STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING -- B. WING	09/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/26/22 Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100 At this Emergency Preparedness survey, Morning Breeze Retirement Community and Healthcare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 64 certified beds. At the time of the survey, the census was 60. Quality Review completed on 09/29/22	E 0000	We would like to request a desk review. Please let me know if their are additional documents that would allow this to occur. I would be happy to send to you. Thank you.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	§491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of an all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika	E 0006	E006 Correction action to be accomplished for residents found to have been affected by the deficient practice: The Emergency Operations Plan was updated to include Emerging Infectious Diseases in Appendix A – Hazard Vulnerability Analysis. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: - All residents have to	10/21/2022

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	Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 07/01/22 with the Administrator and the Director of Maintenance during record review from 9:30 a.m. to 1:00 p.m. on 09/26/22, the "Hazard Vulnerability Analysis (HVA)" section of the emergency preparedness program documentation did not list EID as a potential risk. EID was not included in the current emergency preparedness risk assessment for the facility. Based on interview at the time of record review, the Administrator agreed the emergency preparedness program risk assessment documentation did not include EID. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference.		potential to be effected. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur: - The EOP was reviewed and updated to reflect the inclusion of the Emerging Infectious Diseases in HVA. - The EOP will be reviewed/updated annually and throughout the year as any additional information or changes that are identified that would improve the plan including any guidance or instructions from ISDH. How the corrective actions will be monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor EOP. PI tool will be completed by the Maintenance Director or designee. The EOP will be reviewed/updated annually and throughout the year as any additional information or changes that are identified that would improve the plan including any guidance or instructions from ISDH. Updates will be reviewed and monitored weekly for six months with results being forwarded to QAPI committee for	

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			any further recommendations and/or resolution. Date of Compliance October 21, 2022	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/26/22 Facility Number: 011039 Provider Number: 155675 AIM Number: 200299100 At this Life Safety Code survey, Morning Breeze Retirement Community and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 64 and had a census of 60 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached	K 0000	We would like to request a desk review. Please let me know if their are additional documents that would allow this to occur. I would be happy to send to you. Thank you.	

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	building providing facility storage services which was not sprinklered. Quality Review completed on 09/29/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection			

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	systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2.	K 0222	K222 Correction action to be accomplished for residents found to have been affected by the deficient practice: - Immediate action was taken.	10/21/2022

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	This deficient practice could affect over 5 residents, staff and visitors if needing to exit the facility by using the exit door by Room 51. Findings include: Based on observations with the Director of Maintenance during the initial walk through of the facility from 9:10 a.m. to 9:25 a.m. on 09/26/22, the exit door to the outside of the facility by Room 51 could be opened by entering a code into a keypad at the exit door but the code was not posted at the exit door. Based on interview at the time of the observations, the Director of Maintenance stated the facility does not have a secure wing for residents with a clinical diagnosis requiring specialized security measures, the code was not posted at the exit door because one resident was an elopement risk and agreed the code was not posted at the exit door. Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 2:30 p.m. on 09/26/22, the exit door code was posted at the keypad by the exit door by Room 51. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: - All residents have the potential to be effected. Exit code was displayed at the door immediately. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur: - Walking rounds will be performed Monday-Friday, to verify placement of exit codes to be performed by the Maintenance Director or designee. - Ongoing education with staff, on the importance of the code being displayed. How the corrective actions will be monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor the Display of exit codes at door. PI tool will be completed by the Maintenance Director or designee daily for one month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations	

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			and/or resolution. Ongoing QAPI review of findings, results, outcomes. Date of Compliance October 21, 2022	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out-of-service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Operations Plan: Fire Watch" documentation dated 07/01/22 with the Administrator and the Director of Maintenance during record review from 9:30 a.m. to 1:00 p.m. on 09/26/22, the fire watch plan for fire alarm system impairment was incomplete. The plan did not expressly state when a fire watch for fire alarm system would be initiated. The plan did not state when the required fire alarm system is	K 0346	K346 Correction action to be accomplished for residents found to have been affected by the deficient practice: The Emergency Operations Plan verbiage was updated for the Fire Watch Policy to include: - Evacuation of a building or the instituting of an approved Fire Watch when a (Fire Alarm and/or sprinkler system is out of service for more than 4 hours in a 24 hour period until the system has been returned to service. How other residents having the potential to be affected by the same deficient practice will be	10/21/2022

