STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2024	
	PROVIDER OR SUPPLIE		12802	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 OOTEE, IN 47553	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
E 0025 SS=F Bldg	conducted by the I accordance with 42 Survey Date: 03/2 Facility Number: Provider Number: AIM Number: 100 At this Emergency Sycamore Care Str. Compliance with E Requirements for I Participating Provides 3.73 The facility has 56 the survey, the cent Quality Review conductor The requirement at MET as evidenced 403.748(b)(7), 41482.15(b)(7), 483485.625(b)(7), 483403.748(b)(7), §460.84(b)(8)(7), §460.84(b)(8)(7), §483.475(b)(8)(8), §485.920(b)(6), §485.920(b)(6), §50.00000000000000000000000000000000000	5/24 000164 155263 0289550 Preparedness survey, rategies was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of sus was 32. mpleted on 03/28/24 142 CFR, Subpart 483.73 is NOT by: 8.113(b)(5), 441.184(b)(7), 8.475(b)(7), 483.73(b)(7), 95.920(b)(6), 494.62(b)(6) on Other Facilities (418.113(b)(5), §441.184(b) (3), §482.15(b)(7), §483.73(b) (7), §485.625(b)(7),	E 0000	By submitting the following material, we are not admitting truth or accuracy of any speci findings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit to responses to regulatory obligations. The facility requestion of correction be consider our allegation of compliance effective 4/25/2024 to the state findings of the Recertification State Licensure Survey. We respectfully request paper compliance in leu of a post surveview. Please contact the faif additional information is need for a desk review.	fic e of these ests eed de and
		OVIDER/SUPPLIER REPRESENTATIVE'S S		TITLE	(X6) DATE
Brandi Gla	เนเรท		HFA		04/12/2024

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 disclosable 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		(X2) MULTI A. BUILDI B. WING	IPLE CONSTRUCTION ING <u></u>	COMPI	x3) date survey completed 03/25/2024	
	PROVIDER OR SUPPLIEF DRE CARE STRATI		12	REET ADDRESS, CITY, STATE, ZIP COI 2802 EAST US HWY 50 DOGOOTEE, IN 47553)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PRE	FIX PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE
TAG	on the emergency (a) of this section, paragraph (a)(1) of communication played section. The policy be reviewed and unique years [annually for minimum, the policy address the follow *[For Hospices at §441.184,(b) Hospices at §483.475 (b) CAP at §483.475 (b), CAP at §483.475 (b), CAP at §485.920 (b) an §494.62 (b):] Policy (6), (8)] The development of operations of	§418.113(b), PRFTs at pitals at §482.15(b), and §483.73(b):] Policies and or (5)] The development of hother [facilities] [and] receive patients in the event essation of operations to inuity of services to facility 60.84(b), ICF/IIDs at Hs at §486.625(b), CMHCs at §486.625(b), CMHCs at Essand procedures. (7) [or lopment of arrangements es] [or] other providers to a the event of limitations or ations to maintain the ces to facility patients. §403.748(b):] Policies and he development of hother RNHCIs and other ve patients in the event of sation of operations to inuity of non-medical cli patients.	TA			DATE
	Based on record rev failed to ensure emo	view and interview, the facility ergency preparedness policies lude the development of	E 0025	Corrective actions accomplished for those if the found to be affected by the		04/25/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2024		
	ROVIDER OR SUPPLIER		12802	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 OOTEE, IN 47553		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG		ther LTC facilities and other	TAG	deficient practice.	DATE	
		e residents in the event of		a. Sycamore Care Strategies		
	•	tion of operations to maintain		transfer agreements have been		
		rvices to LTC residents in		updated and reflect name changes		
	accordance with 42 CFR 483.73(b)(7). This			of receiving facilities.		
	deficient practice co	ould affect all occupants.				
				2. Identify other residents who		
	Findings include:			have the potential to be affect	ed	
				by the same alleged deficient		
		the Emergency Preparedness		practice.		
		4 between 9:15 a.m. and 12:30		a. No residents have the pote	ntial	
	p.m. with the Maintenance Supervisor and			to be affected by the alleged		
	Administrator present, documentation of			deficient practice.		
	emergency preparedness policies and procedures					
		opment of arrangements with		3. Measures and systemic		
		and other providers to receive		changes put into place to ens		
		nt of limitations or cessation		that the alleged deficient prac	tice	
	-	vailable for review, however, 2 facilities list was 2009 for the		does not recur.	unafar	
		furthermore, the name of one		a. Reviewing and updating tra agreements have been added		
	· ·	d has had a name change.		the maintenance annual dutie		
	_	at the time of record review,		signature form will be placed		
		greed the documentation of		Emergency Preparedness Bir		
		other facilities needs to be		for confirmation of completion		
	corrected and updat					
				4. Corrective action will be		
	This finding was re	viewed with the Administrator		monitored to ensure alleged		
	and Maintenance St	upervisor during the exit		deficient practice does not red	cur	
	conference.			and quality assurance measu	res	
				put into place.		
				a. An Audit tool will be added		
				the Quarterly Assurance Mee	-	
				agenda. The audit tool will be		
				utilized quarterly at the QA	,	
				assurance meeting to docum	ent	
				what exercises need to be		
				completed within the annual t	ime	
				frame. The audit will be	l and	
				completed during the meeting	•	
			İ	will be filed with the QA meeti	ng	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		A. BUILDING B. WING		COM	TE SURVEY MPLETED 25/2024	
	PROVIDER OR SUPPLIER		12802	ADDRESS, CITY, STATE, ZIP EAST US HWY 50 DOTEE, IN 47553	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) documentation. Completion date. 3/2	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §48 §483.475(d)(2), §48 §485.625(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.93 §491.12, and ESR (2) Testing. The [faction of the entire exempt from entire of the entire exempt from entire of the entire exempt from entire exem	8.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d) §494.62(d)(2). 6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]: acility] must conduct the emergency plan lity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is induct a facility-based				

