PRINTED: 10/20/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155675			, ,	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2022	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD LAKEVIEW DR		
MORNIN	G BREEZE RETIRE	EMENT COMMUNITY AND HEA	LTHC		NSBURG, IN 47240		
(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)	ιΤΕ	(X5) COMPLETION DATE
E 0000							
E 0006 SS=F Bldg	conducted by the In accordance with 42 Survey Date: 09/26 Facility Number: 0 Provider Number: AIM Number: 2002 At this Emergency Breeze Retirement of found not in compli Preparedness Requi Medicaid Participat CFR 483.73. The facility has 64 of the survey, the cens Quality Review con 403.748(a)(1)-(2), (1)-(2), 441.184(a) 483.475(a)(1)-(2), (1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2)	11039 155675 299100 Preparedness survey, Morning Community and Healthcare was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 60. Inpleted on 09/29/22 416.54(a)(1)-(2), 418.113(a) (1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) (1)-(2), 485.920(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment (1), §416.54(a)(1)-(2),	E 00	000	We would like to request a de review. Please let me know if are additional documents that would allow this to occur. I wo be happy to send to you. That you.	their	
	§460.84(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2) §485.625(a)(1)-(2)), §441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),), §486.360(a)(1)-(2),					

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

(X6) DATE

TITLE

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 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155675			UILDING	NSTRUCTION	COMPL 09/26/	ETED			
		ROVIDER OR SUPPLIER G BREEZE RETIRE	EMENT COMMUNITY AND HEAL	STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR LTHC GREENSBURG, IN 47240					
	(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	
		develop and maint preparedness plar and updated at lea must do the follow (1) Be based on a facility-based and assessment, utilizing approach.* (2) Include strategemergency events assessment. * [For Hospices at Plan. The Hospice maintain an emergency are assessment. (1) Be based on a facility-based and assessment, utilizing approach. (2) Include strategemergency events assessment, includes assessment	an. The [facility] must tain an emergency in that must be reviewed, ast every 2 years. The plan ing:] Ind include a documented, community-based risk ing an all-hazards ies for addressing identified by the risk §418.113(a):] Emergency is must develop and igency preparedness plan wed, and updated at least is plan must do the ind include a documented, community-based risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards ies for addressing identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing is identified by the risk ing an all-hazards in its for addressing in its for addressi						

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED		
		155675	B. W	ING		09/26	/2022		
							-		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD				
					_AKEVIEW DR				
MORNIN	IG BREEZE RETIRI	EMENT COMMUNITY AND HEA	LTHC	THC GREENSBURG, IN 47240					
(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	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE		
	(1) Be based on a	and include a documented,							
	` '	community-based risk							
		ing an all-hazards							
		ng missing residents.							
		gies for addressing							
	. ,	s identified by the risk							
	assessment.	s identified by the risk							
	assessifierit.								
	*IEor ICE/IIDs at 8	§483.475(a):] Emergency							
	-	must develop and maintain							
		-							
		eparedness plan that must							
	be reviewed, and updated at least every 2 years. The plan must do the following:								
	(1) Be based on a	and include a documented,							
	1 ' '	community-based risk							
	1 -	ing an all-hazards							
		ng missing clients.							
		gies for addressing							
	. ,	_							
	assessment.	s identified by the risk							
		view and interview, the facility	E 0	006	E006		10/21/2022		
		n emergency preparedness		000	2000		10/21/2022		
		used on and includes a			Correction action to be				
	* '	y-based and community-based				ınd			
		lizing an all-hazards approach			accomplished for residents for	ai IU			
	· ·	d within the most recent twelve			to have been affected by the				
		2) included strategies for			deficient practice:	lan			
		ncy events identified by the			The Emergency Operations P				
		-			was updated to include Emerg				
		accordance with 42 CFR			Infectious Diseases in Append				
		2 CFR 483.73(a) (2). In the			Hazard Vulnerability Analysi	S.			
		tion memo QSO: 19-06-ALL							
		Centers for Medicare and							
		(CMS) updated Appendix Z of							
	_	s Manual to reflect changes to			How other residents having th				
		tious diseases to the definition			potential to be affected by the				
		proach and stated "Planning			same deficient practice will be	!			
	_	ards approach should also			identified and what corrective				
		nfectious disease (EID) threats.			action will be taken:				
	Examples of EIDs i	include Influenza, Ebola, Zika			 All residents have to 				

