CENTERS FO	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155535	B. WING		03/20/2023
	PROVIDER OR SUPPLIED	TH & REHABILITATION CENTE	3550 C	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVE MBUS, IN 47203	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the Ir accordance with 42		E 0000	Submission of this plan of correction does not constitute admission or agreement by th provider of the truth of facts	
	Survey Date: 03/20	0/23		alleged or correction set forth the statement of deficiencies.	
	Facility Number: (000572		plan of correction is prepared	
	Provider Number:			submitted because of requirer	
	AIM Number: 100			under state and federal law.	nent
	Alivi Nulliber. 100	20//10			
	A. d. F	D 1 17711		Please accept this plan of	
		Preparedness survey, Willow		correction as our credible	
	-	Rehabilitation Center was		allegation of compliance. Plea	se
	_	iance with Emergency		find enclosed this plan of	
	Preparedness Requ	irements for Medicare and		correction for this survey. Due	; to
	Medicaid Participal CFR 483.73.	ting Providers and Suppliers, 42		the low scope and severity of survey finding, please find the sufficient documentation provi	:
	The feeility has 11'	2 certified beds. At the time of		-	-
				evidence of compliance with the	ne
	the survey, the cens	sus was 56.		plan of correction. The documentation serves to confi	irm
	Quality Review con	mpleted on 03/27/23		the facility's allegation of compliance. Thus, the facility respectfully requests the gran of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.	ting
E 0039 SS=F Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), \$441.184(d)(2).			

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

§460.84(d)(2), §482.15(d)(2), §483.73(d)(2),

(X6) DATE

TITLE

Alisha Miller Administrator 04/07/2023

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: 11XC21 Facility ID: 000572 If continuation sheet Page 1 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155535	B. W	ING		03/20	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER	2		1BUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. , , , ,	484.102(d)(2), §485.68(d)(2),					
	§485.625(d)(2), §485.727(d)(2), §485.920(d)						
	(2), §491.12(d)(2)	, §494.62(d)(2).					
	*IF A O O + C 4 4	10.54.00D5+ \$405.00					
	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,						
		20, RHCs/FQHCs at RD Facilities at §494.62]:					
	9491.12, and ESF	ND Facilities at §494.02].					
	(2) Testing. The [f	acility] must conduct					
		he emergency plan					
	annually. The [fac	ility] must do all of the					
	following:						
	(i) Doublein etc in e	full and a system that is					
		full-scale exercise that is					
	•	every 2 years; or					
	1 ' '	nunity-based exercise is					
		onduct a facility-based e every 2 years; or					
		ility] experiences an actual					
	. ,	ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
		or individual, facility-based					
	•	e following the onset of the					
	actual event.	o renewing the enest of the					
		ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
		scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise						
	(B) A mock disast	er drill; or					
	' '	ercise or workshop that is					
		and includes a group					
	discussion using a	-					
	-	emergency scenario, and a					
	set of problem sta						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1XC21

Facility ID: 000572

If continuation sheet Page 2 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE (A. BUILDING B. WING	COMPI	B) DATE SURVEY COMPLETED 03/20/2023		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTE	3550	r address, city, state, zip co CENTRAL AVE IMBUS, IN 47203	DD .	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
TAG	messages, or prepto challenge an er (iii) Analyze the [famintain documer exercises, and em the [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional emergency exempt from engascale community-facility-based functional exercise of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (B) A mock dis	cared questions designed mergency plan. cacility's] response to and natation of all drills, tabletop mergency events, and revise regency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or every 2 years; or experiences a natural or ency that requires activation plan, the hospital is reging in its next required full chased exercise or individual stional exercise every 2 eyears the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise or workshop that is and includes a group a narrated, emergency scenario, and a	TAG	CROSS-REFERENCED TO THE AIDEFICIENCY)	PROPRIATE	DATE
	messages, or prepared	pared questions designed				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 3 of 53

	NT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/20/2023	
	PROVIDER OR SUPPLIED	TH & REHABILITATION CENTER	₹	3550 CE	DDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community-based functional exercise emergency event (ii) Conduct an arthat may include, following: (A) A second full-community-based functional exercise functional exercise (B) A mock disast (C) A tabletop expenditation that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the hospice's emerger's emergency in the hospice's emerger's exercises, and entitle the percent in the hospice's emerger's exercises in the hospice's exercises in the hospice's emerger's exercises in the hospice's exercises in	spices that provide inpatient c hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the -scale exercise that is l or a facility based e; or						
	§482.15(d), CAH	* *						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 4 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/20/2023		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550	T ADDRESS, CITY, STATE, ZIP CO CENTRAL AVE JMBUS, IN 47203)	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE ((X5) COMPLETION DATE
	(2) Testing. The [F conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community. (A) When a commaccessible, condurt facility-based function of the participate in a ctual natural of the participate in a ctual natural of the participate its next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A mo (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or prepare to challenge an er (iii) Analyze the and maintain docutabletop exercises and revise the [facineeded. *[For PACE at §46 (2) Testing. The Pace in a community problem.]	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following: an annual full-scale exercise abased; or aunity-based exercise is not ct an annual individual, attional exercise; or dospital, CAH] experiences or man-made emergency attion of the emergency attion of the emergency as exempt from engaging in all-scale community based ty-based functional exercise at of the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a attional exercise; or ck disaster drill; or or exercise or workshop that or and includes a group an arrated, emergency scenario, and a tements, directed pared questions designed mergency plan. The [facility's] response to a tementation of all drills, and emergency events collity's] emergency plan, as				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 5 of 53

PRINTED: 04/18/2023

DEPARTMEN CENTERS FOI		FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535		UILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/20/2023	
	PROVIDER OR SUPPLIE	R.TH & REHABILITATION CENTE	·R	3550 C	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE MBUS, IN 47203		
VVILLOVV	T CROSSING FIEAE	THE REHABILITATION CENTE	.1\	COLON	1000, IN 47200		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	MATION TAG DEFICIENCY)			DATE	
	that is community (A) When a commaccessible, condu- facility-based function (B) If the PACE e- or man-made emactivation of the e- is exempt from en- full-scale community-based functional exercis of this section is of but is not limited to (A) A second full- community-based based functional (B) A mock disase (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an en- (iii) Analyze the F- maintain docume exercises, and en-	an annual full-scale exercise a-based; or nunity-based exercise is not act an annual individual, ctional exercise; or experiences an actual natural ergency that requires emergency plan, the PACE agaging in its next required nity based or individual, ctional exercise following the agency event. In additional exercise every the year the full-scale or the under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is a or individual, a facility exercise; or the dill; or the recise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. PACE's response to and intation of all drills, tabletop mergency events and revise gency plan, as needed.					
	-	ity] must conduct exercises					

FORM CMS-2567(02-99) Previous Versions Obsolete

to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility,

ICF/IID] must do the following:

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 6 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPL	
		155535	B. W	ING		03/20/	2023
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ENTRAL AVE		
VVILLOVV	CKUSSING HEAL	TH & REHABILITATION CENTER		COLUM	IBUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!		DATE
	that is community	an annual full-scale exercise					
		nunity-based exercise is not					
	1 ' '	ict an annual individual,					
	facility-based fund						
	1	ility] facility experiences an					
	_ ' ' -	nan-made emergency that					
	requires activation	n of the emergency plan, the					
	LTC facility is exe	mpt from engaging its next					
		lle community-based or					
		based functional exercise					
	_	et of the emergency event.					
	1 ' '	dditional annual exercise					
	· ·	but is not limited to the					
	following:	and aversion that in					
	1 ' '	scale exercise that is					
	based functional	or an individual, facility					
	(B) A mock disas						
	1 ' '	ercise or workshop that is					
	led by a facilitator	· · · · · · · · · · · · · · · · · · ·					
	discussion, using						
	_	emergency scenario, and a					
	set of problem sta	•					
		pared questions designed					
	to challenge an er	•					
	(iii) Analyze the [l	LTC facility] facility's					
	response to and n	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	\$483 475(d)]·					
	l -	CF/IID must conduct					
	l ' '	he emergency plan at least					
		ie ICF/IID must do the					
	following:						
	_	n annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1XC21

Facility ID: 000572

If continuation sheet Page 7 of 53

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		A. BUILDING B. WING		COMPLETED 03/20/2023		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	accessible, conduction facility-based function (B) If the ICF/IID enatural or man-material activation of the enis exempt from engul-scale community-based function onset of the emerging (ii) Conduct an additivation may include, it following: (A) A second full-scommunity-based facility-based function (B) A mock disasted (C) A tabletop exelled by a facilitator discussion, using a clinically-relevant eset of problem star messages, or prepto challenge an entition (iii) Analyze the IC maintain document exercises, and emithe ICF/IID's emerities (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based; (A) When a control individual, facility-levery 2 years; or.	experiences an actual de emergency that requires mergency plan, the ICF/IID gaging in its next required ity-based or individual, tional exercise following the gency event. ditional annual exercise out is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or roise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. F/IID's response to and station of all drills, tabletop ergency events, and revise gency plan, as needed. 4.102] HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is for emmunity-based exercise	TAG	DEFICIENCY		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

