STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155535	A. BUILDING -- B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/20/23 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Emergency Preparedness survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 112 certified beds. At the time of the survey, the census was 56. Quality Review completed on 03/27/23	E 0000	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 on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement 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 to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alisha Miller	Administrator	04/07/2023

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	§483.475(d)(2), §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). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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	to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]			

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	(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE			

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	organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises 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:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual			

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	natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a	E 0039	E 039 requires the facility to conduct exercises to test the emergency plan annually. 1. No residents were harmed by the alleged deficient practice. The director of Maintenance and the Administrator was educated on the requirement that the facility must participate in a full scale exercise that is community based and when a community based exercise is not accessible that the facility must complete a facility based functional exercise (See Attachment A)	04/07/2023

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	community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Program 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, the facility was able to provide documentation of two tabletop exercises dated 08/29/22 and 03/02/23, however, the facility was unable to provide documentation of a community-based exercise performed during the past 12-month period. This was confirmed by the facility Maintenance Director during record review. This finding was reviewed with both Maintenance Director's during the exit conference.		2. No residents were affected by this alleged deficient practice. All residents had the potential to be affected. The director of maintenance and Administrator has been educated on the requirement that the facility must participate in a full scale exercise that is community based and when a community based exercise is not accessible that the facility must complete a facility based functional exercise 3. The Facility's Emergency Preparedness Program/Plan was reviewed with no changes made to the policy. The Administrator will be responsible for attending a community- based exercise (See Attachment B) Registration for the Community based exercise on May 16th and 17th. 2023 (See Attachment C) a facility based functional exercise that has been completed until the facility is able to attend the community- based exercise on May 16th and 17th. 4. The Administrator, director of maintenance or designee will review monthly to ensure all required exercises have been completed, and the facility attends the next community exercise. Any negative findings will be immediately corrected. Monitoring forms will be reviewed monthly during quality assurance meetings and will remain ongoing for compliance. (See Attachment D) 5. The above corrective measures	

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			will be completed on or before April 7th, 2023.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care			

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	Facilities Code, NFPA 110, and Life Safety Code. 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 have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.			

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	155535	A. BUILDING -- B. WING	03/20/2023

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	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly,	E 0041	E-041 requires that the facility implement Emergency Generator inspection, testing, and maintenance. 1. No residents were harmed by this alleged deficient practice. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual minimum 30 minute weekly run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with	04/07/2023

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	for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. 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 no documentation on the emergency generator monthly test form for a 30-minute run time during the monthly load tests during the past 12 months. The information provided for run time was based on a counter number from the generator panel. Based on interview at the time of record review, the facility Maintenance Director agreed the actual run time		functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspection. (Attachment A) picture of light (Attachment E) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual minimum 30 minute run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspection. 3. The facility's emergency generator logs were reviewed with no changes needed. The director of maintenance or designee will be responsible for completing the emergency generator logs with the actual start and stop times for the minimum 30 minute run time, completing the monthly load testing with the proper cool down	

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	was not properly documented on the monthly generator load test form. This finding was reviewed with both Maintenance Director's during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime 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 test, however, it was documented for a 2-minute cool down time only for the past 3 months (when the facility's new generator was installed). Based on interview at		time, and completing the visual inspection and testing of the battery powered light set located at the emergency generator. (Attachment F) 4. The Administrator, director of maintenance or designee will be responsible to review the emergency generator documentation weekly to ensure the required documentation has been completed as required. Any negative findings will be immediately corrected. Monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance. (Attachment D) 5. The above corrective measures will be completed on or before April 7th, 2023.	

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	the time of record review, the facility Maintenance Director said the cool down time for the new generator was at least 10 minutes but was confused by the monthly generator load test form and wrote the wrong time down. This finding was reviewed with both Maintenance Director's during the exit conference. 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator was provided with a battery backup light set. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. 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, there was no battery powered light set at the emergency generator. The emergency generator was located at least 100 feet from the rear parking lot. Based on an interview at the time of record review, the facility			

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	Maintenance Director confirmed there was no battery powered light set at the emergency generator. This finding was reviewed with both Maintenance Director's during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/20/23 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to corridor and hard wired smoke detectors in all resident rooms. The facility has a capacity of 112 and had a census of 96 at the time of the survey. All areas where residents have customary access were sprinklered. All areas providing facility	K 0000	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 on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement 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 to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.	