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	out-of-service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. The plan also failed to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Administrator and the Director of Maintenance agreed the fire watch documentation for fire alarm system impairment was incomplete. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		identified and what corrective action will be taken: - All residents have to potential to be effected. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur: - The EOP The heading verbiage for the Fire Watch Policy was updated, to include the fire alarm and/or Sprinkler System. - The EOP will be reviewed/updated annually and throughout the year as any additional information or changes that are identified that would improve the plan including any guidance or instructions from ISDH. How the corrective actions will be monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor EOP. PI tool will be completed by the Maintenance Director or designee The EOP will be reviewed/updated weekly as needed for 6 months and throughout the year as any additional information or changes that are identified that would improve the plan including any guidance or instructions from	

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			ISDH with results being forwarded to QAPI committee for any further recommendations and/or resolution. Date of Compliance October 21, 2022	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 2:30 p.m. on 09/26/22, the following two water heaters located in the Mechanical Room in the kitchen had no Certificate of Inspection documentation from the State of Indiana available for review:	K 0500	K500 Correction action to be accomplished for residents found to have been affected by the deficient practice: - Inspection has been scheduled for next available date. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: - All residents have to potential to be effected. Inspection has been scheduled.	10/21/2022

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	a. the service water heater identified as IN300158. b. the service water heater identified as IN338070. Based on interview at the time of the observations, the Director of Maintenance stated he was not aware if Certificate of Inspection documentation from the State of Indiana was required for the units which also may be replacement units of the original units which required the Certifications but agreed the aforementioned water heaters had no Certificate of Inspection documentation from the State of Indiana available for review at the time of the survey. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur: - Walking rounds will be performed Monday-Friday, to verify no concerns with systems for 6 months. Inspections will be completed annually. How the corrective actions will be monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor the water heater system. PI tool will be completed by the Maintenance Director or designee daily for six months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes. Date of Compliance: October 21, 2022	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.			

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MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

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	>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 3 of 4 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section	K 0923	K923- Unsecured cylinders Correction action to be accomplished for residents found to have been affected by the	10/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155675	A. BUILDING 01 B. WING	09/26/2022

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

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	11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room at the Station 2 (west) nurse's station. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 2:30 p.m. on 09/26/22, three of four 'E' type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room at the Station 2 (west) nurse's station and were not properly secured from falling. Five liquid oxygen containers and four 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the three oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling in the oxygen storage and transfilling room. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as carbon dioxide were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states		deficient practice: - Removed unsecured cylinders and had them returned to vendor, the remaining cylinders continued to be secured. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: - All residents have to potential to be effected. What measures will be put in place and what systematic changes will be made to ensure that the deficient practice not recur: - Walking rounds will be performed Monday-Friday by Maintenance Director or designee to verify compliance with keeping all cylinders secured. - Ongoing education with staff, on the importance of securing cylinders. How the corrective actions will be monitored to ensure the deficient practice will not recur: - A performance improvement tool has been developed that will monitor the cylinder storage. PI tool will be completed by the Maintenance Director or designee daily for one	

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	storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over three staff in the kitchen. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 2:30 p.m. on 09/26/22, one of one carbon dioxide cylinders were standing upright on the kitchen floor near the kitchen entrance door set and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Director of Maintenance agreed one of one carbon dioxide cylinders in the kitchen were not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		month, weekly for 5 months with results being forwarded to QAPI committee for any further recommendations and/or resolution. Ongoing QAPI review of findings, results, outcomes. Date of Compliance October 21, 2022	