 ${\it Facility ID:} \quad 000572$

If continuation sheet

Page 8 of 53

	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	ľ í	UILDING	NSTRUCTION	(X3) DATE COMPI 03/20	
	OF PROVIDER OR SUPPLIED	TH & REHABILITATION CENTER	₹	3550 CE	DDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	natural or man-ma activation of the exempt from enga full-scale communifacility based fundonset of the emer (ii) Conduct an activational exercise of this section is conclude, but is not (A) A second community-based facility-based fundonset of the functional exercise facility-based fundonset of the functional exercise facility-based fundonset of the functional exercise facility-based fundonset of facility-based fundonset of functional exercises of the functional exercises of problem statemes and entire the functional exercises, and entire the functional exercises, and entire the functional exercises to test to OPO must do the (i) Conduct a papor workshop at leaver exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan.	ade emergency that requires aging in its next required nity-based or individual, ctional exercise following the gency event. Iditional exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is a or an individual, ctional exercise; or isaster drill; or preserving exercise or workshop that the rand includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 9 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155535	B. W	NG _		03/20/	2023
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ENTRAL AVE		
\\/\ \ \ \\\\	CBOSSING HEAL	TH & REHABILITATION CENTER			1BUS, IN 47203		
VVILLOVV	CINOSSING FILAL	TH & REHABIEITATION CENTER		COLOIV			
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY)	
	-	n of the emergency plan, the					
	1	om engaging in its next					
	required testing exercise following the onset						
	of the emergency						
	1 ' '	PO's response to and					
		ntation of all tabletop					
	l ·	nergency events, and revise					
		OPO's] emergency plan, as					
	needed.						
	**	7.401					
	*[RNCHIs at §403						
	(d)(2) Testing. The RNHCl must conduct						
		he emergency plan. The					
	RNHCI must do th	<u> </u>					
		er-based, tabletop exercise					
	I -	A tabletop exercise is a					
		led by a facilitator, using a					
		r-relevant emergency et of problem statements,					
		s, or prepared questions					
	_	enge an emergency plan.					
	_	NHCI's response to and					
	1 ' '	ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 00)39	E 039 requires the facility to		04/07/2023
		tercises to test the emergency	- "	, , , ,	conduct exercises to test the		0 1/0 //2023
		per year, including			emergency plan annually.		
		drills using the emergency			No residents were harmed	bv	
		C facility must do the			the alleged deficient practice.	-	
	following:	•			director of Maintenance and th		
	(i) Participate in an	annual full-scale exercise that			Administrator was educated or	n	
	is community-based				the requirement that the facility	,	
	· ·	ity-based exercise is not			must participate in a full scale		
		an annual individual,			exercise that is community bas		
	facility-based funct	ional exercise.			and when a community based		
	b. If the LTC facilit	y experiences an actual natural			exercise is not accessible that		
		gency that requires activation			facility must complete a facility	,	
	of the emergency p	lan, the LTC facility is exempt			based functional exercise (Se		
	from engaging its n	ext required full-scale in a			Attachment A)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 10 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/20/2023		
		133333	D. W.	_		03/20/	2023
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203				
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		or individual, facility-based			No residents were affected	•	
	full-scale functional exercise for 1 year following				this alleged deficient practice.		
	the onset of the actu			residents had the potential to be			
	1 ' '	itional exercise that may			affected. The director of		
		imited to the following:			maintenance and Administrate	or	
	a. A second full-sca				has been educated on the		
		r an individual, facility-based			requirement that the facility m		
	functional exercise.				participate in a full scale exerc	cise	
	b. A mock disaster				that is community based and		
	_	se or workshop that is led by a			when a community based		
		des a group discussion, using			exercise is not accessible that		
	·	y relevant emergency scenario,			facility must complete a facility	y	
	_	n statements, directed		based functional exercise			
		red questions designed to			3. The Facility's Emergency		
	challenge an emerg				Preparedness Program/Plan v		
		CC facility's response to and	reviewed with no changes made to				
		ation of all drills, tabletop		the policy. The Administrator will			
		gency events, and revise the			be responsible for attending a		
		gency plan, as needed in			community- based exercise (S		
	accordance with 42				Attachment B) Registration fo		
	1	ice could affect all occupants			Community based exercise or		
	in the facility.				May 16th and 17th. 2023 (See		
					Attachment C) a facility based		
	Findings include:				functional exercise that has be		
					completed until the facility is a		
		the Emergency Preparedness			to attend the community- base		
	_	23 between 9:30 a.m. and 2:00			exercise on May 16th and 17t		
	1 ^	enance Director and			4. The Administrator, director	of	
		for from a sister facility			maintenance or designee will		
		was able to provide			review monthly to ensure all		
		wo tabletop exercises dated			required exercises have been		
		/23, however, the facility was	1		completed, and the facility atte	ends	
	unable to provide d				the next community exercise.		
		xercise performed during the			Any negative findings will be		
		od. This was confirmed by the			immediately corrected. Monito	•	
		e Director during record			forms will be reviewed monthl	-	
	review.				during quality assurance mee	tings	
					and will remain ongoing for		
	_	viewed with both Maintenance			compliance. (See Attachment	D)	
	Director's during the	e exit conference.			5. The above corrective meas	sures	

I1XC21

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/20/2023	
NAME OF PROVIDER OR SUPPLIE WILLOW CROSSING HEA	GR LTH & REHABILITATION CENTER	3550	ET ADDRESS, CITY, STATE, ZIP CO D CENTRAL AVE UMBUS, IN 47203	D .		
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
			will be completed on or April 7th, 2023.	before		
Bldg §482.15(e) Cond (e) Emergency at The hospital must standby power semergency plan this section and procedures plan (i) and (ii) of this §483.73(e), §488 (e) Emergency at The [LTC facility implement emergency generator must be the location required care Facilities Conterim Amendments TIA and TIA 12-4), a structure is built structure or build 482.15(e)(2), §48 Emergency generator must be the location required care facilities Conterim Amendments TIA and TIA 12-4), a structure is built structure or build 482.15(e)(2), §48 Emergency generator the entity of the properties of the	d LTC Emergency Power lition for Participation: nd standby power systems. st implement emergency and systems based on the set forth in paragraph (a) of in the policies and set forth in paragraphs (b)(1) section. 5.625(e) and standby power systems. and the CAH] must gency and standby power on the emergency plan set th (a) of this section. 483.73(e)(1), §485.625(e)(1) erator location. The pe located in accordance with irements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety I and Tentative Interim A 12-1, TIA 12-2, TIA 12-3, and NFPA 110, when a new or when an existing					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 12 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155535	B. W	ING		03/20/	/2023
NAME OF I	DEOMDED OF CHIRD TER)	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER			3550 CI	ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	IBUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY 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
	· ·	FPA 110, and Life Safety					
	Code.						
	/82 15(a)(3) 8/8°	3 73(a)(3)					
	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs						
	and LTC facilities] that maintain an onsite fuel						
	source to power emergency generators must						
		w it will keep emergency					
		perational during the					
	emergency, unles						
	*[For hospitals at	§482.15(h), LTC at					
	§483.73(g), and CAHs §485.625(g):]						
		corporated by reference in					
	-	pproved for incorporation by					
	-	Director of the Office of the					
	_	n accordance with 5 U.S.C.					
	` '	R part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	, ,	mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:	on gov/fodoral register/oode					
	1	es.gov/federal_register/code					
		ations/ibr_locations.html. this edition of the Code are					
	, ,	eference, CMS will publish a					
	1 .	ederal Register to					
	announce the cha						
		Protection Association, 1					
	Batterymarch Parl						
	Quincy, MA 02169						
	1.617.770.3000.	-,					
		th Care Facilities Code,					
		ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99 issued	` ,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 13 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		155535	B. W	NG		03/20/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	/IBUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	(III) 11A 12-3 to NF 2012.	FPA 99, issued August 9,					
		FPA 99, issued March 7,					
	2013.	1 A 99, Issued March 1,					
	(v) TIA 12-5 to NFPA 99, issued August 1,						
	2013.	•					
	' '	FPA 99, issued March 3,					
	2014.	fo Cofety Code 2010					
	edition, issued Au	fe Safety Code, 2012					
		IFPA 101, issued August					
	11, 2011.	Tr / To I, Issaed / August					
	· ·	FPA 101, issued October					
	30, 2012.	•					
	(x) TIA 12-3 to NF	PA 101, issued October					
	22, 2013.						
	, , ,	FPA 101, issued October					
	22, 2013.						
		standard for Emergency and					
		ystems, 2010 edition, chapter 7, issued August 6,					
	2009	Chapter 7, issued August 6,					
		view and interview, the facility	E 00)41	E-041 requires that the facilit	V	04/07/2023
		the emergency power system		, 11	implement Emergency Genera	•	01/07/2023
	_	and maintenance requirements			inspection, testing, and		
		Care Facilities Code, NFPA			maintenance.		
	110, and Life Safet	y Code in accordance with 42			1. No residents were harmed	by	
	CFR 483.73(e)(2).				this alleged deficient practice.	The	
					director of maintenance has be		
		review and interview, the			educated on the documentation		
		intain a complete written record			requirements for the emergen	СУ	
		or load testing for 1 of 1 e past 12 months. Chapter			generator including how to		
		12 NFPA 99 requires monthly			properly document the actual minimum 30 minute weekly rule	n	
		ator serving the emergency			time, how to complete the mor		
		be in accordance with NFPA			load testing for the generator	y	
		or Emergency and Standby			including the proper cool dowr	1	
		hapter 8. Chapter 8.4.2.			time, and the requirement to h		
	Section 8.4.2 states	diesel generator sets in			battery powered light set at the		
	service shall be exe	rcised at least once monthly,			emergency generator with		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1XC21

Facility ID: 000572

If continuation sheet Page 14 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/20/2023		
NAME OF I	PROVIDER OR SUPPLIER	₹	•		ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE	_	
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUMBUS, IN 47203			
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		0 minutes, using one of the			functional testing conducted		
	following methods:				monthly for not less than 30		
	(1) Loading that maintains the minimum exhaust				seconds, functional testing		
		s recommended by the			annually for a minimum of 90		
	manufacturer				minutes, visual inspections ar		
		g temperature conditions and at			tests shall be kept for inspect		
	•	cent of the EPS (Emergency			(Attachment A) picture of light	İ	
	Power Supply) nam				(Attachment E)		
		es diesel-powered EPS			2. No residents were harmed		
		not meet the requirements of			this alleged deficient practice.		
		ised monthly with the available			resident had the potential to b	е	
	, ,	Power Supply System) load and			affected. The director of		
	shall be exercised annually with supplemental				maintenance has been educa	ted	
	`	Test) at not less than 50 percent			on the documentation		
	_	ate kW rating for 30 continuous			requirements for the emerger	су	
		less than 75 percent of the EPS			generator including how to		
	_	ng for 1 continuous hour for a			properly document the actual	h	
		f not less than 1.5 continuous			minimum 30 minute run time,	now	
	hours.	AIEDA 00 magninga a vimittan			to complete the monthly load	ali.a. a.	
		NFPA 99 requires a written 1, performance, exercising			testing for the generator inclu	-	
	_	for the generator to be			the proper cool down time, ar	u me	
	_	ed and available for inspection			requirement to have battery powered light set at the		
		ving jurisdiction. This			emergency generator with		
		ould affect all residents, staff,			functional testing conducted		
	and visitors.	cara arrest un regraciito, stari,			monthly for not less than 30		
					seconds, functional testing		
	Findings include:				annually for a minimum of 90		
					minutes, visual inspections ar	nd	
	Based on record rev	view on 03/20/23 between 9:30			tests shall be kept for inspect		
		with the Maintenance Director			The facility's emergency		
	_	Director from a sister facility			generator logs were reviewed	with	
		no documentation on the			no changes needed. The dire		
		or monthly test form for a			of maintenance or designee v		
		during the monthly load tests			responsible for completing the		
	during the past 12 r	nonths. The information			emergency generator logs wit		
		ne was based on a counter			actual start and stop times for		
	number from the ge	enerator panel. Based on			minimum 30 minute run time,		
		e of record review, the facility			completing the monthly load		
	Maintenance Direct	tor agreed the actual run time			testing with the proper cool do	own	

