	T OF HEALTH AND HUI R MEDICARE & MEDIC						TED: RM APP B NO. 09	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ULTIPLE CO JILDING	DNSTRUCTION 	(X3) DATE SURVEY COMPLETED		7	
		155783	B. WI	ING	09/26/20			
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 1201 E BEARDSLEY AVE ELKHART, IN 46514					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE			LETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DA	ATE
E 0000 Bldg	,		E 00	000	Preparation or execution of the plan of correction does not constitute admission or agreed of provider of the truth of the falleged or conclusions set fort the Statement of Deficiencies.	ment acts th on		

At this Emergency Preparedness survey,
Greenleaf Health Campus was found not in compliance with Emergency Preparedness
Requirements for Medicare and Medicaid
Participating Providers and Suppliers, 42 CFR
483.73.

position of Federal and State Law.
The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on September 26th, 2024.

The facility has 60 certified beds. At the time of the survey, the census was 55.

The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:

Quality Review completed on 09/30/24

Facility Number: 002661

Provider Number: 155783 AIM Number: 201056540

E 0041 SS=F Bldg. -- 482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power

1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power

E 0041 E 041

Hospital CAH and LTC Emergency Power

Plan of Correction is prepared and executed solely because it is

required it is required by the

Immediate intervention

1.) The natural gas provider was

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

TITLE

(X6) DATE

10/26/2024

Brittney Plantinga ED

10/08/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FHE921 Facility ID: 002661 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
	155783		B. WING 09/26/20			/2024	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BEARDSLEY AVE		
CDEENII	EAF HEALTH CAM	ADI IS			RT, IN 46514		
GNEENL	LAFTIEALTIT CAIV			ELKITA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ion. Section 5.1.1 states the			contacted for an updated Lette	er of	
		ources shall be permitted to be			reliability with all required		
	_	ency power supply (EPS):			components. This deficient		
	(1) Liquid petroleur	m products at atmospheric			practice could affect all		
	pressure				occupants.		
	(2) Liquefied petrol	leum gas (liquid or vapor					
	withdrawal)				2.) Generator was run for 4		
	(3) Natural or synth				continuous hours with		
		el 1 installations in locations			documentation to meet the 36		
	•	ty of interruption of off-site			month period requirements. TI	his	
	fuel supplies is high	n, on-site storage of an			deficient practice could affect	all	
	alternate energy sou	arce sufficient to allow full			occupants.		
	output of the EPSS	to be delivered for the class					
	specified shall be re	equired, with the provision for					
	automatic transfer f	from the primary energy source			Compliance date 10/26/2024		
	to the alternate ener	rgy source. This deficient					
	practice could affect	et all residents, staff, and			The director of plant operation	S	
	visitors.				and the executive director wer	e	
					educated by Regional Facilitie	s	
	Findings include:			Support on processes and			
					procedures listed for emergen	су	
		view and interview with the		operations as they pertain to CFR			
		perations (DPO) from 9:20 a.m.			483.73		
	•	1/26/24, the facility's emergency					
	_	ural gas fuel source. The		Exhibit A – Inservice			
		letter of reliability dated					
		from NIPSCO, the utility					
		al gas; however, the letter did			The director of plant operation	s will	
	not include all of th	e required information. There			maintain, and review		
		nat there was a low likelihood			documentation as pertains to t	the	
	of an interruption w	vith a description as to why			generator in accordance with I	LSC.	
		letter was not authored by a					
	technical person wh						
		those statements. The letter			Executive Director will review		
	1	e Manager, Major Account			documentation thru the QAPI		
	* *	not an engineer and there was			committee for further		
	no explanation of the	ne author's job responsibilities			recommendations and will		
		had the technical knowledge			continue until QAPI team		
	to make the require	d statements. This finding was			determines substantial		
	discussed with the l	DPO during record review.	1		compliance has been achieved	d.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155783		JILDING	NSTRUCTION	COMPL 09/26/	ETED
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS			1201 E	DDRESS, CITY, STATE, ZIP COD BEARDSLEY AVE RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
		viewed with the Director of the exit conference.				
	interview; the facili period emergency gemerated and NFPA 110. NF Code, 2012 Edition 1 and Type 2 essent sources (EPSS) shat Class X, Level 1 gen NFPA 110, the Star Standby Powers System States Level 1 once within every 3 states Level 1 EPSS for the duration of i 4.2). Section 8.4.9. class is greater than to terminate the test Section 8.4.9.5 states test shall be specifically 8.4.9.5.3. Section 8 EPS's, loading shall This deficient pract staff and visitors.	review, observation, and ty failed to document 36-month generator testing for 1 of 1 or in accordance with NFPA 99 of PA 99, Health Care Facilities, Section 6.4.1.1.6.1 states Type gial electrical system power ll be classified as Type 10, merator sets per NFPA 110. Indiard for Emergency and stems, 2010 Edition, Section EPSS shall be tested at least 6 months. Section 8.4.9.1 is shall be tested continuously the assigned class (See Section 2 states where the assigned 4 hours, it shall be permitted after 4 continuous hours. The set in shall be the assigned as the minimum load for this ed in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3 states for spark-ignited be the available EPSS load. The second of the second affect all residents,				