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	OF CORRECTION	IDENTIFICATION NUMBER 155263	l í	UILDING	INSTRUCTION	COMPI 03/25	LETED
NAME OF I	PROVIDER OR SUPPLIEF	· !			ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50		
SYCAMO	ORE CARE STRATE	EGIES			OOTEE, IN 47553		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1710		cise under paragraph (d)(2)		1110			DITTE
		s conducted, that may					
	, , ,	limited to the following:					
	(A) A second full-scale exercise that is						
	, ,	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	(C) A tabletop exe	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant emergency scenario, and a						
	set of problem statements, directed						
	messages, or prepared questions designed						
	to challenge an emergency plan.						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at						
		spices that provide care in					
		e. The hospice must					
		to test the emergency					
	· ·	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	community based						
	' '	nunity based exercise is not let an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	facility-based functional exercise following the onset of the emergency event.						
		dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/25/2024	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION
TAG	of this section is of include, but is not (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an electric discussion using a clinically-relevant set of problem star messages, or preto challenge an electric discussion using a clinically-relevant set of problem star messages, or preto challenge an electric discussion using a clinically-relevant set of problem star messages, or preto challenge an electric discussion using a clinically discussion using a clinica	ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the -scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion		TAG	DEPICIENCY)		DATE
	using a narrated,	clinically-relevant	1				I

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/25/2024	
	PROVIDER OR SUPPLIE			12802 E	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 DOTEE, IN 47553			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homination docume exercises, and enthe hospice's emergency emergency plan. *[For PRFTs at § § 482.15(d), CAH: (2) Testing. The [conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community (A) When a community (A) When a community (B) If the [PRTF, an actual natural that requires active plan, the [facility] its next required for individual, facility following the onse (ii) Conduct exercise or and the limited to the following the onse facility-based function (B) A more (C) A tableto is led by a facilitate discussion, using	R LSC IDENTIFYING INFORMATION ario, and a set of problem ted messages, or prepared ed to challenge an hospice's response to and intation of all drills, tabletop mergency events and revise ergency plan, as needed. 441.184(d), Hospitals at as at §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency ar. The [PRTF, Hospital, a following: an annual full-scale exercise an annual individual, ctional exercise; or Hospital, CAH] experiences or man-made emergency vation of the emergency is exempt from engaging in full-scale community based ity-based functional exercise et of the emergency event. an [additional] annual mat may include, but is not lowing: -scale exercise that is a or individual, a ctional exercise; or pock disaster drill; or p exercise or workshop that tor and includes a group a narrated,		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	1 -	emergency scenario, and a atements, directed						