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING		COMPLE	
		155535	B. WIN	IG		03/20/2	2023
		L	'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER			IBUS, IN 47203	_	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cumented on the monthly			time, and completing the visua	al	
	generator load test f	form.			inspection and testing of the		
					battery powered light set locat	ed	
	This finding was reviewed with both Maintenance				at the emergency generator.		
	Director's during the	Director's during the exit conference.			(Attachment F)	,	
	2 D1	and an artist of			4. The Administrator, director		
		review and interview, the intain a complete written record			maintenance or designee will	pe	
	•	or load testing for 1 of 1			responsible to review the		
		e past 12 months. Chapter			emergency generator documentation weekly to ensu	ıro	
	_	12 NFPA 99 requires monthly			the required documentation ha		
	` ′	ator serving the emergency			been completed as required.		
		be in accordance with NFPA			negative findings will be	y	
	-	or Emergency and Standby			immediately corrected. Monito	rina	
		hapter 8. Chapter 6.4.4.2 of			logs will be reviewed monthly	9	
	-	written record of inspection,			during the quality assurance		
	-	ising period, and repairs for the			meetings and will remain ongo	oing	
	generator to be regu	larly maintained and available			for compliance. (Attachment D	- 1	
	for inspection by the	e authority having			·	, l	
	jurisdiction. NFPA	110, 6.4.2.1.5.9 Time Delay on			5. The above corrective meas	sures	
	Engine Shutdown re	equires that a minimum time			will be completed on or before		
		shall be provided for unloaded			April 7th, 2023.		
	_	rgency Power Supply (EPS)					
	*	This delay provides					
	_	ool down. This time delay					
	-	d on small (15 kW or less)					
	_	overs. This deficient practice					
	could affect all resid	dents, staff, and visitors.					
	Findings include:						
		view on 03/20/23 between 9:30					
	-	with the Maintenance Director					
		irector from a sister facility					
	-	ocumentation on the					
		oad test log for a cool down					
	_	l test, however, it was					
		-minute cool down time only					
	-	ns (when the facility's new					
	generator was instal	lled). Based on interview at	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 16 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		A. BUILDING COMPLETED B. WING 03/20/2023			ETED		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CE	DDRESS, CITY, STATE, ZIP COD ENTRAL AVE BUS, IN 47203		
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
mo	the time of record re Director said the co- generator was at lea	eview, the facility Maintenance ol down time for the new st 10 minutes but was nthly generator load test form		mo			Bill
	This finding was reviewed with both Maintenance Director's during the exit conference.						
	facility failed to ensigenerator was provilight set. NFPA 110 requires the Level 1 location(s) shall be battery-powered em requirement shall no outdoors in enclosus access. Section 7.9.2 testing shall be condiminimum of 3 week between tests, for no Functional testing shall be condiminimum of 1 1/2 system is battery poof visual inspections the owner for inspections. This deresidents in the facility	respency lighting. This of apply to units located res that do not include walk-in 3.1.1 (1) requires functional ducted monthly, with a res and a maximum of 5 weeks of less than 30 seconds, (3) shall be conducted annually for hours if the emergency lighting wered and (5) Written records and tests shall be kept by cition by the authority having reficient practice could affect all					
	Findings include: Based on observation	ons on 03/20/23 between 2:00					
	p.m. and 4:45 p.m. of the Maintenance Di Director from a siste powered light set at The emergency gen feet from the rear pa	during a tour of the facility with rector and Maintenance er facility, there was no battery the emergency generator. erator was located at least 100 arking lot. Based on an e of record review, the facility					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 17 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		l í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/20/2023		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTE	R	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Director confirmed there was no battery powered light set at the emergency generator.			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0000	This finding was red	viewed with both Maintenance e exit conference.					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 03/20 Facility Number: 0 Provider Number: 100 At this Life Safety O Health & Rehabilita compliance with Re Medicare/Medicaid Life Safety From Fi National Fire Protec Life Safety Code (L Health Care Occupa This one story facili Type V (111) const: The facility has a fi detection in the corr corridor and hard w resident rooms. The and had a census of	00572 155535	K 0	000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirer under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due the low scope and severity of survey finding, please find the sufficient documentation provievidence of compliance with the plan of correction. The documentation serves to confit the facility's allegation of compliance. Thus, the facility respectfully requests the gran of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.	on The and ment ase to the ding he irm	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 18 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMP				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155535	B. WI		<u>01</u>	03/20/	
		155555	B. WI			03/20/	2023
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	DATE
	services were sprink	klered.					
	Quality Review completed on 03/27/23						
K 0100	0 NFPA 101						ľ
SS=E	General Requirem	nents - Other					
Bldg. 01	General Requirem						
	List in the REMAR	RKS section any LSC					
	Section 18.1 and	19.1 General Requirements					
		ssed by the provided					
	•	ficient. This information,					
		olicable Life Safety Code or					
		tation, should be included					
	on Form CMS-256				K 100 requires the lounday area		
		on and interview, the facility	K 0	100	K 100 requires the laundry are		04/07/2023
		f 1 laundry area dryer room			dryer room enclosure to be fre		
		of lint and trash. NFPA 101 at health care facilities shall be			lint and trash.		
		ed, maintained and operated			No residents were harmed the alleged deficient practice.	-	
	_	sibility of a fire emergency			the alleged deficient practice. I laundry area dryer enclosure h		
	_	ation of occupants. This			been cleaned and is free of lin		
		ould affect mostly laundry			and trash. (Attachment G) The		
	staff, plus residents				director of maintenance has be		
	compartment.				educated on ensuring that the	,011	
	1				dryer room enclosure remains	free	
	Findings include:				from lint and trash. (Attachmer 2. No residents were harmed	nt A)	
		ons on 03/20/23 between 2:00			this alleged deficient practice.	All	
		during a tour of the facility with			resident had the potential to be	•	
		rector and Maintenance			affected. The director of		
		er facility, the floor and			maintenance has been educat		
		ck of the dryer enclosure			on ensuring that the dryer roor		
		area was substantially covered			enclosure remains free from lin	nt	
		some paper and plastic trash.			and trash.		
		at the time of observation, the			3. The facility's preventative		
		e Director agreed there was a			maintenance plan for dryers w		
		of dryer lint and paper and			reviewed with no changes nee		
	_	floor and equipment within the			The director of maintenance w		
		e dryers, and further said they			required to keep the dryers an		
	would increase the cleaning schedule.		Ī		the dryer room enclosure free	IIOIII	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 19 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPLETED	
		155535	B. WI	NG		03/20/	2023
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)				any lint and trash. 4. The Administrator, director maintenance or designee will I responsible to monitor the dry room enclosure to ensure that remains free from lint and tras Any negative findings will be corrected immediately. The monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance (Attachment D) 5. The above corrective meas will be completed on or before April 7th, 2023	oe er it h. ed e.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 8 exit discharge areas. This deficient practice could affect up to 30 residents if needing to exit the main dining room. Findings include: Based on observations on 03/20/23 between 2:00 p.m. and 4:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Director from a sister facility, the outside exit from		K 02	271	K271 requires the walking sur from an exit to be a smooth transition to prevent any trippir hazards. 1. No residents were harmed the alleged deficient practice. Concrete Slab and connecting sidewalk has been repaired to provide a smooth transition to prevent any tripping hazards. (Attachment H) The director of maintenance has been educated.	ng by The	04/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 20 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/20/2023		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF the main dining roo	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION om had a nine foot long, rel change between the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) on the requirement that all concrete slabs and sidewalks	51112		
	one-to-two-inch lev concrete slab and the public way. The les and connecting side be a tripping hazard the event of an emet the time of observation Director agreed the change in the concresidewalk from the residence of the control	rel change between the ne connecting sidewalk to the vel change in the concrete slab ewalk to the public way could If while exiting from this area in regency. Based on interview at tion, the facility Maintenance are was a one-to-two-inch level rete slab and connecting main dining room.		concrete slabs and sidewalks exits must be a smooth transi to prevent any tripping hazard (Attachment A) 2. No residents were harmed this alleged deficient practice, resident had the potential to be affected. The director of maintenance has been educa on the requirement that all concrete slabs and sidewalks exits must be a smooth transi to prevent any tripping hazard. 3. The facility's preventative maintenance for outside of fact was reviewed with no change required. The director of maintenance will be responsite ensure all exits are maintaine prevent any tripping hazards. 4. The Administrator, director maintenance or designee will responsible to check the exit areas of the facility to ensure remain free from any uneven concrete that could cause a tripping hazard. Any negative findings will be corrected immediately. The monitoring I will be reviewed during the mediately. The monitoring I will be reviewed during the mediately assurance meetings at will remain ongoing for compliance. (Attachment D) 5. The above corrective mean will be completed on or before April 7th, 2023.	tion ds. by All de ted at tion ds. cility s ble to d to of be they ogs onthly nd sures		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: I1XC21 Facility ID: 000572 If continuation sheet Page 21 of 53

PRINTED: 04/18/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED		
		155535	B. WING		03/20/2023		
	T	TH & REHABILITATION CENTER					
PREFIX TAG	(EACH DEFICIEN	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)	(X5) COMPLETION DATE		
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be either or capable of auto manual interventic 18.2.8, 19.2.8 Based on observatic failed to ensure the egress was properly leave the area in darillumination shall be failure of any single in an illumination le in any designated are could affect at least and visitors. Findings include: Based on observatic p.m. and 4:45 p.m. the Maintenance Di Director from a siste exterior light with or Room egress hall extime of observations, the facility Mainten	ans of Egress ans of egress, including exit anged in accordance with 7.8 recontinuously in operation imatic operation without on. On and interview, the facility lighting for 1 of 8 exit means of a maintained and would not ackness. LSC 7.8.1.4 requires a arranged so that that the alighting unit does not result evel of less than 0.2 foot-candle area. This deficient practice 10 residents as well as staff Ons on 03/20/23 between 2:00 during a tour of the facility with a rector and Maintenance are facility, there was only one one bulb outside the Activity acit. Based on interview at the part of the facility with an acknowledged by annee Director.	K 0281	K281 requires that the facility ensure illumination of means of egress 1. No residents were harmed the alleged deficient practice. lighting has been changed out the Activity Room door to inclumore than 1 light bulb (Attachrell) The director of maintenance been educated (Attachment A ensure the lighting for means egress was properly maintaine and would not leave any area darkness. 2. No residents were harmed this alleged deficient practice. resident had the potential to be affected. ensure The director of maintenance has been educated (Attachment A) to the lighting means of egress was properly maintained and would not leave any area in darkness. 3. The facility's preventative maintenance for outside of the facility was reviewed with no changes required. The director maintenance will be responsible ensure all lighting for means of egress at all exits to the facility.	The side ude ment has) to of ed in H by All e of ted for ve		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