	Findings include: Based on record rev	riew and interview with the				
	Director of Plant Opto 12:30 p.m. on 09 available to show a continuous hours for generator. Based or record review, the I generator service versions of the property of the pr	perations (DPO) from 9:20 a.m. /26/24, documentation was not 36-month period test for 4 or the natural gas emergency in interview at the time of DPO stated he spoke with the endor and they did not knowing to and confused him about				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155783		JILDING	ONSTRUCTION	(X3) DATE COMPI 09/26		
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 1201 E BEARDSLEY AVE ELKHART, IN 46514					
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
K 0000	This finding was re Operations at the ex	viewed with Director of Plant cit conference.						
K 0000 Bldg. 02	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/26. Facility Number: 00 Provider Number: 1 AIM Number: 2010 At this Life Safety of Campus was found Requirements for Pomedicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (I Health Care Occupation This one-story facil Type V (111) const sprinklered. The bu 2010, is adjacent to	22661 55783 256540 Code survey, Greenleaf Health not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 Edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of ruction and was fully fillding was constructed in an assisted living unit and	K 0	000	Preparation or execution of plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set for the Statement of Deficiencies. Plan of Correction is prepare executed solely because it is required it is required by the position of Federal and State. The Plan of Correction is submitted in order to responsite the allegation of noncompliancited during the survey visit exit on September 26th, 202	ement e facts orth on es. The ed and es e Law. d to nce with		
	Resistive Rating. T system with smoke open to the corridor detectors in the resi	Wall with a two-hour Fire The facility has a fire alarm detection in corridors, in areas and hard-wired smoke dent rooms. The facility is by a 150 kW Natural Gas						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155783		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIER		1	1201 E	ADDRESS, CITY, STATE, ZIP COD BEARDSLEY AVE RT, IN 46514	<u> </u>	
(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
	The facility has a cacensus of 55 at the t	pacity of 60 beds and had a					
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors						
	failed to ensure 1 of doors in the 100 hal suitable for keeping impediment to closi the passage of smok could affect 13 resides 5 smoke compartments. Findings include: Based on observation Director of Plant Opto 2:30 p.m. on 09/2 corridor door was not latched. At the time attempted to close at three times but was Based on interview DPO stated he just of	on and interview, the facility is 13 resident room corridor l were provided with a means the door closed, had no ng, latching and would resist the. This deficient practice dents, staff and visitors in 1 of ents. On and interview with the perations (DPO) from 12:45 p.m. 12:45 p.m. 12:45 p.m. 12:45 p.m. 12:45 p.m. 13:45 p.m. 14:45 p.m. 15:45 p.m. 16:45 p.m. 16:4	K 0.	363	Immediate intervention Adjusted the door that would have prevented, the door from closing and positive latching into the frame, it had no impediment to closing, latching and would resist the passage of smoke that could affect 13 staff, residents, and visitors in 1 of the 5 smoke compartments to meet K363 deficiency. Compliance date 10/26/2024		10/26/2024
		viewed with the DPO during			The Director of Plant Operation was educated by Regional Support on K363 corridor – do protecting corridor openings in other than required enclosures vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertain NFPA 101 in compliance with 7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.42 CFR parts	oors n s of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155783		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/26/2024		
NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS			1201 E	ADDRESS, CITY, STATE, ZIP COD BEARDSLEY AVE RT, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
					403,418,460,482,483 and 485	i.		
					Exhibit A – Inservice			
					The Director of Plant Operatio assigned party will visually ins the corridor doors weekly X 3 months			
					Exhibit B - Audit tool			
					Executive Director will present results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	u the		
K 0511 SS=F Bldg. 02	NFPA 101 Utilities - Gas and	Electric						
	failed to ensure 1 or reliable source of fu requirements of NF	riew and interview, the facility f 1 emergency generator had a uel in accordance with the PA 101 - 2012 edition, Section 1 and NFPA 110, 2010 Edition,	K 0	511	K511 Utilities – Gas and electric Immediate intervention The director of plant operation	ıs	10/26/2024	