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	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155263	r í	UILDING	INSTRUCTION	COMPL 03/25/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		ιΤΕ	(X5) COMPLETION DATE
	to challenge an er (iii) Analyze the and maintain documentabletop exercises and revise the [factineeded.	ne [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as					
	conduct exercises plan at least annu organization must (i) Participate in a that is community. (A) When a comm accessible, condu facility-based function (B) If the PACE expression of the entire exempt from en full-scale communifacility-based functionset of the emergency (ii) Conduct a	ACE organization must to test the emergency ally. The PACE do the following: In annual full-scale exercise I-based; or Inunity-based exercise is not ct an annual individual, Itional exercise; or Ixperiences an actual natural Ixperiences an actual					
	functional exercise of this section is community-based based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem sta	scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a					

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	OF CORRECTION	IDENTIFICATION NUMBER 155263	l í	UILDING	NSTRUCTION	COMPL 03/25/	ETED
	PROVIDER OR SUPPLIER			12802 E	DDRESS, CITY, STATE, ZIP COD EAST US HWY 50 POTEE, IN 47553		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ΤE	(X5) COMPLETION DATE
	maintain documer exercises, and em	ACE's response to and nation of all drills, tabletop nergency events and revise gency plan, as needed.					
	(2) The [LTC facili to test the emerge year, including un- the emergency pro ICF/IID] must do to	ty] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: an annual full-scale exercise					
	(A) When a commaccessible, condufacility-based functions (B) If the [LTC facactual natural or natur	unity-based exercise is not ct an annual individual,					
	required a full-sca individual, facility- following the onse (ii) Conduct an ac	le community-based or based functional exercise t of the emergency event. Iditional annual exercise but is not limited to the					
	community-based based functional e (B) A mock disas	ter drill; or ercise or workshop that is					
	discussion, using clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze the [I	a narrated, emergency scenario, and a tements, directed pared questions designed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155263	B. W	ING		03/25/	/2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EAST US HWY 50		
SYCAMC	ORE CARE STRATE	-GIES		LOUGO	OOTEE, IN 47553		
(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 DEFICIENCY)	TE	COMPLETION
TAG		ELSC IDENTIFYING INFORMATION exercises, and emergency		TAG	DEI ICIENCI I		DATE
	•	e the [LTC facility] facility's					
	emergency plan, a						
	*[For ICF/IIDs at §	• •=					
	(2) Testing. The ICF/IID must conduct						
	exercises to test the emergency plan at least						
	twice per year. The ICF/IID must do the following:						
	-	n annual full-scale exercise					
	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,						
	•	tional exercise; or.					
	• •	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID gaging in its next required					
	· ·	nity-based or individual,					
		tional exercise following the					
	onset of the emerg	_					
	(ii) Conduct an ad	ditional annual exercise					
	-	but is not limited to the					
	following:						
	` '	scale exercise that is					
	community-based facility-based func						
	(B) A mock disaste						
	, ,	ercise or workshop that is					
	. ,	and includes a group					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise						
		rgency plan, as needed.					
	2 1212 2 201	J Francis and Albandari					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155263		UILDING	NSTRUCTION	COMP	ESURVEY LETED 5/2024
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For HHAs at §48	=					
		e HHA must conduct					
		he emergency plan at					
	following:	e HHA must do the					
	_	full-scale exercise that is					
	community-based						
	•	ommunity-based exercise					
	, ,	conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires						
	activation of the emergency plan, the HHA is						
		aging in its next required					
		nity-based or individual,					
	-	tional exercise following the					
	onset of the emer						
	' '	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	onducted, that may limited to the following:					
		full-scale exercise that is					
	community-based						
	-	ctional exercise; or					
	-	isaster drill; or					
	` ′	exercise or workshop that					
	· , , .	or and includes a group					
	discussion, using	— ·					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	36.360]					