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	services were sprinklered. Quality Review completed on 03/27/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer room enclosure was free of lint and trash. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff, plus residents in the same smoke compartment. 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 floor and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint and some paper and plastic trash. Based on interview at the time of observation, the facility Maintenance Director agreed there was a substantial amount of dryer lint and paper and plastic trash on the floor and equipment within the enclosure behind the dryers, and further said they would increase the cleaning schedule.	K 0100	K 100 requires the laundry area dryer room enclosure to be free of lint and trash. 1. No residents were harmed by the alleged deficient practice. The laundry area dryer enclosure has been cleaned and is free of lint and trash. (Attachment G) The director of maintenance has been educated on ensuring that the dryer room enclosure remains free from lint and trash. (Attachment A) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on ensuring that the dryer room enclosure remains free from lint and trash. 3. The facility's preventative maintenance plan for dryers was reviewed with no changes needed. The director of maintenance will be required to keep the dryers and the dryer room enclosure free from	04/07/2023

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	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 of maintenance or designee will be responsible to monitor the dryer room enclosure to ensure that it remains free from lint and trash. 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 measures will be completed on or before April 7th, 2023	
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 0271	K271 requires the walking surface from an exit to be a smooth transition to prevent any tripping hazards. 1. No residents were harmed by the alleged deficient practice. The 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	04/07/2023

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	the main dining room had a nine foot long, one-to-two-inch level change between the concrete slab and the connecting sidewalk to the public way. The level change in the concrete slab and connecting sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the facility Maintenance Director agreed there was a one-to-two-inch level change in the concrete slab and connecting sidewalk from the main dining room. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		on the requirement that all concrete slabs and sidewalks at exits must be a smooth transition to prevent any tripping hazards. (Attachment A) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the requirement that all concrete slabs and sidewalks at exits must be a smooth transition to prevent any tripping hazards. 3. The facility's preventative maintenance for outside of facility was reviewed with no changes required. The director of maintenance will be responsible to ensure all exits are maintained to prevent any tripping hazards. 4. The Administrator, director of maintenance or designee will be responsible to check the exit areas of the facility to ensure they remain free from any uneven concrete that could cause a tripping hazard. 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. (Attachment D) 5. The above corrective measures will be completed on or before April 7th, 2023.	

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K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 8 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 10 residents as well as staff and visitors. 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, there was only one exterior light with one bulb outside the Activity Room egress hall exit. Based on interview at the time of observation, this was acknowledged by the facility Maintenance Director. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)	K 0281	K281 requires that the facility ensure illumination of means of egress 1. No residents were harmed by the alleged deficient practice. The lighting has been changed outside the Activity Room door to include more than 1 light bulb (Attachment I) The director of maintenance has been educated (Attachment A) to ensure the lighting for means of egress was properly maintained and would not leave any area in darkness. 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. ensure The director of maintenance has been educated (Attachment A) to the lighting for 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 of maintenance will be responsible to ensure all lighting for means of egress at all exits to the facility is maintained to prevent the	04/07/2023

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			possibility of leaving any area in darkness. 4. The Administrator, director of maintenance or designee will be responsible to monitor (Attachment D) all outside exits to ensure the proper lighting is in place to prevent any area being left in darkness. 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.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 3 of 82 hard wired smoke detectors in the existing portion of the facility	K 0341	K341 requires the facility to ensure that hard wired smoke detectors are not installed where	04/07/2023