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5.1. LSC Section 9.1.3.1 states emergency

maintained in accordance with NFPA 110,

generators shall be installed, tested and

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contacted the Natural Gas provider

to submit an updated letter of

reliability with correct

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155783	A. B	MULTIPLE CO UILDING 'ING	onstruction 02	(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIED		•	1201 E	ADDRESS, CITY, STATE, ZIP COD BEARDSLEY AVE RT, IN 46514		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
	+	gency and Standby Power			requirements to meet deficien		
	1 -	tion. Section 5.1.1 states the			K511. This deficient practice of	could	
		ources shall be permitted to be			affect all occupants.		
	_	ency power supply (EPS):					
	(1) Liquid petroleu	m products at atmospheric			Compliance date: 10/26/2024		
	pressure						
		leum gas (liquid or vapor			Director of plant Operations w		
	withdrawal)				educated by the regional supp	port	
	(3) Natural or synth	rel 1 installations in locations			on K511 NFPA 70, National		
	_	ity of interruption of off-site			Electric Code. Existing installations can continue in		
	_	h, on-site storage of an			service provided no hazard to	life	
	**	urce sufficient to allow full			18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2		
	output of the EPSS to be delivered for the class				Additionally, NFPA 101 – 201		
	1 -	equired, with the provision for			edition Section 19.5.1.1, 9.1,	_	
	1 -	from the primary energy source			9.1.3.1 and NFPA 110, 2010		
	to the alternate ene				Edition 5.1.		
	A.5.1.1 states exam	pples of probability of			Exhibit A – Inservice		
	interruption could i	include the following:			Documentation		
	earthquake, flood d	lamage, or a demonstrated					
	utility unreliability	. This deficient practice could			Director of plant Operations w	vill	
	affect all residents,	staff and visitors.		verify required documentation is			
	Findings include:				reviewed and updated as requ	uired.	
	i manigo meiade.				The Executive Director will re	view	
	Based on record re	view and interview with the			results of paperwork thru the		
	Director of Plant O	perations (DPO) from 9:20 a.m.			committee for further		
	to 12:30 p.m. on 09	0/26/24, the facility's emergency			recommendations and will		
	~	ural gas fuel source. The			continue until QAPI team		
		letter of reliability dated			determines substantial		
		from NIPSCO, the utility			compliance has been achieve	ed.	
		ral gas; however, the letter did					
		ne required information. There					
		nat there was a low likelihood					
	•	vith a description as to why					
		letter was not authored by a					
	_	ho had the technical e those statements. The letter					
	_	e those statements. The letter e Manager, Major Account					
	1	not an engineer and there was					
	aupport, who was i	not an engineer and there was	1		I	ı	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155783 B. WING 09/26/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1201 E BEARDSLEY AVE **GREENLEAF HEALTH CAMPUS** ELKHART. IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE no explanation of the author's job responsibilities to confirm that they had the technical knowledge to make the required statements. This finding was discussed with the DPO during record review. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b) K 0712 **NFPA 101** SS=F Fire Drills Bldg. 02 Based on record review and interview, the facility K 0712 K712 10/26/2024 failed to conduct quarterly fire drills under varying Fire Drill conditions according to LSC 101 19.7.1.6 and LSC 4.7.4 which require drills be conducted at Immediate Intervention unexpected times under varying conditions. This As noted during survey findings deficient practice could affect all residents, staff the fire drills were scheduled to and visitors. close to the end of the month going forward all drills will be Findings include: performed in various times and dates. This deficient practice Based on record review with the Director of Plant could affect all occupants to meet Operations (DPO) from 9:20 a.m. to 12:30 p.m. on K712. 09/26/24, the "Fire Drill Report" indicated 10 of 12 fire drills conducted were all conducted between Compliance Date 10/26/2024 the 24th and 31st of each month. In the first quarter of 2024 fire drills were conducted on: first The director of plant operations shift at 7:19 a.m. on 01/31/24, second shift at 89:30 was educated by regional support p.m. on 02/20/24, and third shift at 11:00 p.m. on on the requirements of NFPA 101 03/31/24. In the second quarter of 2024 fire drills concerning fire drills are to be held were conducted on: second shift at 2:40 p.m. on at various times and dates to 05/31/25, and on third shift at 1:0 a.m. on 06/29/24. ensure conditions of drills being In the third quarter of 2024 fire drills were conducted on unexpected days conducted on: on second shift at 5:56 p.m. on and unpredictable times under

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08/24/24. In the third quarter of 2023 a third shift

the fourth quarter of 2023 fire drills were conducted on: first shift at 9:34 a.m. on 10/31/23,

fire drill was conducted at 3:45 a.m. on 09/30/23. In

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Facility ID: 002661

varying conditions, at least

quarterly on each shift.