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	OF CORRECTION	IDENTIFICATION NUMBER 155263		ILDING	NSTRUCTION	COMPL 03/25/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	exercises to test the OPO must do the (i) Conduct a pape or workshop at lease exercise is led by group discussion, relevant emergency problem statement prepared question emergency plan. It actual natural or more exercises activation OPO is exempt from the emergency (ii) Analyze the OF maintain document exercises, and emit the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. A group discussion I narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain document exercises, and emit the RNHCl's emer Based on record reverses and emit the RNHCl's emer Based on record reverses.	er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically by scenario, and a set of a designed to challenge an an an-made emergency that a of the emergency plan, the amengaging in its next arecise following the onset event. PO's response to and attation of all tabletop ergency events, and revise OPO's] emergency plan, as 8.748]: PRNHCI must conduct the emergency plan. The perfollowing: Pr-based, tabletop exercise and attation of all tabletop exercise is a ped by a facilitator, using a perferency event and tattor of all tabletop exercise and the problem statements, and revise of problem statements, and revise and emergency plan. NHCI's response to and attation of all tabletop ergency events, and revise and energency plan, as needed. The problem is and revise and revise and interview, the facility is response to and interview.	E 00	39	1. Corrective actions		04/25/2024
		ercises to test the emergency	EUC	צטי	accomplished for those resider found to be affected by the alle		U 4 /23/2024

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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		COMPL	ETED
		155263	B. WI	NG		03/25/	2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			EAST US HWY 50		
SVCAMO	ORE CARE STRATE	EGIES			OTEE, IN 47553		
STUANIC	DNE CARE STRATE			LOUGO	OTEE, IN 47 000		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		drills using the emergency			deficient practice.		
	procedures. The LT	°C facility must do the			a. The facility will complete a		
	following:				full-scale community-based		
		annual full-scale exercise that			exercise.		
	is community-based				b. If a community-based exerc	ise	
	a. When a community-based exercise is not				is not accessible the facility wi	II	
		an annual individual,			conduct a facility based function	onal	
	facility-based funct				exercise.		
		y experiences an actual natural					
	or man-made emergency that requires activation				2. Identify other residents who		
		lan, the LTC facility is exempt			have the potential to be affect	ed	
		ext required full-scale in a			by the same alleged deficient		
	community-based or individual, facility-based				practice.		
		l exercise for 1 year following			a. All residents have the poter	ntial	
	the onset of the actu				to be affected by the alleged		
	1 1	itional exercise that may			deficient practice.		
		imited to the following:					
	a. A second full-sca				3. Measures and systemic		
		or an individual, facility-based			changes have been put into pl		
	functional exercise.				to ensure that the alleged defi	cient	
	b. A mock disaster				practice does not recur.		
	_	se or workshop that is led by a			a. Facility will participate in an		
		ides a group discussion, using			annual full-scale community-b	ased	
	I	y-relevant emergency scenario,			exercise.		
		n statements, directed			b. When a community-based		
	• • • •	red questions designed to			exercise is not accessible the	_	
	challenge an emerg				facility will conduct a facility ba	ased	
		TC facility's response to and			functional exercise.		
		ation of all drills, tabletop			c. Community based exercise		
		gency events, and revise the			been added to the maintenand	ce	
	I	gency plan, as needed in			annual duties.		
	accordance with 42						
	_	ice could affect all occupants			4. Corrective action will be		
	in the facility.				monitored to ensure alleged		
					deficient practice does not rec		
	Findings include:				and quality assurance measur	es	
					put into place.		
		the Emergency Preparedness			a. An Audit tool will be added		
		4 between 9:15 a.m. and 12:30			the Quarterly Assurance Meet	-	
	p.m. with the Maint	tenance Supervisor and			agenda. The audit tool will be		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155263	l í	JILDING	NSTRUCTION	(X3) DATE COMPL 03/25 /	ETED
	PROVIDER OR SUPPLIER			12802 E	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 DOTEE, IN 47553		
(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
	provide documentat dated 10/10/23 and unable to provide do based exercise or do event during the pasinterview at the time Administrator said or Emergency Event to review during the This finding was reand Maintenance Su	nt, the facility was able to ion of two table top exercises 01/04/24, however, they were ocumentation of a community ocumentation of an emergency at 12 months. Based on the of record review, the the community Based Exercise to documentation was available to past twelve month period.			utilized quarterly at the QA assurance meeting to docume what exercises need to be completed within the annual til frame. The audit will be completed during the meeting will be filed with the QA meetin documentation.	me and	
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power sys emergency plan s this section and in	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1)					
	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.						
	Emergency gener generator must be the location requir Care Facilities Co- Interim Amendme	33.73(e)(1), §485.625(e)(1) ator location. The located in accordance with ements found in the Health de (NFPA 99 and Tentative hts TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155263	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 03/25	LETED
	PROVIDER OR SUPPLIEF			12802 E	DDRESS, CITY, STATE, ZIP COD EAST US HWY 50 OTEE, IN 47553		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Code (NFPA 101 Amendments TIA and TIA 12-4), and	and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing					
	Emergency gener The [hospital, CAl implement the em inspection, testing requirements four	3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] nd in the Health Care FPA 110, and Life Safety					
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the sit evacuates.					
	§483.73(g), and C The standards incomplete this section are appreference by the E Federal Register in 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information material at NA go to:	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. R part 51. You may obtain the sources listed below. a copy at the CMS curce Center, 7500 Security ore, MD or at the National cords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code					
	_of_federal_regul	ations/ibr_locations.html.					