 ${\it Facility ID:} \quad 000572$

maintained to prevent the

If continuation sheet

Page 22 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE S COMPLE 03/20/2	ETED
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 C	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVE MBUS, IN 47203		
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
K 0341 SS=E Bldg. 01	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1, Based on observation failed to ensure 3 of	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment. wiring or other is are monitored for	K 0341	possibility of leaving any area darkness. 4. The Administrator, director maintenance or designee will responsible to monitor (Attachment D) all outside exensure the proper lighting is place to prevent any area be left in darkness. Any negative findings will be corrected immediately. The monitoring will be reviewed during the moutable quality assurance meetings awill remain ongoing for compliance. 5. The above corrective measuill be completed on or before April 7th, 2023.	or of I be kits to in ing e logs nonthly and asures re	04/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 23 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155535	B. W	ING		03/20/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER			1BUS, IN 47203		
			1				T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		t ito	DATE
		where air flow would adversely NFPA 72, 2010 edition,			air flow would adversely affect	เ เเร	
	*	that smoke detectors shall not			operation.	by	
	-	in the airstream of supply			 No residents were harmed the alleged deficient practice. 	-	
					director of maintenance has b		
	registers. Section 17.7.4.1 requires in spaces served by air handling systems; detectors shall				educated (Attachment A) to the		
	-	- -			requirement that all hard wired		
	not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors				smoke detectors should not be		
		ed in a direct airflow or closer			located in a direct airflow or cl		
		an air supply diffuser or			than 36 inches from an air sup		
		This deficient practice could			diffuser or return air opening.		
	affect at least 20 residents, staff, and visitors.				hard wired smoke detectors h		
	arrest at reast 20 residents, starr, and visitors.				been re located away from air		
	Findings include:				supply diffusers and return air		
					openings. (Attachment J)		
	Based on observation	ons on 03/20/23 between 2:00			No residents were harmed	d by	
		during a tour of the facility with			this alleged deficient practice.	-	
		rector and Maintenance			resident had the potential to b		
	Director from a sist	er facility, the following was			affected. The director of		
	noted:	·			maintenance has been educa	ted	
	a. There was a ceil	ing mounted smoke detector			to the requirement that all har	d	
	within three feet of	an air supply vent in the			wired smoke detectors should		
	Movie Theatre.				be located in a direct airflow o	r	
		ing mounted smoke detector			closer than 36 inches from an	air	
	within three feet of	an air supply vent in the			supply diffuser or return air		
	Library.				opening. The hard wired smol	ке	
		ing mounted smoke detector			detectors have been re locate		
		in air supply vent in the			away from air supply diffusers		
	Maintenance Office				return air openings. (Attachme	ent J)	
	Based on interview				3. The facility's interior		
		ility Maintenance Director			preventative maintenance pro	gram	
	-	etectors in question were too			was reviewed and updated to		
	close to air supply v	vents.			check all hard wired smoke		
	TE1 : C 1:	t i did disetti			detectors to ensure none are		
	_	viewed with both Maintenance			installed to where air flow wou	ıld	
	Director's during th	e exit conterence.			adversely affect its operation.		
	2.1.10(1)				4. The Administrator, director		
	3.1-19(b)				maintenance or designee will	pe	
					responsible to monitor		
	l		1		(Attachment D) all hard wired		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572 If continuation sheet Page 24 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		A. BUILDING B. WING	01	COMPLETED 03/20/2023
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203	
(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)	(X5) COMPLETION DATE
				smoke detectors in the facility ensure none are within 36 inch of an air supply diffuser or retuair opening. Any negative findiwill be corrected immediately. monitoring logs will be reviewed during the monthly quality assurance meetings and will remain ongoing for compliance 5. The above corrective meas will be completed on or before April 7th, 2023.	nes urn ings The ed e. sures
K 0345 SS=E Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, NI Based on record rev failed to ensure door show that all 82 smo portion of the facilit within the past 24 m National Fire Alarm 14.4.5.3.1 states det checked within 1 ye alternate year therea required calibration indicate that the determined complete in the state of the complete in the com	n is tested and maintained an approved program requirements of NFPA 70, code, and NFPA 72, an and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 riew and interview, the facility sumentation was available to obke detectors in the existing ry were sensitivity tested anonths or prior. NFPA 72, a Code, 2010 Edition, Section rector sensitivity shall be ar of installation, and every after. After the second test, if sensitivity tests remained within its	K 0345	K345 requires that the facility ensure that all smoke detector are sensitivity tested within 24 months. 1. No residents were harmed the alleged deficient practice. director of maintenance has be educated (Attachment A) to the requirement that the smoke detectors have to be sensitivity tested every 24 months or price.	by The een e y yor.
	time between calibra	ensitivity range, the length of ation tests shall be permitted maximum of 5 years. If the		The smoke detectors have be sensitivity tested. (Attachment 2. No residents were harmed	K)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 25 of 53

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION O O O O O O O O O O O O	COMP	E SURVEY PLETED 0/2023
	PROVIDER OR SUPPLIEF	TH & REHABILITATION CENTER	3550	ET ADDRESS, CITY, STATE, ZIP O CENTRAL AVE .UMBUS, IN 47203	COD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	nuisance alarms and alarms shall be main where nuisance alarms where nuisance alar previous year, calib To ensure that each listed and marked setsed using any of (1) Calibrated test of (2) Manufacturer's instrument. (3) Listed control expurpose. (4) Smoke detectors arrangement where at the control unit with its listed sensitivity (5) Other calibrated to the authority have Detectors found to listed and marked seleaned and recalib The detector sensiti measured using any an unmeasured condetector. This defice residents, staff, and Findings include: Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of the parecent smoke detector sensiti materials. Based on record revision of record r	nethod. calibrated sensitivity test quipment arranged for the /fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ing jurisdiction. have sensitivity outside the ensitivity range shall be		this alleged deficient resident had the pote affected. The director maintenance has been to the requirement the detectors have to be tested every 24 month The smoke detectors sensitivity tested. (Attable Elwood Fire. 3. The facility's smoke was tested and no conted. 4. The Administrator Maintenance or design responsible to monitor (Attachment D) the fasensitivity reports to sensitivity is complete months or prior. Any findings will be correct immediately. The mowill be reviewed during quality assurance mewill remain ongoing for compliance. 5. The above correct measures will be combefore April 7th, 2023	ential to be of of on educated at the smoke sensitivity hs or prior. have been tachment K) on educated at the smoke sensitivity hs or prior. have been tachment K) on education of gnee will be or educated on or education of gnee will be or educated on or educ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 26 of 53

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/20/2023
	PROVIDER OR SUPPLIEF	TH & REHABILITATION CENTE	3550 C	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVE MBUS, IN 47203	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	02/12/21.	ocumentation available since			
	Director's during th 3.1-19(b)	e exit conference.			
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar	· 			
		•			
	Based on observation failed to ensure spring compartments cover replaced. NFPA 25 sprinklers shall not be free of corrosion physical damage; and correct orientation (sidewall). Furthern that shows signs of	inkler heads in 1 of 5 smoke red with corrosion were 5, 2011 edition, at 5.2.1.1.1 show signs of leakage; shall a, foreign materials, paint, and and shall be installed in the (e.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be ge (2) Corrosion (3) Physical	K 0353	K353 requires automatic sprink heads to be free from any corrosion, foreign material, pair and physical damage. 1. No residents were harmed the alleged deficient practice. If director of maintenance has be educated (Attachment A) to the requirement that the sprinkler heads must remain free from corrosion, foreign material, pair	nt, by The een

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 27 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155535		· ′	JILDING	onstruction 01	(X3) DATE (COMPL 03/20/	ETED	
	PROVIDER OR SUPPLIEF	TH & REHABILITATION CENTER		3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
	SUMMARY (EACH DEFICIENT REGULATORY OF Damage (4) Loss of responsive element unless painted by the This deficient practical plus any resident we compartment. Findings include: Based on observation p.m. and 4:45 p.m. the Maintenance Di Director from a sist sprinkler head in the covered with green at the time of observation Maintenance Director the 100 Hall Mechangreen corrosion and	TH & REHABILITATION CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION If fluid in the glass bulb heat (5) Loading (6) Painting The sprinkler manufacturer. The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff In the same smoke The could affect mostly staff The could affect		3550 CI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) and physical damage. The sprinkler head in the 100 hall mechanical room has been replaced. (Attachment L) 2. No residents were harmed this alleged deficient practice. resident had the potential to baffected. The director of maintenance has been educate to the requirement that the sprinkler heads must remain for from corrosion, foreign material paint, and physical damage. The sprinkler head in the 100 hall mechanical room has been replaced. 3. The facility's sprinkler head throughout the facility were all checked to ensure they remain free from corrosion, foreign material, paint, and physical damage. 4. The Administrator, Director maintenance or designee will responsible to check sprinkler heads throughout the facility	I by All e ted ree al , rhe	(X5) COMPLETION DATE
					(Attachment D) to ensure they remain free from corrosion, for material, paint, and physical damage. Any negative finding be corrected immediately. The monitoring logs will be reviewed during the monthly quality assurance meetings and will remain ongoing for compliance. The above corrective meas will be completed on or before April 7th, 2023.	reign s will e ed e. sures	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1XC21

Facility ID: 000572

If continuation sheet Page 28 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 03/20/2023			ETED		
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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)	TE	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 3 of provided with ground (GFCI) protection a 70, NEC 2011 Edition Circuit-Interrupter I states, ground-fault personnel shall be permitted to with 426.28 or 427.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric italiations can continue in no hazard to life. 9, 9.1.1, 9.1.2 on and interview, the facility fover 20 wet locations, were nd fault circuit interrupter regainst electric shock. NFPA ion at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault hall be installed in a readily ESee 215.9 for ground-fault rotection for personnel on relling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault rotection for personnel.	K 0	511	K511 requires ground fault cirinterrupter GFCI receptacles binstalled close to all wet location. No residents were harmed the alleged deficient practice. director of maintenance has beeducated (Attachment A) to the requirement for installation of receptacles near any wet located throughout the facility. The identified receptacles have all been replaced with a new GFC receptacle. (Attachment M) 2. No residents were harmed this alleged deficient practice. resident had the potential to be affected. The director of maintenance has been educated regarding the requirement for installation of GFCI receptacle near any wet location throughout the facility. 3. The facility's Interior preventative maintenance log been updated to include check GFCI receptacles to ensure the are installed near all wet location to prevent any hazards to life, electric shock. 4. The Administrator,	be ons. by The een e GFCI tion CI by All e e ed es out has king ey	04/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 29 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	ETED
		155535	B. WIN	NG		03/20/	/2023
				CTREET A	DDBECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
14/11 1 014/	ODOCOINO LIEAL	TIL & DELIABILITATION OFNITED			ENTRAL AVE		
VVILLOVV	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	IBUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	only, where the con	ditions of maintenance and			Maintenance Director or desig	nee	
	supervision ensure	that only qualified personnel			will be responsible to check al		
	_	sured equipment grounding			wet locations throughout facilit		
		as specified in 590.6(B)(2)			ensure all have GFCI receptac	-	
		or only those receptacle			installed to prevent electric she		
	_	ly equipment that would			(Attachment D) Any negative		
		ard if power is interrupted or			findings will be corrected		
	_	t is not compatible with GFCI			immediately. The monitoring lo	oas	
	protection.	1			will be reviewed during the mo	-	
	1 ^	eceptacles are installed within			quality assurance meetings ar	-	
		outside edge of the sink.			will remain ongoing for		
	` ′	(5): In industrial laboratories,			compliance.		
		supply equipment where			The above corrective measure	ures	
	_	vould introduce a greater			will be completed on or before		
		mitted to be installed without			April 7th, 2023.		
	GFCI protection.	milica to so histanica without			πριτι τιτι, 2020.		
	_	(5): For receptacles located in					
		s of general care or critical					
	1 -	care facilities other than those					
	covered under	care racinties other than those					
		protection shall not be required.					
	(6) Indoor wet locat						
		with associated showering					
	facilities	The abbotated bile world					
		e bays, and similar areas where					
	electrical						
		nt, electrical hand tools.					
		Wet Locations, requires all					
		ed equipment within the area of					
	_	have ground-fault circuit					
		protection. Note: Moisture can					
		resistance of the body, and					
		is more subject to failure.					
		ice could affect staff only.					
	This deficient pract	ice could unlest start only.					
	Findings include:						
	Based on absorbed	ons on 03/20/23 between 2:00					
		during a tour of the facility with					
	the Maintenance Di	rector and Maintenance					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 30 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/20/2023	
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 C	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE MBUS, IN 47203	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	Director from a sistenoted:	er facility, the following was	TAG	DEFICIENCY)	DATE
	within three feet of was not provided w	the sink in the Med Room that ith GFCI protection. When testing device, the electric			
	circuit was not brok b. There was one el				
	sink. The receptacle however, when teste	e was a GFCI receptacle, ed with a GFCI testing device, ated it was wired Hot/Neutral			
	Reverse and did not c. There was one si	break the circuit when tested. ngle electrical receptacle and l receptacle in the kitchen,			
	not provided with C with a GFCI testing	et of the single sink, that were FCI protection. When tested device, the electric circuit for			
	properly GFCI prote	-			
	This finding was red Director's during the	viewed with both Maintenance e exit conference.			
IZ 0764	3.1-19(b)				
K 0761 SS=F Bldg. 01					
	interview; the facili inspection and testin door assembly and doors assembly betv portions of the Skill in accordance with	on, record review, and ty failed to ensure an annual ng of 1 of 1 oxygen room fire 1 of 1 set of separation fire ween the New and Existing ed Care Units were completed LSC 19.1.1.4.1.1. enings in dividing fire barriers	K 0761	K761 requires maintenance, testing, and inspection of all fi doors 1. No residents were harmed the alleged deficient practice. director of maintenance has b educated on the fire door inspections, testing and	by The

