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	04/09/2025

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: 04/09/25 Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550 At this Emergency Preparedness survey, Sycamore Care Strategies was found 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 33. Quality Review completed on 04/11/25	E 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the sight 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 5/15/2025 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 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 Dates: 04/09/25 Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550 At this Life Safety Code survey, Sycamore Care	K 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the sight 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 5/15/2025 to the state	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Gladish	Health Facility Administrator	04/25/2025

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

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	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 33 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 04/11/25		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 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to maintain the walking surface for 1 of 5 exit discharge areas. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 04/09/25 at 1:00 p.m. during a tour of the facility with the Maintenance Director, the sidewalk outside the west exit door	K 0271	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. The sidewalk on the west exit door was repaired on (DATE). 2. Identify other residents who have the potential to be affected by the same alleged deficient practice.	05/15/2025

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	was damaged. A previous concrete patch had broken into pieces and left a two inch gap between the concrete slabs. The two inch gap between the slabs of concrete in this sidewalk which leads to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at 1:00 p.m., the Maintenance Director acknowledged the two inch gap between the concrete slabs in the sidewalk to the public way and agreed it needed to be repaired. This finding was reviewed with the Maintenance Director and Director of Nursing during the exit conference. 3.1-19(b)		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. Monthly inspection of sidewalks will be implemented for all exits and added to the monthly maintenance duties list. b. Sidewalks that fail to provide a level walking surface will undergo necessary repairs to ensure long-term safety and accessibility, aligning with systemic improvements for life safety compliance. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures are put into place. The administrator/designee will review the completed maintenance duties list and form monthly to ensure compliance. Should findings of non-compliance be observed, corrective action shall be taken. The monitoring will be ongoing to ensure compliance. The observations and corrective actions taken will be reviewed during quarterly Q/A meetings and adjusted as warranted.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure sprinkler heads at 1 of 1 porch overhang covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 resident, as well as staff and visitors. Findings include: Based on observations on 04/09/25 at 1:15 p.m. during a tour of the facility with the Maintenance Director, 13 of 14 pendent type sprinkler heads under the front wrap-around porch overhang were partially or fully covered with corrosion. Based on interview at 1:15 p.m., the Maintenance Director acknowledged the sprinkler heads were covered with corrosion and needed to be replaced. This finding was reviewed with the Maintenance Director and Director of Nursing during the exit conference. 3.1-19(b)	K 0353	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Corroded sprinkler heads that were identified on the porch were replaced by (Date and name of company). 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and corrective action taken. 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. Visual sprinkler inspection has been added to the maintenance duties list that includes sprinklers on the porch. This list will identify the date of visual sprinkler inspection completed monthly. b. Sprinkler heads identified as deficient will be promptly replaced to uphold fire protection standards and ensure continued compliance. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures	05/15/2025

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			are put into place. The administrator/designee will review completed maintenance duties list monthly to ensure inspection of sprinkler heads. Should findings of non-compliance be observed, corrective action shall be taken. The monitoring will be ongoing to ensure compliance. The observations and corrective actions taken will be reviewed during quarterly Q/A meetings and adjusted if warranted.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels	K 0921	1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. The maintenance director will complete PCREE testing on nebulizers, oxygen concentrators, air pump mattress and other electrical medical equipment. 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. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures	05/15/2025

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	and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 04/09/25 at 10:10 a.m. with the Maintenance Director present, there was documentation dated 04/04/25 for the testing of resident beds for PCREE, however, there was no PCREE testing documentation for items such as nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at 10:10 a.m., the Maintenance Director said the facility had just found and purchased the equipment to test all of the electrical medical equipment and had started with the resident beds, but has not yet completed the other items, such as, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on observations between 12:15 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Maintenance Director and Director of Nursing during the exit conference. 3.1-19(b)		are put into place. a. The maintenance director has implemented an electrical safety inspection PRCEE form to identify items that need to be repaired, tested and documented. b. A record of electrical equipment tests, repairs, and modification will be maintained and updated as needed. 4. Corrective action will be monitored to ensure alleged deficient practice does not recur and quality assurance measures are put into place. The administrator/designee will review the completed electrical safety inspection PRCEE form monthly to ensure compliance. Should findings of non-compliance be observed, corrective action shall be taken. The monitoring will be ongoing to ensure compliance. The observations and corrective actions taken will be reviewed during quarterly Q/A meetings and adjusted as warranted.	

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