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	OF CORRECTION	IDENTIFICATION NUMBER 155263	A. BUILDING B. WING	onstruction 	COMPLETED 03/25/2024
	PROVIDER OR SUPPLIER		12802	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 OOTEE, IN 47553	
(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)	(X5) COMPLETION DATE
	If any changes in incorporated by redocument in the Fannounce the cha (1) National Fire FBatterymarch Parl Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Healt 2012 edition, issued (iii) Technical inter NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Lit edition, issued Au (viii) TIA 12-1 to NF 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xii) NFPA 110, S Standby Power Syincluding TIAs to C2009.	this edition of the Code are ference, CMS will publish a ederal Register to nges. Protection Association, 1 K, P, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	E 0041	Corrective actions	
	failed to implement inspection, testing, found in the Health	the emergency power system and maintenance requirements Care Facilities Code, NFPA Code in accordance with 42	E 0041	accomplished for those reside found to be affected by the all deficient practice. a. SafeCare has been contact and is scheduled to inspect ar	eged ed

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263 X1) PROVIDER/SUPPLIER/CLIA A. BUILDING B. WING		NSTRUCTION	(X3) DATE COMPL 03/25 /	ETED			
	PROVIDER OR SUPPLIEF DRE CARE STRATI			12802 E	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 DOTEE, IN 47553		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	TE	(X5) COMPLETION DATE
	failed to ensure the emergency generate condition. This def residents, as well as facility. Findings include: Based on observation p.m. and 2:15 p.m. the Maintenance Suthe emergency generalluminated, plus the light did not illuminated observing the diese indicated the fuel lewhen asked, the M was not sure what to tank is, but thought gallons. Furthermore emergency generate the Nurse's Station, for "Low Fuel". Be observation, the Maconfirmed the "Low and the "Low Enginilluminating when to button was pushed of This finding was re	on and interview, the facility display panel for 1 of 1 or was in proper operating ficient practice could affect all savisitors and staff in the country of the facility with approvisor, the display panel on the erator had a "Low Fuel" light the fuel gauge evel in the tank was 1/2 full. In aintenance Supervisor said he he gallon capacity of the fuel it might be around 250 to 300 ore, when observing the or annunciator panel located at there was no indicating light the properator of the fuel light being illuminated the Temperature" light not the display panel Lamp Test on the emergency generator.			fix the display panel lamp test button on the generator. 2. Identify other residents who have the potential to be affect by the same alleged deficient practice. a. All residents have the poter to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensut that the alleged deficient practice does not recur. a. A monthly audit tool will be developed and completed to ensure the display panel is in working order. 4. Corrective action will be monitored to ensure alleged deficient practice does not recand quality assurance measur put into place. a. Administrator/designee will review completed maintenance duties/check list to ensure compliance. Should the findin of non- compliance be observed corrective action shall be take The observation and corrective action taken will be reviewed during the quarterly Q/A meetiand adjusted if warranted.	ed Intial Ire Itice Ires Ire Ires Ire Ires Ire Ires Ire Ire	
K 0000							
Bldg. 01	A Life Safety Code	Recertification and State	K 0	000	By submitting the following		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		155263	B. W	ING		03/25/	/2024
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
00/04840		-0150			EAST US HWY 50		
SYCAMO	ORE CARE STRATE	EGIES		LOUGO	OOTEE, IN 47553		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Licensure Survey w	vas conducted by the Indiana			material, we are not admitting	the	
	Department of Heal	th in accordance with 42 CFR			truth or accuracy of any specif	ic	
	483.90(a).				findings or allegations. We		
					reserve the right to contest the	ا د	
	Survey Dates: 03/2	5/24			findings or allegations as part		
	·				any proceedings and submit the		
	Facility Number: 0	00164			responses to regulatory		
	Provider Number:				obligations. The facility reque	ests	
	AIM Number: 100	289550			plan of correction be considered		
					our allegation of compliance		
	At this Life Safety	Code survey, Sycamore Care			effective 4/25/2024 to the state	e	
	Strategies was found not in compliance with				findings of the Recertification		
	Requirements for Participation in				State Licensure Survey. We		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				respectfully request paper		
		re and the 2012 edition of the			compliance in leu of a post su	rvev	
		ction Association (NFPA) 101,			review. Please contact the fac	-	
		LSC), Chapter 19, Existing			if additional information is nee	•	
		ancies and 410 IAC 16.2.			for a desk review.	404	
	1						
	This one story facil	ity was determined to be of					
	-	ruction and was fully					