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155675	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/26/2022
	PROVIDER OR SUPPLIER G BREEZE RETIREMENT COMMUNITY AND HEAL	STREET 950 N THC GREEN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Virus and others". This deficient practice could affect all occupants.		potential to be effected.	
	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		What measures will be put in place and what systematic changes will be made to ensu 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 an throughout the year as any additional information or change that are identified that would improve the plan including any guidance or instructions from ISDH.	d d ges
	conference.		How the corrective actions will monitored to ensure the defici practice will not recur: - A performance improvement tool has been developed that will monitor ECPI tool will be completed by the Maintenance Director or design The EOP will be reviewed/upon annually and throughout the yeas any additional information of changes that are identified that would improve the plan including any guidance or instructions for ISDH. Updates will be reviewed and monitored weekly for six months with results being forwarded to OAPI committee.	ent DP. e nnee. lated ear or ut ing rom

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155675		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2022		
	PROVIDER OR SUPPLIER	EMENT COMMUNITY AND HEA	LTHC	950 N I	ADDRESS, CITY, STATE, ZIP COD LAKEVIEW DR NSBURG, IN 47240		
(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)	·ΤΕ	(X5) COMPLETION DATE
K 0000					any further recommendations and/or resolution. Date of Compliance October 2 2022	21,	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/26 Facility Number: 0 Provider Number: 200 At this Life Safety of Retirement Communot in compliance w Participation in Mesubpart 483.90(a), 2012 Edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facil Type V (111) const sprinklered. The fawith smoke detection open to the corridor rooms. The facility census of 60 at the second control of the second control of the corridor rooms. The facility census of 60 at the second control of the corridor rooms.	201039 155675 299100 Code survey, Morning Breeze unity and Healthcare was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, in all areas and in all resident sleeping thas a capacity of 64 and had a	K 0	000	We would like to request a de review. Please let me know if are additional documents that would allow this to occur. I wo be happy to send to you. That you.	their	
		idents have customary access The facility has one detached					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675	A. E	MULTIPLE CO BUILDING VING	nstruction 01	COM	E SURVEY PLETED 6/2022
	PROVIDER OR SUPPLIEF	EMENT COMMUNITY AND HEA	ALTHC	STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR THC GREENSBURG, IN 47240			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		facility storage services which					
	Quality Review cor	npleted on 09/29/22					
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and clinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks afety needs of the Clinical or Secure being met. In electrical locks that release upon loss building is protect automatic sprinklesspace is protected detection system.	king arrangements for the seds of the patient are sking device shall be a door and provisions shall apid removal of occupants of of locks; keying of all sed by staff at all times; or a means available to the selection. LOCKING Sking arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the eed by a supervised or system and the locked of by a complete smoke (or is constantly monitored)					
		ation within the locked the sprinkler and detection					

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CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155675			A. B	UILDING 'ING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/26/2022		
	PROVIDER OR SUPPLIER G BREEZE RETIRI	EMENT COMMUNITY AND HEA	LTHC	950 N L	ADDRESS, CITY, STATE, ZIP COD AKEVIEW DR ISBURG, IN 47240			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ged to unlock the doors		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an a	2.2.5.2, TIA 12-4 SS LOCKING S elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system. 2.4 OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS IGEMENTS It access door locking in 1.2.1.6.3 shall be permitted as in buildings protected approved, supervised ection system and an sed automatic sprinkler						
	Based on observation failed to ensure the	on and interview, the facility means of egress through 1 of accessible for residents	K)222	K222 Correction action to be		10/21/2022	

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without a clinical diagnosis requiring specialized

of egress shall not be equipped with a latch or

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.

security measures. Doors within a required means

lock that requires the use of a tool or key from the

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taken.

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accomplished for residents found