Exhibit A - Inservice

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STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
		155783	B. WING 09/26/2024			/2024	
		l .	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			BEARDSLEY AVE		
CDEENII	EAF HEALTH CAM	IDLIS			RT, IN 46514		
GIVELINE	LAI TILALTIT CAIV			LLINIA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		p.m. on 11/30/23, and on the			Documentation		
		a.m. on 12/31/23. Based on					
		e of record review, the DPO			The Executive director and the		
	_	lates and times of fire drills			Director of plant operations wi		
		hat he only had to vary the			present information x 12 mont		
	time of the fire drill	ls by 2 hours.			to the QAPI committee for furt		
					recommendation and will cont		
	1	viewed with Director of Plant			until the QAPI team determine		
	Operations at the ex	kit conference.			substantial compliance has be	en	
					achieved.		
	3.1-19(b)						
	3.1-51(c)						
IZ 0040	NEDA 404						
K 0918 SS=F	NFPA 101	- Farantial Flactuic Occata					
	Electrical Systems	s - Essential Electric Syste					
Bldg. 02	D11	.:1	17.0	010	KOAO Flantinal Overhouse		10/26/2024
		view, observation, and	K 0	918	K918 – Electrical Systems		10/26/2024
		ty failed to document 36-month			lassa salista latamantisa		
	1	generator testing for 1 of 1 or in accordance with NFPA 99			Immediate Intervention		
	1				The Director of Plant Operatio		
		FPA 99, Health Care Facilities , Section 6.4.1.1.6.1 states Type		conducted a 4hr continuou			
		tial electrical system power		test with Documentation to sa		-	
		ll be classified as Type 10,		this deficient practice of KS could affect all residents, s			
	` ′	enerator sets per NFPA 110.		and visitors.		,	
	_	ndard for Emergency and			and visitors.		
		stems, 2010 Edition, Section			Exhibit C – Documentation		
		EPSS shall be tested at least			Exhibit C = Documentation		
		66 months. Section 8.4.9.1					
	1	S shall be tested continuously			Compliance Date: 10/26/2024		
		ts assigned class (See Section			Compliance Date: 10/20/2024		
		2 states where the assigned					
	1	4 hours, it shall be permitted					
		t after 4 continuous hours.			The Director of Plant Operatio	ine	
		es the minimum load for this			was educated by the Regional		
		ed in 8.4.9.5.1, 8.4.9.5.2, or			Support on NFPA 101 Electric		
	_	3.4.9.5.3 states for spark-ignited			Systems, Generator sets are	ui	
		be the available EPSS load.			inspected weekly, exercised u	ınder	
		ice could affect all residents,			load 30 minutes 12 times a ye		
	staff and visitors.	ico coura arroct air residents,			20-40 day intervals, and exerc		
	Juli alla visitors.		1		I LUTTU WAY IIILU VAIS, AIN EXEIL	nocu	I

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FHE921 Facility ID: 002661

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155783		(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 09/26/2024	
	PROVIDER OR SUPPLIE LEAF HEALTH CAI		1201 E	ADDRESS, CITY, STATE, ZIP COD BEARDSLEY AVE RT, IN 46514		
GREENI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C Findings include: Based on record re Director of Plant C to 12:30 p.m. on 0 available to show continuous hours to generator. Based record review, the generator service what he was refer what was required	eview and interview with the Operations (DPO) from 9:20 a.m. 9/26/24, documentation was not a 36-month period test for 4 for the natural gas emergency on interview at the time of DPO stated he spoke with the vendor and they did not know ring to and confused him about .	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) once every 36 months for 4 continuous hours. Scheduled under load conditions includes complete simulated cold start automatic or manual transfer (EES loads and are conducted competent personnel. Maintenance and testing of stenergy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder of breakers are inspected annual and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained an readily available. EES electric panels and circuits are market.	test s a and of all by ored 3 ircuit lly,	
				and readily identifiable. Minim the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Exhibit A - Inservice The Director of Plant Operation will maintain testing records to ensure proper cycles of completion.	izing e 4	

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