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 31 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2023	
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 C	ADDRESS, CITY, STATE, ZIP COD EENTRAL AVE MBUS, IN 47203	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	required by 19.1.1.4	R LSC IDENTIFYING INFORMATION 4.1 shall be permitted only in	TAG	maintenance to include all fire	
	self-closing fire do	be protected by approved or assemblies. (See also		doors. (Attachment A) The fact map has been updated to incl	-
		8.3.3.1 Openings required to on rating by Table 8.3.4.2 shall		all fire doors that need inspect tested, and maintained. The	ted,
		proved, listed, labeled fire door window assemblies and their		director of maintenance has completed the fire door assen	ably
	accompanying hard	lware, including all frames,		maintenance, testing, and	ibly
		chorage, and sills in e requirements of NFPA 80,		inspections of the oxygen transfilling room, and the set of	of .
	Standard for Fire D	oors and Other Opening		separation fire doors assemble	у
	Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies			between the new and existing portions of the units with no	
	shall be inspected and tested not less than			concerns noted. (Attachment	•
	1	tten record of the inspection kept for inspection by the		No residents were harmed this alleged deficient practice.	·
		2.4.1 states fire door assemblies		residents had the potential to	be
		spected from both sides to ondition of door assembly.		affected. The director of maintenance has been educa	ted
	NEDA 80 5242 g	tates as a minimum, the		regarding the annual maintena	
	following items sha			testing, and inspection of all fi doors.	ie
	(1) No open holes of either the door or fr	or breaks exist in surfaces of		3. The facility's annual maintenance, inspection, and	
		light frames, and glazing beads		testing form was reviewed with	h no
	are intact and secur equipped.	rely fastened in place, if so		changes needed. The facility's map was updated to include a	
	(3) The door, frame	e, hinges, hardware, and		doors that need maintenance,	
		reshold are secured, aligned, er with no visible signs of		testing, and inspection. 4. The Administrator, director	of
	damage.			maintenance, or designee will	be
	(4) No parts are mis	ssing or broken. s do not exceed clearances		responsible to check all fire do to ensure all have been	oors
	listed in 4.8.4 and 6			maintained, inspected, and te	sted
		g device is operational; that is,		annually. (Attachment D) Any	
	from the full open	oppletely closes when operated position.		negative findings will be corre immediately. The monitoring leads	
	(7) If a coordinator	is installed, the inactive leaf		will be reviewed during the mo	-
	closes before the ac			quality assurance meetings ar	nd
	(8) Latching hardw	are operates and secures the		will remain ongoing for	

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535		UILDING	onstruction 01	(X3) DATE COMPL 03/20	ETED
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	l	3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE MBUS, IN 47203		
(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)	TE	(X5) COMPLETION DATE
TAG	door when it is in the (9) Auxiliary hardwork prohibit operation as frame. (10) No field modification (11) Gasketing and inspected to verify the This deficient pract as well as staff, and Findings include: Based on record revalum, and 2:00 p.m. and Maintenance Direct documentation for a oxygen transfilling the set of separation the New and Existin Units during the pasinterview at the tim Maintenance Direct door assembly insperview. Based on othe facility with both between 2:00 p.m. at there was one oxygen assembly and one sassembly between tof the Skilled Care.	re closed position. Frare items that interfere or re not installed on the door or recard installed on the door or recard in the provide and integrity. The provide rector from a sister facility was unable to provide an annual inspection of the room fire door assembly and a fire doors assembly between region portions of the Skilled Care at 12 month period. Based on re of record review, the facility for confirmed there were no fire rection records available to observations during a tour of the Maintenance Director's read 4:45 p.m., it was confirmed the ransfilling room fire door ret of separation fire doors the New and Existing portions Units noted in the facility.		TAG	compliance. 5. The above corrective measuril be completed on or before April 7th, 2023.	sures	DATE
K 0781	NFPA 101						
SS=E	Portable Space H	eaters					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 33 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/20/2023 155535 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3550 CENTRAL AVE WILLOW CROSSING HEALTH & REHABILITATION CENTER COLUMBUS, IN 47203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 K781 requires heating elements Based on record review, observation, and K 0781 04/07/2023 interview; the facility failed to ensure complete not to exceed 212 degrees documentation was provided for the use of fahrenheit in space heaters that portable space heaters in staff areas only. This are used in employee areas. deficient practice could affect staff in the 1. No residents were harmed by Respiratory Office, plus any residents and staff the alleged deficient practice. The within the same smoke compartment. director of maintenance has been educated on space heater Findings include: requirements in employee areas (Attachment A). The space heater Based on record review on 03/20/23 between 9:30 located in the respiratory office a.m. and 2:00 p.m. with the Maintenance Director has been removed. (Attachment and Maintenance Director of a sister facility present, the facility did have a portable space 2. No residents were harmed by heater policy and procedure that allowed portable this alleged deficient practice. All space heaters to be used in staff areas only. The residents had the potential to be policy also indicated the heating elements in such affected. The director of devices to not exceed 212 degrees F. Based on maintenance has been educated observations between 2:00 p.m. and 4:45 p.m. on space heater requirements. during a tour of the facility with both 3. The facility's space heater Maintenance Director's, there was a portable policy and procedure was reviewed space heater turned on in the Respiratory Office with no changes needed. The while no staff was present. Respiratory staff did space heater was removed from show up within a few minutes. Furthermore, there the RT office. was no documentation available either on the 4. The Administrator, director of portable space heater or in written/booklet form to maintenance, or designee will be show that the heating element would not exceed responsible to check all employee 212 degrees F. This was confirmed by the facility areas to ensure there are no Maintenance Director at the time of observation. space heaters in use. (Attachment D) Any negative findings will be This finding was reviewed with both Maintenance corrected immediately. The monitoring logs will be reviewed Director's during the exit conference.

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTI A. BUILDI B. WING		nstruction 01	(X3) DATE COMPL 03/20 /	ETED
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	35	50 CE	DDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3.1-19(b)				during the monthly quality assurance meetings and will remain ongoing for compliance 5. The above corrective meas will be completed on or before April 7th, 2023.	ures	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar	other alternate power inted equipment is capable on the within 10 seconds. If the in is not met during the posess shall be provided to this capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised intervals.					
	and circuits are m	arked, readily identifiable, n normal power circuits.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 35 of 53

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155535	B. W	ING		03/20/2023	
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	t			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	/IBUS, IN 47203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY 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
		ssibility of damage of the					
	emergency power source is a design						
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	` ,	17.0	010	KOAO waxayina a that the a fa silitu.		04/07/2022
		review and interview, the	K 0	918	K918 requires that the facility	_4	04/07/2023
	-	intain a complete written record			implement Emergency General	alor	
		or load testing for 1 of 1			inspection, testing, and		
	-	e past 12 months. Chapter 12 NFPA 99 requires monthly			maintenance.	d by	
		ator serving the emergency			 No residents were harmed this alleged deficient practice. 	-	
		be in accordance with NFPA			director of maintenance has	me	
	-	or Emergency and Standby			been educated on the		
		hapter 8. Chapter 8.4.2.				for	
		diesel generator sets in			documentation requirements f		
		reised at least once monthly,			the emergency generator inclusion how to properly document the	_	
		0 minutes, using one of the			actual minimum 30 minute rur		
	following methods:				time, how to complete the mo		
	-	intains the minimum exhaust			load testing for the generator	пшпу	
		recommended by the			including the proper cool down	n	
	manufacturer	recommended by the			time, and the requirement to h		
		temperature conditions and at			battery powered light set at th		
		cent of the EPS (Emergency			emergency generator with	C	
	Power Supply) nam	` •			functional testing conducted		
		es diesel-powered EPS			monthly for not less than 30		
		not meet the requirements of			seconds, functional testing		
		ised monthly with the available			annually for a minimum of 90		
		Power Supply System) load and			minutes, visual inspections an	nd	
		nnually with supplemental			tests shall be kept for inspecti		
		est) at not less than 50 percent			(Attachment A) picture of light		
		ate kW rating for 30 continuous			(Attachment E)		
	_	ess than 75 percent of the EPS			2. No residents were harmed	by	
		g for 1 continuous hour for a			this alleged deficient practice.	•	
	-	f not less than 1.5 continuous			resident had the potential to b		
	hours.				affected. The director of		
	Chapter 6.4.4.2 of N	NFPA 99 requires a written			maintenance has been educa	ted	
	_	n, performance, exercising			on the documentation		
	_	for the generator to be			requirements for the emergen	су	
		d and available for inspection			generator including how to	,	
		ying jurisdiction. This			properly document the actual		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155535	B. WI	NG		03/20	/2023
		1		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEI	R			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER			1BUS, IN 47203		
			T		- ,		T ~~~
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ould affect all residents, staff		TAG		h	DATE
	and visitors.	ould affect all residents, staff			minimum 30 minute run time,	now	
	and visitors.				to complete the monthly load	dina	
	Findings include:				testing for the generator include the proper cool down time, an	_	
	rindings include.					u iiie	
	Rased on record re	view on 03/20/23 between 9:30			requirement to have battery powered light set at the		
		with the Maintenance Director			emergency generator with		
	_	Director from a sister facility			functional testing conducted		
		no documentation on the			monthly for not less than 30		
	-	or monthly test form for a 30			seconds, functional testing		
		ring the monthly load tests			annually for a minimum of 90		
		months. The information			minutes, visual inspections ar	nd	
		ne was based on a counter			tests shall be kept for inspetio		
	-	enerator panel. Based on			The facility's emergency		
	_	ne of record review, the facility			generator logs were reviewed	with	
		tor agreed the actual run time			no changes needed. The direct		
		ocumented on the monthly			of maintenance or designee w		
	generator load test	_			responsible for completing the		
					emergency generator logs wit		
	This finding was re	eviewed with both Maintenance			actual start and stop times for		
	Director's during th	ne exit conference.			minimum 30 minute run time,		
					completing the monthly load		
	3.1-19(b)				testing with the proper cool do	own	
					time, and completing the visua	al	
	2. Based on record	review and interview, the			inspection and testing of the		
	facility failed to ma	aintain a complete written record			battery powered light set locat	ted	
		or load testing for 1 of 1			at the emergency generator.		
	-	e past 12 months. Chapter			4. The Administrator, director	of	
		12 NFPA 99 requires monthly			maintenance or designee will	be	
		rator serving the emergency			responsible to review the		
	-	be in accordance with NFPA			emergency generator		
		or Emergency and Standby			documentation weekly to ensu		
	-	Chapter 8. Chapter 6.4.4.2 of			the required documentation ha		1
	-	a written record of inspection,			been completed as required.	Any	
	•	ising period, and repairs for the			negative findings will be		1
	generator to be regularly maintained and available				immediately corrected. Monito	oring	1
	for inspection by th				logs will be reviewed monthly		
	°	110, 6.4.2.1.5.9 Time Delay on			during the quality assurance		1
	-	requires that a minimum time			meetings and will remain ongo	_	
	I delay of 5 minutes	shall be provided for unloaded	1		for compliance (Attachment Γ))	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155535	B. W	ING		03/20/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER			1BUS, IN 47203		
	ı						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCIT		DATE
	_	rgency Power Supply (EPS)			5 The character was the control of the character of the c		
	1 ~	This delay provides additional This time delay shall not be			5. The above corrective meas will be completed on or before		
	_		April 7th, 2023.				
	required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, staff and visitors.				April 7th, 2023.		
	residents, starr and	visitors.					
	Findings include:						
	<i>5</i>						
	Based on record rev	view on 03/20/23 between 9:30					
	a.m. and 2:00 p.m.	with the Maintenance Director					
	and Maintenance D	irector from a sister facility					
	present, there was o	locumentation on the					
	generator monthly	oad test log for a cool down					
	period after the load	d test, however, it was					
		minute cool down time only					
	_	ns (when the facility's new					
	_	lled). Based on interview at					
		eview, the facility Maintenance					
		ol down time for the new					
	_	ast 10 minutes, but was					
	· ·	nthly generator load test form					
	and wrote the wron	g time down.					
	TE1 ' C' 1'						
		viewed with both Maintenance					
	Director's during th	e exit conference.					
	3.1-19(b)						
	3.1-17(0)						
	3. Based on observ	ration and interview, the					
		sure 1 of 1 emergency task					
	1	ided with a battery backup					
		0, 2010 Edition at section 7.3.1					
		or Level 2 EPS equipment					
	location(s) shall be						
	1 1	nergency lighting. This					
		ot apply to units located					
		res that do not include walk-in					
		3.1.1 (1) requires functional					
		ducted monthly, with a					
		•	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 38 of 53