Immediate action was

to have been affected by the

deficient practice:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPL	
		155675	B. W	ING		09/26/	2022
NAME OF I	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP COD		
					LAKEVIEW DR		
MORNIN	IG BREEZE RETIR	EMENT COMMUNITY AND HEAL	THC GREEN		NSBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	tice could affect over 5			l		
	· ·	visitors if needing to exit the			How other residents having the		
	facility by using th	e exit door by Room 51.			potential to be affected by the		
	Findings in the 4				same deficient practice will be		
	Findings include:				identified and what corrective		
	Rosed on observati	ions with the Director of			action will be taken:		
		g the initial walk through of the			 All residents have the potential to be effected. Exit of 	oho	
		a.m. to 9:25 a.m. on 09/26/22, the			was displayed at the door	oue	
	-	tside of the facility by Room 51			immediately.		
		y entering a code into a keypad			ininicalatory.		
		the code was not posted at the					
		n interview at the time of the			What measures will be put in		
		Director of Maintenance stated			place and what systematic		
	the facility does no	ot have a secure wing for			changes will be made to ensu	ıre	
	residents with a cli	nical diagnosis requiring			that the deficient practice not		
	specialized security	y measures, the code was not			recur:		
	posted at the exit d	oor because one resident was			- Walking rounds will be		
	an elopement risk a	and agreed the code was not			performed Monday-Friday, to	verify	
	_	oor. Based on observations			placement of exit codes to be		
		of Maintenance during a tour of			performed by the Maintenance	е	
		00 p.m. to 2:30 p.m. on 09/26/22,			Director or designee.		
		was posted at the keypad by			- Ongoing education wit		
	the exit door by Ro	pom 51.			staff, on the importance of the	,	
	TTI : (" 1:				code being displayed.		
		eviewed with the Administrator					
	_	Maintenance during the exit			Lieux de a como estivo e esti-		
	conference.				How the corrective actions wi		
	3.1-19(b)				monitored to ensure the defic practice will not recur:	IEIIL	
	3.1-17(0)				- A performance		
					improvement tool has been		
					developed that will monitor th	e	
					Display of exit codes at door.		
					tool will be completed by the	• •	
					Maintenance Director or design	gnee	
					daily for one month, weekly for		
					months with results being		
					forwarded to QAPI committee	for	
					any further recommendations		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675	î ´	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/26/2022
	PROVIDER OR SUPPLIEF	EMENT COMMUNITY AND HEAL	_THC	950 N L	ADDRESS, CITY, STATE, ZIP COD LAKEVIEW DR ISBURG, IN 47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
					and/or resolution. Ongoing Q/ review of findings, results, outcomes.	API
					Date of Compliance October 2 2022	21,
K 0346 SS=F Bldg. 01	services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to see 9.6.1.6 Based on record reside be followed in the eto be placed out-of-in a twenty four hor LSC, Section 9.6.1. affects all residents Findings include: Based on review of Fire Watch" document the Administrator and Maintenance during to 1:00 p.m. on 09/2 alarm system impain plan did not express.	of Service re alarm system is out of than 4 hours in a 24-hour lity having jurisdiction shall be building shall be approved fire watch shall be rities left unprotected by the fire alarm system has service. The wind interview, the facility complete written policy for the ents indicating procedures to event the fire alarm system has service for four hours or more ar period in accordance with 6. This deficient practice, staff and visitors.	K 0	346	K346 Correction action to be accomplished for residents for to have been affected by the deficient practice: The Emergency Operations Preventiage was updated for the Watch Policy to include: Evacuation of a building the instituting of an approved Watch when a (Fire Alarm and sprinkler system is out of service) for more than 4 hours in a 24 period until the system has be returned to service. How other residents having the potential to be affected by the	Plan Fire ag or Fire d/or rice hour een
		rould be initiated. The plan did equired fire alarm system is			potential to be affected by the same deficient practice will be	:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675	ì í	JILDING	onstruction 01	(X3) DATE : COMPL 09/26/	ETED	
	PROVIDER OR SUPPLIER G BREEZE RETIR	EMENT COMMUNITY AND HEAL	STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR THC GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	period, the authority notified, and the bu approved fire watch parties left unproted	nore than 4 hours in a 24-hour y having jurisdiction shall be ilding shall be evacuated or an a shall be provided for all cted by the shutdown until the as been returned to service.			identified and what corrective action will be taken: - All residents have to potential to be effected.	9		
	The plan also failed Department of Hea at https://gateway.is method or by the se IDOH Gateway is the Incident Report incidents@isdh.in.g time of record revied Director of Mainter documentation for was incomplete.	It to contact the Indiana Ith via the IDOH Gateway link solh.in.gov as the primary econdary method when the monoperational by completing ing form and e-mailing it to gov. Based on interview at the ew, the Administrator and the mance agreed the fire watch fire alarm system impairment viewed with the Administrator Maintenance during the exit			What measures will be put in place and what systematic changes will be made to ens that the deficient practice not recur: The EOP The heading verbiage for the Fire Watch F was updated, to include the falarm and/or Sprinkler Syste The EOP will be reviewed/updated annually a throughout the year as any additional information or chat that are identified that would improve the plan including all guidance or instructions from ISDH.	ure t g Policy fire m. and nges		
					How the corrective actions we monitored to ensure the deficiency practice will not recur: - A performance improvement tool has been developed that will monitor EPI tool will be completed by the Maintenance Director or desens The EOP will be reviewed/up weekly as needed for 6 monitand throughout the year as a additional information or chat that are identified that would improve the plan including an guidance or instructions from	COP. the tignee odated ths thy nges		

