)	
TAG		ead at the exit conference.	TAG		DATE
	facility failed to ensincluded the verifical alarm signal to the reconducted between fourth quarter. LSC health care occupant transmission of a fin of emergency fire copractice affects all ras staff and visitors.	review and interview, the sure a third shift fire drill ation of transmission of the fire monitoring station in fire drills 6:00 a.m. and 9:00 p.m. for the 19.7.1.4 requires fire drills in scies shall include the re alarm signal and simulation conditions. This deficient residents in the facility as well			
	forms with the Main 12:20 p.m., the third 12/20/24 did not ind fire alarm signal. The was left blank. Add of alarm documented the 'time of alarm' a time of record revie confirmed the 12/20 include verification alarm signal and no was documented.  This finding was review.	riew of "Fire Drill Report" Intenance Lead on 02/13/25 at a shift silent fire drill for clude the transmission of the nat section of the fire drill report itionally, there was not a time ed, as 'Silent Drill' was wrote in rea. Based on interview at the two the Maintenance Lead 0/24 third shift drill did not of the transmission of the fire time of when the drill occured viewed with the Administrator			
	3.1-19(b) 3.1-51(c)	ead at the exit conference.			
K 0918 SS=F Bldg. 01	-	s - Essential Electric Syste	K 0918	Desktop review requested	03/02/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155719	A. BU		01	COMPLETED 02/13/2025	
		100/18	B. WII			02/13/	2020
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER		3623 EAST STATE RD 16 BROOK, IN 47922			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION  annual fuel quality test was		TAG	No residents were found to be		DATE
		acility's diesel powered			harmed by this finding. The		
	•	9, Health Care Facilities Code,			annual fuel sample in question	1	
	2012 Edition Section	on 6.5.4.1.1.2 states Type 2 EES			was done for 2023. The annu		
		l System) generator sets shall			fuel quality test requirements f		
	-	sted in accordance with			diesel generators. The test fo	r	
		Section 6.4.4.1.1.3 states be performed in accordance			2025 is being processed with		
		andard for Emergency and			results to follow. The environmental supervisor or		
		tems, 2010 Edition, Chapter 8.			designee will be responsible to	)	
		8.3.8 states a fuel quality test			see this is conducted annually		
	shall be performed	at least annually using tests			prevent further concerns. See		
		I standards. This deficient			attached fuel sample.		
	practice could affec	et all residents.			Done as of 3/2/2025		
	Findings include:						
	Lead on 02/13/24 at annual fuel quality fired emergency get twelve month period Based on interview the Maintenance Lean annual fuel qualifuel fired emergence recent twelve month review.	view with the Maintenance t 1:00 p.m., documentation of an test for the facility's diesel fuel nerator within the most recent d was not available for review. at the time of record review, ead agreed documentation of ity test for the facility's diesel y generator within the most h period was not available for viewed with the Administrator					
		ead at the exit conference					
	3.1-19(b)						
K 0920 SS=B Bldg. 01	Extens	ent - Power Cords and					
	failed to ensure 1 of	on and interview, the facility f 1 flexible cords were not used ixed wiring. NFPA-70/2011,	K 09	920	K920 Desktop review requested. No residents were found to be		02/14/2025

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025 FORM APPROVED OMB NO. 0938-039

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> COMPLETED			LETED	
		155719	B. W	NG		02/13	/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	ROVIDER OR SUPPLIEF	₹			AST STATE RD 16		
GEORGE	ADE MEMORIAL	HEALTH CARE CENTER			K, IN 47922		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (2)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		pecifically permitted in 400.7			harmed by this finding. The		
		eables shall not be used for (1)			observed cord was removed,		
		ixed wiring. This deficient			residents, staff and families h		
	*	et 12 residents, staff and			been reminded not to use the		
	visitors in one smoke compartment.			any extension cords for safety			
			purposes. The environmental				
	Findings include:				supervisor and/or designee w		
					responsible for maintaining th	nis to	
		on with the Administrator and			prevent further concerns.		
		on 02/13/25 at 2:41 p.m. during			Done as of 2/14/2025.		
	-	y, in resident room 111, an					
		in use powering a cell phone					
	_	imp. Based on an interview at					
		tion, the Administrator agreed					
		vas in use powering a table					
	-	the extension cord upon					
	observation.						
	This finding was re	viewed with the Administrator					
	_	the Lead during the exit and the					
	conference.	Lead during the exit and the					
	Comercice.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3X9521 Facility ID: 000559 If continuation sheet Page 11 of 11