		cility has a fire alarm system					
	-	oke detectors in the corridors					
		the corridors, plus battery					
		rms in all resident sleeping					
	-	has a capacity of 56 and had a					
	census of 32 at the						
		-					
	All areas where the	residents have customary					
	access were sprinkl	ered and all areas providing					
		re sprinklered, except two					
	detached structures.	, a wood shed containing the					
		nd a wood framed garage used					
	for facility storage.						
	Quality Review cor	npleted on 03/28/24					
K 0324	NFPA 101						
SS=F	Cooking Facilities						
Bldg. 01	Cooking Facilities						
	i		1			,	1

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155263	B. WI	NG		03/25	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	Cooking equipment accordance with Nontrol Commercial Cooking appliances such a toasters) are used cooking in accordance with a toasters) are used cooking in accordance and in	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under .5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not reidor. 18.3.2.5.4, 19.3.2.5.1 19.9.2.3, TIA 12-2 11 hood extinguishing systems inspected and serviced every 96, the Standard for Ventilation of Commercial standard for Ventilation of Commercial standard for Section 11-2 on and servicing of the fire mat least every six months. ince was not in a resident area	K 03	324	1. Corrective actions accomplished for those reside found to be affected by the alledeficient practice. a. SafeCare performed the kits suppression system test and maintenance on 3.26.2024. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents have the potent to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure	eged chen ed ntial	04/25/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLETE B. WING 03/25/20:			ETED		
	PROVIDER OR SUPPLIER			12802 E	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 OOTEE, IN 47553		
(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)	TE	(X5) COMPLETION DATE
	months after the mo 07/05/23. The 07/2 system inspection re available during the on interview at the Maintenance Super report was the most review. This finding was re	ost recent inspection dated 5/24 range hood extinguishing eport was the only report e past 12 month period. Based time of record review, the visor confirmed the 07/25/24 recent report available for viewed with the Administrator apervisor during the exit			that the alleged deficient prace does not recur. a. An audit will be completed a ensure that the range hood extinguishing system is inspect at least every 6 months. 4. Corrective action will be monitored to ensure alleged deficient practice does not recand quality assurance measure put into place. a. Administrator /designee will review audit tool monthly for conjugar and the results will be reported to Quarterly Assurant Meeting. Should findings of non-compliance be observed corrective action shall be taked The audit may stop after one will 100% compliance has been achieved and no other problem identified.	cted cur res nne ce n.	
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills a routine. Where dr 9:00 PM and 6:00	ay be used instead of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155263		(X2) MULTIP A. BUILDIN B. WING	DLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED 03/25/2024	
	PROVIDER OR SUPPLIER		128	REET ADDRESS, CITY, STATE, ZIP COD 802 EAST US HWY 50 OGOOTEE, IN 47553	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
	Based on record reverse failed to provide queries for 1 of 3 shifts during deficient practice of as staff and visitors. Findings include: Based on review of on 03/25/24 between the Maintenance Sueries lacked fire drill doce (day) of the second of 2023. Based on review, the Maintenlack of a fire drill resecond quarter of 20 normally runs the fice COVID during a part of the second quarter of 20 normally runs the fice of the second quarter of 20 normally runs th	the facility's fire drill reports in the facility's fire drill reports in 9:15 a.m. and 12:30 p.m. with pervisor present, the facility umentation for the first shift quarter (April, May, and June) interview at the time of record report for the first shift of t	K 0712	1. Corrective actions accomplished for those refound to be affected by the deficient practice. a. A backup person has be trained to perform the firefincase Maintenance supernot present to perform a control of the practice. 2. Identify other residents have the potential to be aby the same alleged deficient practice. a. No residents have the to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to that the alleged deficient does not recur. a. An audit will be completensure that all fire drills a completed during each slevery quarter. 4. Corrective action will be monitored to ensure alleged deficient practice does not and quality assurance may be put into place. a. Administrator /designereview audit tool monthly year and the results will be reported to Quarterly Assemeting. Should findings non-compliance be observed if 100% compliance has be the properties of the proper	esidents ne alleged peen dills ervisor is drill. who affected cient potential ged c ensure practice eted to re nift for e ged ot recur easures e will for one pe aurance of rved taken. one year