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STATEMEN	T 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
		155675	B. WI	NG		09/26/	2022
	ROVIDER OR SUPPLIER	EMENT COMMUNITY AND HEALT	НС	950 N L	ADDRESS, CITY, STATE, ZIP COD AKEVIEW DR ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		CORRECTION (X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					ISDH with results being forward to QAPI committee for any furtirecommendations and/or resolution.		
					Date of Compliance October 2 2022	<u>?</u> 1,	
K 0500 SS=F Bldg. 01	Section 18.5 and requirements that provided K-tags, be information, along Safety Code or NF should be included Based on observation failed to ensure 2 of current inspection of heaters were in safe 101, Section 19.1.1. to be designed consoperated to minimizemergency requiring		K 0:	500	K500 Correction action to be accomplished for residents for to have been affected by the deficient practice: Inspection has been scheduled for next available definition.	ate.	10/21/2022
	Findings include: Based on observation	ons with the Director of			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective		
	Maintenance during	a tour of the facility from 1:00			action will be taken:		
		n 09/26/22, the following two			- All residents have to		
		d in the Mechanical Room in			potential to be effected. Inspec	ction	
		Certificate of Inspection			has been scheduled.		
	documentation from	the State of Indiana available					

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for review:

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	OF CORRECTION	IDENTIFICATION NUMBER 155675	A. B	UILDING VING	01	COMPL 09/26	LETED
	PROVIDER OR SUPPLIER G BREEZE RETIRE	EMENT COMMUNITY AND HEAL	ТНС	950 N L	ADDRESS, CITY, STATE, ZIP COD LAKEVIEW DR ISBURG, IN 47240		
(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)	.TE	(X5) COMPLETION DATE
	b. the service water Based on interview observations, the Di he was not aware if documentation from required for the unit replacement units of required the Certific aforementioned wat Inspection documen Indiana available fo survey. This finding was rev	heater identified as IN300158. heater identified as IN338070. at the time of the rector of Maintenance stated Certificate of Inspection a the State of Indiana was as which also may be if the original units which reations but agreed the er heaters had no Certificate of itation from the State of ir review at the time of the viewed with the Administrator Maintenance during the exit			What measures will be put in place and what systematic changes will be made to ensu that the deficient practice not recur: - Walking rounds will be performed Monday-Friday, to no concerns with systems for months. Inspections will be completed annually. How the corrective actions wil monitored to ensure the defici practice will not recur: - A performance improvement tool has been developed that will monitor the water heater system. PI tool who be completed by the Maintena Director or designee daily for months with results being forwarded to QAPI committee any further recommendations and/or resolution. Ongoing QA review of findings, results, outcomes. Date of Compliance: October 2022	verify 6 I be ent e vill ance six for	
K 0923 SS=E Bldg. 01	Storag Gas Equipment - (Storage Greater than or eq Storage locations	Cylinder and Container Cylinder and Container ual to 3,000 cubic feet are designed, constructed, ccordance with 5.1.3.3.2					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155675	î í	ultiple construction uilding <u>01</u> ing		(X3) DATE SURVEY COMPLETED 09/26/2022	
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALT			STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR THC 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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	enclosure or within space of non- or laconstruction, with that can be secur stored with flamm from combustibles sprinklered) or en noncombustible of minimum 1/2 hr. If Less than or equal in a single smoke cylinders available patient care areas of less than or equal required to be stored Cylinders must be as specified in 11. A precautionary son each door or groom, where the saminimum "CAU" STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with intesting threshold pressurestablished. Empayoid confusion. Care protected from 11.3.1, 11.3.2, 11.99)	are outdoors in an n an enclosed interior imited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a sire protection rating. In a to 300 cubic feet compartment, individual the for immediate use in the swith an aggregate volume and to 300 cubic feet are not ared in an enclosure. In the handled with precautions are of a cylinder storage sign includes the wording as TION: OXIDIZING GAS(ES) INO SMOKING." Individual to so cylinders are used in the sylinders are segregated and so cylinders are used in the sylinders are segregated and so cylinders are segregated and so cylinders are marked to cylinders stored in the open on weather. In an enclosure.	K O	023	K023. Unsecured cylinders		10/21/2022
	failed to ensure 3 ogases such as oxygfalling in 1 of 1 oxy	ation and interview, the facility f 4 cylinders of nonflammable en were properly secured from ygen storage areas. NFPA 99, ies Code, 2012 Edition, Section	K 0	923	K923- Unsecured cylinders Correction action to be accomplished for residents for to have been affected by the	ınd	10/21/2022