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/20/2023			
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203					
(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)	(X5) COMPLETION DATE			
	between tests, for no Functional testing s a minimum of 1 1/2 system is battery po of visual inspection the owner for insper jurisdiction. This dresidents in the facility of the Maintenance Di Director from a sist powered light set at The emergency gen feet from the rear painterview at the tim Maintenance Direct battery powered light generator.	ons on 03/20/23 between 2:00 during a tour of the facility with rector and Maintenance er facility, there was no battery the emergency generator. erator was located at least 100 arking lot. Based on an e of record review, the facility or confirmed there was no ht set at the emergency						
K 0000								
Bldg. 02	Licensure Survey w Department of Heal 483.90(a). The new 300 Hall u physical therapy roo	Certification and State ras conducted by the Indiana th in accordance with 42 CFR nit consists of occupational & oms and a 16 resident room, including resident rooms	K 0000	Submission of this plan of correction does not constitute admission or agreement by th provider of the truth of facts alleged or correction set forth the statement of deficiencies. plan of correction is prepared submitted because of requirer	e on The and			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

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If continuation sheet Page 39 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	02	COMPL	
		155535	B. WI			03/20/	
				OTD DET	ADDRESS SITE OF THE SEC		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	CDOSSING UEAL	TH & DEHADII ITATION OF NITED			ENTRAL AVE		
VVILLOVV	CKUSSING HEAL	TH & REHABILITATION CENTER		COLUN	1BUS, IN 47203		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	301-318.				under state and federal law.		
		- 1			Please accept this plan of		
	Survey Date: 03/20	0/23			correction as our credible		
		000572			allegation of compliance. Plea	ise	
	Facility Number: 0				find enclosed this plan of		
	Provider Number:				correction for this survey. Due		
	AIM Number: 100	20//10			the low scope and severity of		
	At this I ifo Safata	Code survey Willow Crossing			survey finding, please find the		
	· ·	Code survey, Willow Crossing itation Center was found not in			sufficient documentation prov	•	
		equirements for Participation in			evidence of compliance with t plan of correction. The	ı i C	
	•	Subpart 483.90(a), Life Safety			documentation serves to conf	irm	
		012 edition of the National Fire			the facility's allegation of		
		tion (NFPA) 101, Life Safety			compliance. Thus, the facility		
		er 18, New Health Care			respectfully requests the gran	tina	
	Occupancies.	, <u></u> -			of paper compliance. Should	ਰ	
	1				additional information be		
	This one story build	ding was determined to be of			necessary to confirm said		
	-	truction and was fully			compliance, please feel free t	0	
	sprinklered. The fa	cility has a fire alarm system			contact me.		
	with smoke detection	on in the corridor and in all					
	_	orridor. The facility has smoke					
		d to the building electrical					
	-	Hall resident rooms with battery					
		rt to the 300 Hall nurses'					
		y has a capacity of 112 and had					
	a census of 96 at th	e time of this survey.					
	411 1						
		idents have customary access					
	-	All areas providing facility					
	services were sprin	KIEFEU.					
	Quality Review on	mpleted on 03/27/23					
	Quality Keview col	inproceed on 03/2//23					
K 0227	NFPA 101						
SS=E	Ramps and Other	Exits					
Bldg. 02	Ramps and Other						
	•	ageways, fire and slide					
		ng tread devices, and areas					
		ccordance with the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 40 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	02	COMPL	ETED
		155535	B. Wl	ING		03/20/	/2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
14/11 1 014/	ODOCOINO LIEAL	TIL & DELIABILITATION OFNITED			CENTRAL AVE		
VVILLOVV	CROSSING HEAL	TH & REHABILITATION CENTER		COLUI	MBUS, IN 47203		
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	provisions 7.2.5 th	rough 7.2.12.					
	18.2.2.6 to 18.2.2.	.10 or 19.2.2.6 to 19.2.2.10					
	Based on observation	on and interview, the facility	K 0	227	K227 requires a handrail on b	oth	04/07/2023
	failed to ensure 1 of	f 1 exit ramp from the new 300			sides of an exit ramp		
	Hall unit was provid	ded with a handrail on both			1. No residents were harmed	by	
	sides of the ramp. I	LSC 7.2.5.4.2 states handrails			this alleged deficient practice.	-	
	complying with 7.2	.2.4 shall be provided along			director of maintenance has		
		o run with a rise greater than 6			been educated on the		
		ent practice could affect all			requirements of having a hand	drail	
		visitors if needing to exit the			on both sides of the 300 hall e		
	300 Hall unit.	-			ramp. (Attachment A). A seco		
					handrail has been installed at		
	Findings include:				300 hall exit ramp. (Attachme	nt P)	
					2. No residents were harmed		
	Based on observation	ons on 03/20/23 between 2:00			this alleged deficient practice.	-	
	p.m. and 4:45 p.m.	during a tour of the facility with			resident had the potential to b		
	the Maintenance Di	rector and Maintenance			affected. The director of		
	Director from a sist	er facility, the exit discharge			maintenance has been educa	ted	
	ramp outside the 30	0 Hall exit was was only			on the requirements of having	а	
	provided with a han	drail on one side of the ramp.			handrail on both sides of the 3	300	
	Based on interview	at the time of the observation,			hall exit ramp. A second hand	rail	
	the facility Mainten	ance Director agreed there was			has been installed at the 300	hall	
	a handrail on only o	one side of the exit ramp.			exit ramp.		
					3. The facility's outside		
	This finding was re	viewed with both Maintenance			preventative maintenance forr	n	
	Director's during the	e exit conference.			was reviewed and updated to		
					include checking 300 hall		
	3.1-19(b)				handrails to ensure there are	2	
					rails at the exit.		
					4. The Administrator, director	of	
					maintenance, or designee will	be	
					responsible to monitor the out	side	
					exit ramp to ensure there are	2	
					handrails at the exit. (Attachm	ent	
					D). Any negative findings will	be	
					corrected immediately. Monito	ring	
					logs will be reviewed monthly		
					during the quality assurance		
					meetings and will remain ongo	oing	
					for compliance.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	LETED
		155535	B. WI	NG		03/20	/2023
		l .	<u> </u>	CTDEET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8					
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		3550 CENTRAL AVE COLUMBUS, IN 47203			
VVILLOVV	CITOGOING FIEAL	THE REHABILITATION CLIVIER		COLUN	, IN 77200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					5. The above corrective meas		
					will be completed on or before	•	
					April 7th, 2023.		
K 0303	NEDA 101						
K 0293 SS=E	NFPA 101						
SS-⊑ Bldg. 02	Exit Signage Exit Signage						1
Diag. 02	2012 NEW						
		al signs are displayed in					
		7.10 with continuous					
		erved by the emergency					
	lighting system.	and an amongonity					
	18.2.10.1						1
		on and interview, the facility	K 02	293	K293 requires a NO EXIT sigr	n be	04/07/2023
		f 1 door to the outside		- -	posted on a door that is not ar		
) Hall could not mistaken as a			exit		
	facility exit. LSC 7	7.10.8.3.1 states any door,			1. No residents were harmed	by	
	passage, or stairway	y that is neither an exit nor a			the alleged deficient practice.	-	1
	way of exit access a	and that is located or arranged			director of maintenance has b	een	
		be mistaken for an exit shall			educated on the requirements	of	
		gn that reads as follows: NO			having a NO EXIT sign posted	d on	
		IT sign shall have the word NO			the 300 hall courtyard door to		
		igh, with a stroke width of 3/8			ensure the door could not be		
	· ·	EXIT below the word NO,			mistaken as a facility exit.		
	_	an approved existing sign.			(Attachment A) The 300 hall		
		ice could affect up to all			courtyard door has been equip	-	
		s staff and visitors in the 300			with a NO EXIT sign (Attachm	ent	
	Hall unit.				Q)		
	TO 1' ' 1 1				2. No residents were harmed	-	
	Findings include:				this alleged deficient practice.		
	D11 1	2.00			resident had the potential to b	е	
		ons on 03/20/23 between 2:00			affected. The director of	tad	
	_	during a tour of the facility with			maintenance has been educate		
		rector and Maintenance er facility, the 300 Hall Activity			on the requirements of having		
					NO EXIT sign posted on the 3		1
		ourtyard was not posted with a sed on interview at the time of			hall courtyard door to ensure to		
		Maintenance Director said				а	
		ty Room door to the courtyard			facility exit. 3. The facility's interior.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1XC21