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A. BUILDING	X3) DATE SURVEY COMPLETED 03/25/2024	
B. WING		03/23/2024
12802	EAST US HWY 50	
ID	PROVIDERIC PLAN OF CORRECTION	(X5)
PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	DEFICIENCY)	DATE
	achieved and no other probler identified.	ns
	B. WING STREET 12802 LOOGO ID PREFIX	B. WING STREET ADDRESS, CITY, STATE, ZIP COD 12802 EAST US HWY 50 LOOGOOTEE, IN 47553 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) achieved and no other probler

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LENTERS FOR	R MEDICARE & MEDIC						IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155263	B. WI	NG		03/25	/2024
SYCAMO	PROVIDER OR SUPPLIER ORE CARE STRATE	EGIES		12802 I LOOG(ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 DOTEE, IN 47553		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAG	6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on observation failed to ensure the emergency generated condition. This defines identify. Findings include: Based on observation p.m. and 2:15 p.m. the Maintenance Suther emergency generated illuminated, plus the light did not illuminated, plus the light did not illuminated observing the diese indicated the fuel lewhen asked, the Mindicated the fuel lewhen asked, the Mindicated the fuel lewhen asked, the Mindicated the Nurse's Station, for "Low Fuel". Based observation, the Mindicated the "Low Fuel" and the "Low Engirilluminating when the button was pushed of the This finding was resident the servation of the This finding was resident.	(NFPA 99), NFPA 110,	K 0		1. Corrective actions accomplished for those reside found to be affected by the allideficient practice. a. SafeCare has been contact and is scheduled to inspect ar fix the display panel lamp test button on the generator. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice. a. All residents have the potent to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensut that the alleged deficient practice does not recur. a. A monthly audit tool will be developed and completed to ensure the display panel is in working order. 4. Corrective action will be monitored to ensure alleged deficient practice does not recand quality assurance measur put into place. a. Administrator/designee will review completed maintenance duties/check list to ensure compliance. Should the findin of non- compliance be observed corrective action shall be take The observation and corrective action.	eged ed ed ed htial ure cice ur ees ee gs ed n.	04/25/2024

action taken will be reviewed

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LITERSFOR	M LEAS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155263	B. WI	NG		03/25/	¹ 2024	
	ROVIDER OR SUPPLIER			12802 E	ADDRESS, CITY, STATE, ZIP COD EAST US HWY 50 DOTEE, IN 47553			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					during the quarterly Q/A meeti and adjusted if warranted.	ing		

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