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
15		155675	B. WING			09/26/2022	
		1	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			_AKEVIEW DR		
MORNING BREEZE RETIREMENT COMMUNITY AND HEALT			ГНС		NSBURG, IN 47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	_	e for nonflammable gases			deficient practice:		
	equal to or greater than 85 cubic meters (3000				- Removed unsecured		
	cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3.			cylinders and had them returned			
	NFPA 99, Section 5.1.3.3.2(7) requires cylinders be				to vendor, the remaining cylinders		
	provided with racks, chains, or other fastenings to				continued to be secured.		
	secure all cylinders from falling, whether						
	connected, unconnected, full or empty. This				l		
	deficient practice could affect over 5 residents,			How other residents having			
		the vicinity of the oxygen		potential to be affected by			
	storage and transfilling room at the Station 2			same deficient practice wi			
	(west) nurse's station	on.			identified and what corrective		
	T' 1' 1 1				action will be taken:		
	Findings include:			- All residents ha			
					potential to be effected.		
	Based on observations with the Director of Maintenance during a tour of the facility from 1:00						
		n 09/26/22, three of four 'E' type			What magazines will be put in		
		vere freestanding on the floor in			What measures will be put in		
		and transfilling room at the			place and what systematic	ıro	
		rse's station and were not			changes will be made to ensu that the deficient practice not	ii e	
		om falling. Five liquid oxygen			recur:		
		: 'E' type oxygen cylinders were			- Walking rounds will be		
		Based on interview at the time			performed Monday-Friday by		
					Maintenance Director or design		
	of the observations, the Director of Maintenance agreed the three oxygen cylinders were not			to verify compliance with keeping			
	supported in a cylinder stand or otherwise			all cylinders secured.			
		g in the oxygen storage and			- Ongoing education wit	h	
	transfilling room.	g in the onlygen biologe and			staff, on the importance of		
					securing cylinders.		
	This finding was re	eviewed with the Administrator			Jesuing symiders.		
	and the Director of Maintenance during the exit						
	conference.	<i>6</i>			How the corrective actions wil	ll be	
					monitored to ensure the defici		
	3.1-19(b)				practice will not recur:		
					- A performance		
	2. Based on observation and interview, the facility				improvement tool has been		
		f 1 cylinders of nonflammable			developed that will monitor the	е	
		on dioxide were properly			cylinder storage. PI tool will be		
	secured from falling. NFPA 99, Health Care				completed by the Maintenanc		
	Facilities Code, 20	12 Edition, Section 11.3.3 states			Director or designee daily for		
, , , , , , , , , , , , , , , , , , , ,		1		I Total		I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155675			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/26/2022		
NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALT			STREET ADDRESS, CITY, STATE, ZIP COD 950 N LAKEVIEW DR THC GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	storage for nonflar volume equal to or meters (300 cubic and 11.3.3.2. NFP precautions in hand 11.3.3.1 shall be in 11.6.2.3(11) states properly chained of stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This over three staff in the stand or cart. This finding was resulted in a purpose of the standard or cart. This finding was resulted in a purpose of the standard or cart. This finding was resulted in a purpose of the standard or cart. This finding was resulted in a purpose of the standard or cart. This finding was resulted in a purpose of the standard or cart. This finding was resulted in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three staff in the standard or cart. This over three standar	nmable gases with a total rless than greater than 8.5 cubic feet) shall comply with 11.3.3.1 A 99, Section 11.3.3.2 states dling cylinders specified in accordance with 11.6.2. Section freestanding cylinders shall be r supported in a proper cylinder deficient practice could affect			month, weekly for 5 months versults being forwarded to QA committee for any further recommendations and/or resolution. Ongoing QAPI reversindings, results, outcomes. Date of Compliance October 2022	API riew of	

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