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	were not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems; detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect at least 20 residents, staff, and visitors. 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 following was noted: a. There was a ceiling mounted smoke detector within three feet of an air supply vent in the Movie Theatre. b. There was a ceiling mounted smoke detector within three feet of an air supply vent in the Library. c. There was a ceiling mounted smoke detector within one foot of an air supply vent in the Maintenance Office. Based on interview at the time of each observation, the facility Maintenance Director agreed the smoke detectors in question were too close to air supply vents. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		air flow would adversely affect its operation. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement that all hard wired smoke detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. The hard wired smoke detectors have been re located away from air supply diffusers and return air openings. (Attachment J) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated to the requirement that all hard wired smoke detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. The hard wired smoke detectors have been re located away from air supply diffusers and return air openings. (Attachment J) 3. The facility's interior preventative maintenance program was reviewed and updated to check all hard wired smoke detectors to ensure none are installed to where air flow would adversely affect its operation. 4. The Administrator, director of maintenance or designee will be responsible to monitor (Attachment D) all hard wired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			smoke detectors in the facility to ensure none 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.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure documentation was available to show that all 82 smoke detectors in the existing portion of the facility were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the	K 0345	K345 requires that the facility ensure that all smoke detectors are sensitivity tested within 24 months. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement that the smoke detectors have to be sensitivity tested every 24 months or prior. The smoke detectors have been sensitivity tested. (Attachment K) 2. No residents were harmed by	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 03/20/23 between 9:45 a.m. and 2:00 p.m. with the Maintenance Director and Maintenance Director from a sister facility present, the facility was unable to produce a smoke detector sensitivity report for all smoke detectors for the past 24-month period. The most recent smoke detector sensitivity test available was dated 02/12/21. Based on interview at the time of record review, the facility Maintenance Director confirmed there was no smoke detector		this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated to the requirement that the smoke detectors have to be sensitivity tested every 24 months or prior. The smoke detectors have been sensitivity tested. (Attachment K) by Elwood Fire. 3. The facility's smoke detectors was tested and no concerns were noted. 4. The Administrator, Director of Maintenance or designee will be responsible to monitor (Attachment D) the facility's sensitivity reports to ensure the sensitivity is completed every 24 months or prior. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	sensitivity testing documentation available since 02/12/21. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 5 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical	K 0353	K353 requires automatic sprinkler heads to be free from any corrosion, foreign material, paint, and physical damage. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement that the sprinkler heads must remain free from corrosion, foreign material, paint,	04/07/2023

