STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING -- B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/25/24 Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550 At this Emergency Preparedness survey, Sycamore Care Strategies was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 56 certified beds. At the time of the survey, the census was 32. Quality Review completed on 03/28/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses to regulatory obligations. The facility requests plan of correction be considered our allegation of compliance effective 4/25/2024 to the state findings of the Recertification and State Licensure Survey. We respectfully request paper compliance in leu of a post survey review. Please contact the facility if additional information is needed for a desk review.	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Gladish	HFA	04/12/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of	E 0025	1. Corrective actions accomplished for those residents found to be affected by the alleged	04/25/2024

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	arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 03/25/24 between 9:15 a.m. and 12:30 p.m. with the Maintenance Supervisor and Administrator present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, the date on the LTC facilities list was 2009 for the two facility's listed, furthermore, the name of one of the facility's listed has had a name change. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be corrected and updated. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		deficient practice. a. Sycamore Care Strategies' transfer agreements have been updated and reflect name changes of receiving facilities. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents have the potential to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. Reviewing and updating transfer agreements have been added to the maintenance annual duties. A signature form will be placed in the Emergency Preparedness Binder for confirmation of completion. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures put into place. a. An Audit tool will be added to the Quarterly Assurance Meeting agenda. The audit tool will be utilized quarterly at the QA assurance meeting to document what exercises need to be completed within the annual time frame. The audit will be completed during the meeting and will be filed with the QA meeting	

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			documentation. Completion date. 3/25/2024	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale			

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	or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)			

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	of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant			

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	emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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	to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of			

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	all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (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: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.			

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	*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, 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 exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]			

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	(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including	E 0039	1. Corrective actions accomplished for those residents found to be affected by the alleged	04/25/2024

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	unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 03/25/24 between 9:15 a.m. and 12:30 p.m. with the Maintenance Supervisor and		deficient practice. a. The facility will complete a full-scale community-based exercise. b. If a community-based exercise is not accessible the facility will conduct a facility based functional exercise. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice. a. All residents have the potential to be affected by the alleged deficient practice. 3. Measures and systemic changes have been put into place to ensure that the alleged deficient practice does not recur. a. Facility will participate in an annual full-scale community-based exercise. b. When a community-based exercise is not accessible the facility will conduct a facility based functional exercise. c. Community based exercise has been added to the maintenance annual duties. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures put into place. a. An Audit tool will be added to the Quarterly Assurance Meeting agenda. The audit tool will be	

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	Administrator present, the facility was able to provide documentation of two table top exercises dated 10/10/23 and 01/04/24, however, they were unable to provide documentation of a community based exercise or documentation of an emergency event during the past 12 months. Based on interview at the time of record review, the Administrator said no Community Based Exercise or Emergency Event documentation was available to review during the past twelve month period. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		utilized quarterly at the QA assurance meeting to document what exercises need to be completed within the annual time frame. The audit will be completed during the meeting and will be filed with the QA meeting documentation.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §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. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety			

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	Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.			

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	If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	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).	E 0041	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. SafeCare has been contacted and is scheduled to inspect and	04/25/2024