Facility ID: 000572

If continuation sheet Page 42 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE COMPI 03/20	LETED
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 C	ADDRESS, CITY, STATE, ZIP COD CENTRAL AVE MBUS, IN 47203		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	it did not have a NC	viewed with both Maintenance		preventative maintenance f was reviewed and updated include checking courtyard to ensure there is a NO exilocated on the door. 4. The Administrator, direct maintenance, or designee or responsible to monitor the courtyard doors to ensure the a NO EXIT sign posted on door. Any negative findings corrected immediately. Mor logs will be reviewed month during the quality assurance meetings and will remain or for compliance. 5. The above corrective metallicular will be completed on or before April 7th, 2023.	to doors t sign stor of will be there is the swill be nitoring ally e ngoing easures	
K 0341 SS=E Bldg. 02	and components a accordance with N Code, and NFPA Code to provide et part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1,	n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment. wiring or other is are monitored for	K 0341	K341 requires the facility to		04/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 43 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155535	B. W	ING		03/20/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER			1BUS, IN 47203		
			ı		1.200		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
		of over 10 hard wired smoke			ensure that hard wired smoke		
		w 300 Hall addition of the			detectors are not installed wh		
		stalled where air flow would			air flow would adversely affec	t its	
	-	operation. NFPA 72, 2010			operation.		
		requires that smoke detectors			1. No residents were harmed	-	
		directly in the airstream of			the alleged deficient practice.		
		ection 17.7.4.1 requires in			director of maintenance has b		
		ir handling systems, detectors			educated (Attachment A) to the		
		where air flow prevents			requirement that all hard wire		
	-	tectors. A.17.7.4.1 states			smoke detectors should not b	-	
		ot be located in a direct airflow			located in a direct airflow or c		
		in ches from an air supply			than 36 inches from an air su		
		ir opening. This deficient			diffuser or return air opening.		
	•	ct all residents, staff, and			hard wired smoke detectors h		
	visitors in the new	SUU FIAII AGGILION.			been re located away from air		
	Findings in -11-				supply diffusers and return air	-	
	Findings include:				openings. (Attachment J)	d by	
	Dagad on abaser4:	ons on 03/20/23 between 2:00			2. No residents were harmed	-	
					this alleged deficient practice.		
	_	during a tour of the facility with irector and Maintenance			resident had the potential to b	е	
					affected. The director of maintenance has been educa	tod	
	noted:	ter facility, the following was					
		ling mounted smoke detector			to the requirement that all har wired smoke detectors should		
		an air supply vent in the 300			be located in a direct airflow of		
	Hall corridor outside				closer than 36 inches from an		
		ling mounted smoke detector			supply diffuser or return air	all	
		an air supply vent in the 300			opening. The hard wired smo	ko.	
	Hall Nurses' Station				detectors have been re locate		
		at the time of each			away from air supply diffusers		
		cility Maintenance Director			return air openings. (Attachm		
		letectors in question were to			3. The facility's interior	511L U)	
	close to air supply	-			preventative maintenance pro	aram	
	crose to an suppry				was reviewed and updated to	•	
	This finding was re	eviewed with both Maintenance			check all hard wired smoke		
	Director's during th				detectors to ensure none are		
	Zirector 5 during ti	in this commence.			installed to where air flow wou	ıld	
	3.1-19(b)				adversely affect its operation.	aid.	
	J.1 17(0)				4. The Administrator, director	of	
					maintenance or designee will		
			1		I mamicinarios or acorginos will	50	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 44 of 53

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

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>02</u>			COMPL	ETED
	155535	B. WI	NG		03/20/	2023
		•	3550 C	ENTRAL AVE	•	
SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEOWINERS N. AN OF CORRECTION		(X5)
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
				ensure none are within 36 incl of an air supply diffuser or retu air opening. Any negative find will be corrected immediately. monitoring logs will be reviewed during the monthly quality assurance meetings and will remain ongoing for compliance 5. The above corrective meas	nes urn ings The ed e. sures	
spaces open to consider the constraint of all smoke compresident sleeping sleeping rooms has a small smoke detection and the constraint of all smoke detection and the constraint of a smoke detection and the constraint of a small smoke detectors are interconnected to the constraint of a small s	an automatic smoke is installed in the corridors partments containing rooms, unless the resident ave: on, or closing devices with etectors on the room side pant notification. e electrically the fire alarm system. 1.5.3 view, interview, and cility failed to ensure complete for the preventative of 16 battery operated smoke	K 0:	347	smoke detectors be tested monthly for functionality includ the location of the smoke		04/07/2023
	NFPA 101 Summary (EACH DEFICIENT REGULATORY OF Smoke Detection Smoke Detection Spaces open to conspace of 18.3.6.1 In nursing homes detection system of all smoke compresident sleeping sleeping rooms has "smoke detection system of all smoke detection system of all smoke compresident sleeping sleeping rooms has "smoke detection system of all smoke detection system of all smoke compresident sleeping sleeping rooms has "smoke detection system of all smoke detection integral s	OF CORRECTION IDENTIFICATION NUMBER 155535 PROVIDER OR SUPPLIER CROSSING HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Smoke Detection Smoke Detection 2012 NEW Smoke detection systems are provided in spaces open to corridors as required by	NFPA 101 Smoke Detection Smoke Detection Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: *smoke detection, or *automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3 Based on record review, interview, and observation; the facility failed to ensure documentation was complete for the preventative maintenance of 16 of 16 battery operated smoke detectors in the 300 hall resident rooms. NFPA	NFPA 101 Smoke Detection Smoke	OF CORRECTION IDENTIFICATION NUMBER 155535 ROVIDER OR SUPPLIER CROSSING HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION TAG TESPONSIBLE TABLES OF CORRECTION STRUCK AND PROPRIES IN A COUNTY OF THE ADMINISTRATION OF THE ADMINIS	PROVIDER OR SUPPLIER CROSSING HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (BLACH DEFICIENCY MUST BE PRICEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION TAG TESPONSIBLE TRANSPORTER TO SUBJECT TO THE PRICEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION TO A main and a subject of the facility to ensure one are within 36 inches of an air supply diffuser or return air opening. Any negative findings will be corrected immediately. The monitoring logs will be reviewed during the monthly quality assurance meetings and will remain ongoing for compliance. 5. The above corrective measures will be completed on or before April 7th, 2023. NFPA 101 Smoke Detection Smoke Detection Smoke Detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: "smoke detection, or "automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3 Based on record review, interview, and observation; the facility failed to ensure documentation was complete for the preventative maintenance of 16 of 16 battery operated smoke detectors in the 300 hall resident rooms. NFPA

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet

Page 45 of 53

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039		
S	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
A	ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
			155535	B. W	ING		03/20/	/2023
					·			
N	NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				3550 CENTRAL AVE				
١	WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	1BUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
F	REFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
	TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
			c, if not required by the Code,			the alleged deficient practice.	The	
		•	This deficient practice could			director of maintenance has be		
			esidents, as well as staff and			educated (Attachment A) to th		
		visitors.				requirement that all battery	o .	
		VISITOIS.				operated smoke detectors be		
		Findings include:				tested for functionality including	a	
		r manigs metade.				the location of each smoke	9	
		Dagad on record ray	riew on 03/20/23 between 9:30					
			with the Maintenance Director			detector monthly. The battery		
						operated smoke detectors have been tested and documentation		
			irector from a sister facility					
		_	ocumentation available to			completed for all battery opera		
			battery operated smoke			smoke detectors located on th	е	
			d for functionality on a			300 hall. (Attachment S).		
			g the past twelve months,			2. No residents were harmed	-	
			nentation was incomplete. It			this alleged deficient practice.		
			list of where the smoke			resident had the potential to be	9	
			ted, it was only a form that			affected. The director of		
			Checked" with a check mark			maintenance has been educat		
		-	sed on interview at the time of			to the requirement that all batt	ery	
			acility Maintenance Director			operated smoke detectors be		
			of proper documentation for			tested for functionality includin	g	
			ıll 300 Hall resident room			the location of each smoke		
			oke detectors during the past			detector monthly. The battery		
			on observations between 2:00			operated smoke detectors hav		
			during a tour of the facility with			been tested and documentation	n	
		both Maintenance I	Director's, battery operated			completed for all battery opera	ited	
		smoke alarms were	observed in all resident			smoke detectors located on th	е	
		sleeping rooms in the	ne 300 Hall.			300 hall.		
						The facility's battery opera	ted	
		This finding was re-	viewed with both Maintenance			smoke detector policy was		
		Director's during the	e exit conference.			reviewed with no changes nee	ded.	
						4. The Administrator, director	of	
		3.1-19(b)				maintenance, or designee will	be	
						responsible to monitor		
						(Attachment D) all documenta	tion	
						for the battery operated smoke		
						detectors on 300 hall monthly		
						ensure they have been tested		
						functionality, including the loca		
				1		1,,		