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	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect mostly staff plus any resident while in the same smoke compartment. 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, there was one sprinkler head in the 100 Hall Mechanical Room covered with green corrosion. Based on interview at the time of observation, the facility Maintenance Director agreed the sprinkler head in the 100 Hall Mechanical Room was covered with green corrosion and should be replaced. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		and physical damage. The sprinkler head in the 100 hall mechanical room has been replaced. (Attachment L) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated to the requirement that the sprinkler heads must remain free 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 heads throughout the facility were all checked to ensure they remain free from corrosion, foreign material, paint, and physical damage. 4. The Administrator, Director of maintenance or designee will be responsible to check sprinkler heads throughout the facility (Attachment D) to ensure they remain free from corrosion, foreign material, paint, and physical damage. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of over 20 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments	K 0511	K511 requires ground fault circuit interrupter GFCI receptacles be installed close to all wet locations. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement for installation of GFCI receptacles near any wet location throughout the facility. The identified receptacles have all been replaced with a new GFCI receptacle. (Attachment M) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated regarding the requirement for installation of GFCI receptacles near any wet location throughout the facility. 3. The facility's Interior preventative maintenance log has been updated to include checking GFCI receptacles to ensure they are installed near all wet locations to prevent any hazards to life, electric shock. 4. The Administrator,	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. 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		Maintenance Director or designee will be responsible to check all wet locations throughout facility to ensure all have GFCI receptacles installed to prevent electric shock. (Attachment D) 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	Director from a sister facility, the following was noted: a. There was one electric receptacle on the wall within three feet of the sink in the Med Room that was not provided with GFCI protection. When tested with a GFCI testing device, the electric circuit was not broken. b. There was one electric receptacle on the wall in the Pantry within three feet and to the left of the sink. The receptacle was a GFCI receptacle, however, when tested with a GFCI testing device, the receptacle indicated it was wired Hot/Neutral Reverse and did not break the circuit when tested. c. There was one single electrical receptacle and one double electrical receptacle in the kitchen, both within three feet of the single sink, that were not provided with GFCI protection. When tested with a GFCI testing device, the electric circuit for both receptacles was not broken. Based on interview at the time of each observation, the facility Maintenance Director agreed the receptacles in question were not properly GFCI protected. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)			
K 0761 SS=F Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly and 1 of 1 set of separation fire doors assembly between the New and Existing portions of the Skilled Care Units were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers	K 0761	K761 requires maintenance, testing, and inspection of all fire doors 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated on the fire door inspections, testing and	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the		maintenance to include all fire doors. (Attachment A) The facility map has been updated to include all fire doors that need inspected, tested, and maintained. The director of maintenance has completed the fire door assembly maintenance, 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 N). 2. No residents were harmed by this alleged deficient practice. All residents had the potential to be affected. The director of maintenance has been educated regarding the annual maintenance, testing, and inspection of all fire doors. 3. The facility's annual maintenance, inspection, and testing form was reviewed with no changes needed. The facility's map was updated to include all doors that need maintenance, testing, and inspection. 4. The Administrator, director of maintenance, or designee will be responsible to check all fire doors to ensure all have been maintained, inspected, and tested annually. (Attachment D) Any negative findings will be corrected immediately. The monitoring logs will be reviewed during the monthly quality assurance meetings and will remain ongoing for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as 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, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly and the set of separation fire doors assembly between the New and Existing portions of the Skilled Care Units during the past 12 month period. Based on interview at the time of record review, the facility Maintenance Director confirmed there were no fire door assembly inspection 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 oxygen transfilling room fire door assembly and 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)		compliance. 5. The above corrective measures will be completed on or before April 7th, 2023.	
K 0781 SS=E	NFPA 101 Portable Space Heaters			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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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 Based on record review, observation, and interview; the facility failed to ensure complete documentation was provided for the use of portable space heaters in staff areas only. This deficient practice could affect staff in the Respiratory Office, plus any residents and staff within the same smoke compartment. 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 of a sister facility present, the facility did have a portable space heater policy and procedure that allowed portable space heaters to be used in staff areas only. The policy also indicated the heating elements in such devices to not exceed 212 degrees F. Based on observations between 2:00 p.m. and 4:45 p.m. during a tour of the facility with both Maintenance Director's, there was a portable space heater turned on in the Respiratory Office while no staff was present. Respiratory staff did show up within a few minutes. Furthermore, there was no documentation available either on the portable space heater or in written/booklet form to show that the heating element would not exceed 212 degrees F. This was confirmed by the facility Maintenance Director at the time of observation. This finding was reviewed with both Maintenance Director's during the exit conference.	K 0781	K781 requires heating elements not to exceed 212 degrees fahrenheit in space heaters that are used in employee areas. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated on space heater requirements in employee areas (Attachment A). The space heater located in the respiratory office has been removed. (Attachment O) 2. No residents were harmed by this alleged deficient practice. All residents had the potential to be affected. The director of maintenance has been educated on space heater requirements. 3. The facility's space heater policy and procedure was reviewed with no changes needed. The space heater was removed from the RT office. 4. The Administrator, director of maintenance, or designee will be responsible to check all employee areas to ensure there are no space heaters in use. (Attachment D) Any negative findings will be corrected immediately. The monitoring logs will be reviewed	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	3.1-19(b)		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.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or 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 monthly test, a process shall be provided to annually confirm this capability for the life safety and critical 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 once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This	K 0918	K918 requires that the facility implement Emergency Generator inspection, testing, and maintenance. 1. No residents were harmed by this alleged deficient practice. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual minimum 30 minute run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspection. (Attachment A) picture of light (Attachment E) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 no documentation on the emergency generator monthly test form for a 30 minute run time during the monthly load tests during the past 12 months. The information provided for run time was based on a counter number from the generator panel. Based on interview at the time of record review, the facility Maintenance Director agreed the actual run time was not properly documented on the monthly generator load test form. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded		minimum 30 minute run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspetion. 3. The facility's emergency generator logs were reviewed with no changes needed. The director of maintenance or designee will be responsible for completing the emergency generator logs with the actual start and stop times for the minimum 30 minute run time, completing the monthly load testing with the proper cool down time, and completing the visual inspection and testing of the battery powered light set located at the emergency generator. 4. The Administrator, director of maintenance or designee will be responsible to review the emergency generator documentation weekly to ensure the required documentation has been completed as required. Any negative findings will be immediately corrected. Monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance. (Attachment D)	