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	Based on observation and interview, the facility failed to ensure the display panel for 1 of 1 emergency generator was in proper operating condition. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observations on 03/25/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the display panel on the emergency generator had a "Low Fuel" light illuminated, plus the "Low Engine Temperature" light did not illuminate when the Lamp Test button was pushed several times. When observing the diesel fuel tank, the fuel gauge indicated the fuel level in the tank was 1/2 full. When asked, the Maintenance Supervisor said he was not sure what the gallon capacity of the fuel tank is, but thought it might be around 250 to 300 gallons. Furthermore, when observing the emergency generator annunciator panel located at the Nurse's Station, there was no indicating light for "Low Fuel". Based on interview at the time of observation, the Maintenance Supervisor confirmed the "Low Fuel" light being illuminated and the "Low Engine Temperature" light not illuminating when the display panel Lamp Test button was pushed on the emergency generator. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		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 potential to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure 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 recur and quality assurance measures put into place. a. Administrator/designee will review completed maintenance duties/check list to ensure compliance. Should the findings of non- compliance be observed corrective action shall be taken. The observation and corrective action taken will be reviewed during the quarterly Q/A meeting and adjusted if warranted.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	By submitting the following	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/25/24 Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550 At this Life Safety Code survey, Sycamore Care Strategies was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 32 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached structures, a wood shed containing the facility generator, and a wood framed garage used for facility storage. Quality Review completed on 03/28/24		material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses to regulatory obligations. The facility requests plan of correction be considered our allegation of compliance effective 4/25/2024 to the state findings of the Recertification and State Licensure Survey. We respectfully request paper compliance in leu of a post survey review. Please contact the facility if additional information is needed for a desk review.	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities			

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	Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 edition, Section 11-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on record review on 03/25/24 between 9:15 a.m. and 12:30 p.m. with the Maintenance Supervisor present, there was no documentation available to show that the kitchen range hood extinguishing system was inspected within six	K 0324	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. SafeCare performed the kitchen 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 potential to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure	04/25/2024

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	months after the most recent inspection dated 07/05/23. The 07/25/24 range hood extinguishing system inspection report was the only report available during the past 12 month period. Based on interview at the time of record review, the Maintenance Supervisor confirmed the 07/25/24 report was the most recent report available for review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		that the alleged deficient practice does not recur. a. An audit will be completed to ensure that the range hood extinguishing system is inspected at least every 6 months. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures put into place. a. Administrator /designee will review audit tool monthly for one year and the results will be reported to Quarterly Assurance Meeting. Should findings of non-compliance be observed corrective action shall be taken. The audit may stop after one year if 100% compliance has been achieved and no other problems identified.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			

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	Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/25/24 between 9:15 a.m. and 12:30 p.m. with the Maintenance Supervisor present, the facility lacked fire drill documentation for the first shift (day) of the second quarter (April, May, and June) of 2023. Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of a fire drill report for the first shift of the second quarter of 2023, and further said he normally runs the fire drills and he was out with COVID during a part of April 2023. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. A backup person has been trained to perform the fire drills incase Maintenance supervisor is not present to perform a drill. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents have the potential to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. An audit will be completed to ensure that all fire drills are completed during each shift for every quarter. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures put into place. a. Administrator /designee will review audit tool monthly for one year and the results will be reported to Quarterly Assurance Meeting. Should findings of non-compliance be observed corrective action shall be taken. The audit may stop after one year if 100% compliance has been	04/25/2024

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			achieved and no other problems identified.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.			

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	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation and interview, the facility failed to ensure the display panel for 1 of 1 emergency generator was in proper operating condition. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observations on 03/25/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the display panel on the emergency generator had a "Low Fuel" light illuminated, plus the "Low Engine Temperature" light did not illuminate when the Lamp Test button was pushed several times. When observing the diesel fuel tank, the fuel gauge indicated the fuel level in the tank was 1/2 full. When asked, the Maintenance Supervisor said he was not sure what the gallon capacity of the fuel tank is, but thought it might be around 250 to 300 gallons. Furthermore, when observing the emergency generator annunciator panel located at the Nurse's Station, there was no indicating light for "Low Fuel". Based on interview at the time of observation, the Maintenance Supervisor confirmed the "Low Fuel" light being illuminated and the "Low Engine Temperature" light not illuminating when the display panel Lamp Test button was pushed on the emergency generator. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0918	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. SafeCare has been contacted and is scheduled to inspect and 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 potential to be affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure 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 recur and quality assurance measures put into place. a. Administrator/designee will review completed maintenance duties/check list to ensure compliance. Should the findings of non- compliance be observed corrective action shall be taken. The observation and corrective action taken will be reviewed	04/25/2024

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			during the quarterly Q/A meeting and adjusted if warranted.	