of the smoke detectors.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		î í	JILDING	onstruction 02	(X3) DATE SURVEY COMPLETED 03/20/2023		
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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
					(Attachment D). Any negative findings will be corrected immediately. The monitoring low will be reviewed during the monitoring and the monitoring and the monitoring for compliance. 5. The above corrective means will be completed on or before April 7th, 2023.	onthly nd sures	
K 0761 SS=F Bldg. 02							
	interview; the facilitinspection and testin fire doors assembly portions of the Skill in accordance with a Communicating operequired by 18.1.1.4 corridors and shall be self-closing fire door Section 8.3.) LSC 8 have a fire protection be protected by approassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire De Protectives, except a Code. NFPA 80 5.2 shall be inspected an annually, and a writt shall be signed and AHJ. NFPA 80, 5.2 shall be visually inspected.	enings in dividing fire barriers 1.1 shall be permitted only in the protected by approved to assemblies. (See also 13.3.3.1 Openings required to to rating by Table 8.3.4.2 shall troved, listed, labeled fire door window assemblies and their ware, including all frames,	K 0	761	K761 requires maintenance, testing, and inspection of all fil doors 1. No residents were harmed the alleged deficient practice. director of maintenance has be educated on the fire door inspections, testing and maintenance to include all fire doors. (Attachment A) The fact map has been updated to include all fire doors that need inspect tested, and maintenance has completed the fire door assemmaintenance, testing, and inspections of the oxygen transfilling room, and the set of separation fire doors assembly between the new and existing portions of the units with no concerns noted. (Attachment I 2. No residents were harmed this alleged deficient practice. residents had the potential to affected. The director of	by The een iility ude ed, bly f y N).	04/07/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155535	B. W	ING		03/20/	2023
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUM	1BUS, IN 47203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					maintenance has been educa		
	·	states as a minimum, the			regarding the annual mainten		
	following items sha				testing, and inspection of all fi	re	
		or breaks exist in surfaces of			doors.		
	either the door or fi				3. The facility's annual		
		light frames, and glazing beads			maintenance, inspection, and		
		rely fastened in place, if so			testing form was reviewed wit		
	equipped.	e, hinges, hardware, and			changes needed. The facility's		
	, ,	es, ninges, nardware, and reshold are secured, aligned,			map was updated to include a doors that need maintenance		
		er with no visible signs of			testing, and inspection.	,	
	damage.	er with no visible signs of			4. The Administrator, director	of	
	(4) No parts are mi	ssing or broken			maintenance, or designee will		
		s do not exceed clearances			responsible to check all fire de		
	listed in 4.8.4 and 6				to ensure all have been	5015	
		g device is operational; that is,			maintained, inspected, and te	sted	
		apletely closes when operated			annually. (Attachment D) Any		
	from the full open				negative findings will be corre		
		is installed, the inactive leaf			immediately. The monitoring I		
	closes before the ac				will be reviewed during the mo	-	
	(8) Latching hardw	are operates and secures the			quality assurance meetings a	-	
	door when it is in the				will remain ongoing for		
	(9) Auxiliary hardv	vare items that interfere or			compliance.		
	prohibit operation a	are not installed on the door or			5. The above corrective mea	sures	
	frame.				will be completed on or before	•	
		fications to the door assembly			April 7th, 2023.		
	_	ed that void the label.					
		edge seals, where required, are					
	-	their presence and integrity.					
	•	tice could affect all residents,					
	as well as staff, and	d visitors.					
	Findings include:						
	Based on record review on 03/20/23 between 9:30						
	a.m. and 2:00 p.m. with the Maintenance Director						
	_	Director from a sister facility					
		was unable to provide					
		an annual inspection of the set					
		oors assembly between the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ í				TE SURVEY MPLETED	
155535		155535	B. WING 03/20/202		2023			
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203				
(X4) ID	SUMMARY S	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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ortions of the Skilled Care						
		st 12 month period. Based on						
		e of record review, the facility						
		for confirmed there were no fire						
		ection records available to						
	review. Based on observations during a tour of the facility with both Maintenance Director's							
	between 2:00 p.m. and 4:45 p.m., it was confirmed							
	there was one set of separation fire doors							
	assembly between the New and Existing portions							
	of the Skilled Care Units noted in the facility.							
	This finding was reviewed with both Maintenance							
	Director's during the exit conference.							
	3.1-19(b)							
K 0918	NFPA 101							
SS=F		s - Essential Electric Syste						
Bldg. 02		s - Essential Electric						
	System Maintenar	nce and Testing						
	_	other alternate power						
	source and associated equipment is capable							
	of supplying service within 10 seconds. If the							
	10-second criterion is not met during the							
		ocess shall be provided to						
		his capability for the life						
		branches. Maintenance						
	and testing of the generator and transfer switches are performed in accordance with							
	NFPA 110.							
	Generator sets are inspected weekly,							
	exercised under load 30 minutes 12 times a							
	year in 20-40 day intervals, and exercised							
		nths for 4 continuous hours.						
		der load conditions include						
	a complete simula							
		ual transfer of all EES						
		nducted by competent						
	personnel. Mainte	nance and testing of stored						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 49 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>02</u>			COMPL	COMPLETED	
155535		B. WING 03/20/2023			/2023		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ENTRAL AVE		
WILLOW CROSSING HEALTH & REHABILITATION CENTER					1BUS, IN 47203		
VVILLOVV	CROSSING FIEAL	TH & REHABILITATION CENTER		COLUIV	1603, 111 47203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	energy power sou	rces (Type 3 EES) are in					
	accordance with N	NFPA 111. Main and feeder					
	circuit breakers ar	e inspected annually, and a					
	program for period	dically exercising the					
	components is est	tablished according to					
	manufacturer requ	uirements. Written records					
	of maintenance ar	nd testing are maintained					
	and readily availal	ble. EES electrical panels					
		arked, readily identifiable,					
	•	n normal power circuits.					
		ssibility of damage of the					
	emergency power source is a design						
	consideration for new installations.						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10 (NFPA 70)						
		review and interview, the	K 0	918	K918 requires that the facility		04/07/2023
		intain a complete written record			implement Emergency Genera	ator	
		or load testing for 1 of 1			inspection, testing, and		
		e past 12 months. Chapter			maintenance.		
		12 NFPA 99 requires monthly			No residents were harmed	-	
		ator serving the emergency			this alleged deficient practice.	The	
	-	be in accordance with NFPA			director of maintenance has		
		or Emergency and Standby			been educated on the		
	-	hapter 8. Chapter 8.4.2.			documentation requirements f		
		diesel generator sets in			the emergency generator inclu	-	
		rcised at least once monthly,			how to properly document the		
		0 minutes, using one of the			actual minimum 30 minute rur		
	following methods:		1		time, how to complete the mor		
	` '	nintains the minimum exhaust	1		load testing for the generator		
		recommended by the			including the proper cool down		
	manufacturer	and the state of t	1		time, and the requirement to h		
		temperature conditions and at			battery powered light set at the	Э	
	not less than 30 percent of the EPS (Emergency				emergency generator with		
	Power Supply) nameplate kW rating.				functional testing conducted		
	Section 8.4.2.3 states diesel-powered EPS				monthly for not less than 30		
		not meet the requirements of			seconds, functional testing		
		ised monthly with the available			annually for a minimum of 90		
	, , ,	Power Supply System) load and			minutes, visual inspections an		
		nnually with supplemental			tests shall be kept for inspecti		
	Ioads (Load Bank T	Cest) at not less than 50 percent	1		(Attachment A) picture of light		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 50 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPL		ETED			
155535		B. WING 03/20/2023			/2023			
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					ENTRAL AVE			
WILLOW CROSSING HEALTH & REHABILITATION CENTER					IBUS, IN 47203			
VVILLOVV	UNUSSING FEAL	THE REHABILITATION CENTER		COLUN	1000, IN 47 200			
(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 APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	-	te kW rating for 30 continuous			(Attachment E)			
		ess than 75 percent of the EPS			2. No residents were harmed	,		
	-	g for 1 continuous hour for a			this alleged deficient practice.			
		f not less than 1.5 continuous			resident had the potential to be			
	hours.	TTD 1 00			affected. The director of			
		NFPA 99 requires a written			maintenance has been educated			
	•	n, performance, exercising		on the documentation				
	*	for the generator to be		requirements for the emergency				
		d and available for inspection			generator including how to			
		ving jurisdiction. This			properly document the actual			
	•	ould affect all residents, staff,		minimum 30 minute run time, how				
	and visitors.			to complete the monthly load				
	Findings in details			testing for the generator including				
	Findings include:			the proper cool down time, and the				
	Dogad on moond navious on 02/20/22 hotsyson 0.20				requirement to have battery			
	Based on record review on 03/20/23 between 9:30				powered light set at the			
	a.m. and 2:00 p.m. with the Maintenance Director				emergency generator with			
	and Maintenance Director from a sister facility				functional testing conducted			
	present, there was no documentation on the				monthly for not less than 30			
	emergency generator monthly test form for a				seconds, functional testing			
	30-minute run time during the monthly load tests				annually for a minimum of 90			
	during the past 12 months. The information				minutes, visual inspections and			
	provided for run time was based on a counter number from the generator panel. Based on				tests shall be kept for inspetion	n.		
	_	_			The facility's emergency generator logs were reviewed with			
	interview at the time of record review, the facility			no changes needed. The director				
	Maintenance Director agreed the actual run time		I					
	was not properly documented on the monthly		of maintenance or designee will be					
	generator load test form.				responsible for completing the			
	This finding was reviewed with both Maintenan				emergency generator logs with			
	This finding was reviewed with both Maintenance				actual start and stop times for minimum 30 minute run time,	u I C		
	Director's during the exit conference.			· · · · · · · · · · · · · · · · · · ·				
	3 1-19(b)				completing the monthly load testing with the proper cool do	wn		
	3.1-19(b)				time, and completing the visua			
	Based on record review and interview, the facility failed to maintain a complete written record				inspection and testing of the	ai .		
					battery powered light set locat	ed		
		or load testing for 1 of 1			at the emergency generator.	cu		
		e past 12 months. Chapter			4. The Administrator, director	of		
		-						
	6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly				maintenance or designee will l	D G		

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COM		COMPL	ETED	
155535		B. WING 03/20/2023					
100000					_	00/20/	2020
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WANTE OF TROVIDER OR SOFTELER				3550 CI	ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER	COLUMBUS, IN 47203				
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	electrical system to	be in accordance with NFPA			emergency generator		
	110, the Standard for	or Emergency and Standby			documentation weekly to ensu	ire	
	Powers Systems, Cl	hapter 8. Chapter 6.4.4.2 of			the required documentation ha	as	
	NFPA 99 requires a	written record of inspection,			been completed as required. Any		
	performance, exerc	ising period, and repairs for the			negative findings will be		
	generator to be regu	ılarly maintained and available			immediately corrected. Monito	ring	
	for inspection by th	e authority having			logs will be reviewed monthly	-	
	jurisdiction. NFPA	110, 6.4.2.1.5.9 Time Delay on			during the quality assurance		
	Engine Shutdown r	equires that a minimum time			meetings and will remain ongo	ing	
	_	shall be provided for unloaded			for compliance. (Attachment D	-	
	running of the Eme	rgency Power Supply (EPS)				,	
	prior to shutdown. This delay provides additional				5. The above corrective meas	ures	
	engine cool down. This time delay shall not be				will be completed on or before		
	required on small (15 kW or less) air-cooled prime				April 7th, 2023.		
	movers. This deficient practice could affect all				,		
	residents, staff, and visitors.						
	Findings include:						
	Based on record review on 03/20/23 between 9:30						
	a.m. and 2:00 p.m.	with the Maintenance Director					
	and Maintenance Director from a sister facility						
	present, there was documentation on the						
	generator monthly load test log for a cool down						
	period after the load	l test, however, it was					
	documented for a 2-minute cool down time only						
	for the past 3 month	ns (when the facility's new					
	generator was insta	lled). Based on interview at					
		eview, the facility Maintenance					
		ol down time for the new					
	generator was at lea	ast 10 minutes but was					
		nthly generator load test form					
	and wrote the wrong time down.						
	This finding was next and a side had No. 1						
	This finding was reviewed with both Maintenance Director's during the exit conference.						
	Director's during th	e ean comerence.					
	3.1-19(b)						
	3. Based on observ	ation and interview, the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1XC21

Facility ID: 000572

If continuation sheet Page 52 of 53

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2023	
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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)	(X5) COMPLETION DATE	
	facility failed to ensigenerator was provided to ensigenerator was provided to the generator was provided to the control of th	sure 1 of 1 emergency task ded with a battery backup 0, 2010 Edition at section 7.3.1 or Level 2 EPS equipment provided with hergency lighting. This bot apply to units located res that do not include walk-in 3.1.1 (1) requires functional ducted monthly, with a sa and a maximum of 5 weeks bot less than 30 seconds, (3) shall be conducted annually for thours if the emergency lighting owered and (5) Written records and tests shall be kept by ection by the authority having efficient practice could affect all lity. Sons on 03/20/23 between 2:00 during a tour of the facility with rector and Maintenance er facility, there was no battery the emergency generator. erator was located at least 100 arking lot. Based on an erof record review, the facility for confirmed there was no the set at the emergency wiewed with both Maintenance				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: I1XC21 Facility ID: 000572 If continuation sheet Page 53 of 53