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	155535	A. BUILDING 01 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime 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 test, however, it was documented for a 2 minute cool down time only for the past 3 months (when the facility's new generator was installed). Based on interview at the time of record review, the facility Maintenance Director said the cool down time for the new generator was at least 10 minutes, but was confused by the monthly generator load test form and wrote the wrong time down. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator was provided with a battery backup light set. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a		5. The above corrective measures will be completed on or before April 7th, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. 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, there was no battery powered light set at the emergency generator. The emergency generator was located at least 100 feet from the rear parking lot. Based on an interview at the time of record review, the facility Maintenance Director confirmed there was no battery powered light set at the emergency generator. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The new 300 Hall unit consists of occupational & physical therapy rooms and a 16 resident room, 32-bed locked unit, including resident rooms	K 0000	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 on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement	

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	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	301-318. Survey Date: 03/20/23 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. This one story building was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the building electrical system in the 300 Hall resident rooms with battery backup which report to the 300 Hall nurses' station. The facility has a capacity of 112 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/27/23		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 to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.	
K 0227 SS=E Bldg. 02	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	provisions 7.2.5 through 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 and interview, the facility failed to ensure 1 of 1 exit ramp from the new 300 Hall unit was provided with a handrail on both sides of the ramp. LSC 7.2.5.4.2 states handrails complying with 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 inches. This deficient practice could affect all residents, staff, and visitors if needing to exit the 300 Hall unit. 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 exit discharge ramp outside the 300 Hall exit was was only provided with a handrail on one side of the ramp. Based on interview at the time of the observation, the facility Maintenance Director agreed there was a handrail on only one side of the exit ramp. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)	K 0227	K227 requires a handrail on both sides of an exit ramp 1. No residents were harmed by this alleged deficient practice. The director of maintenance has been educated on the requirements of having a handrail on both sides of the 300 hall exit ramp. (Attachment A). A second handrail has been installed at the 300 hall exit ramp. (Attachment P) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the requirements of having a handrail on both sides of the 300 hall exit ramp. A second handrail has been installed at the 300 hall exit ramp. 3. The facility's outside preventative maintenance form was reviewed and updated to include checking 300 hall handrails to ensure there are 2 rails at the exit. 4. The Administrator, director of maintenance, or designee will be responsible to monitor the outside exit ramp to ensure there are 2 handrails at the exit. (Attachment D). Any negative findings will be corrected immediately. Monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance.	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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			5. The above corrective measures will be completed on or before April 7th, 2023.	
K 0293 SS=E Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 door to the outside courtyard in the 300 Hall could not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect up to all residents, as well as staff and visitors in the 300 Hall unit. 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 300 Hall Activity Room door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Director said the 300 Hall Activity Room door to the courtyard	K 0293	K293 requires a NO EXIT sign be posted on a door that is not an exit 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated on the requirements of having a NO EXIT sign posted on the 300 hall courtyard door to ensure the door could not be mistaken as a facility exit. (Attachment A) The 300 hall courtyard door has been equipped with a NO EXIT sign (Attachment Q) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the requirements of having a NO EXIT sign posted on the 300 hall courtyard door to ensure the door could not be mistaken as a facility exit. 3. The facility's interior	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	is not an exit to the public way and acknowledged it did not have a NO EXIT sign posted. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		preventative maintenance form was reviewed and updated to include checking courtyard doors to ensure there is a NO exit sign located on the door. 4. The Administrator, director of maintenance, or designee will be responsible to monitor the courtyard doors to ensure there is a NO EXIT sign posted on the door. Any negative findings will be corrected immediately. Monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance. 5. The above corrective measures will be completed on or before April 7th, 2023.	
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility	K 0341	K341 requires the facility to	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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	failed to ensure 2 of over 10 hard wired smoke detectors in the new 300 Hall addition of the facility were not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect all residents, staff, and visitors in the new 300 Hall addition. 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 following was noted: a. There was a ceiling mounted smoke detector within one foot of an air supply vent in the 300 Hall corridor outside room 308. b. There was a ceiling mounted smoke detector within two feet of an air supply vent in the 300 Hall Nurses' Station area. Based on interview at the time of each observation, the facility Maintenance Director agreed the smoke detectors in question were to close to air supply vents. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		ensure that hard wired smoke detectors are not installed where air flow would adversely affect its operation. 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement that all hard wired smoke detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. The hard wired smoke detectors have been re located away from air supply diffusers and return air openings. (Attachment J) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated to the requirement that all hard wired smoke detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. The hard wired smoke detectors have been re located away from air supply diffusers and return air openings. (Attachment J) 3. The facility's interior preventative maintenance program was reviewed and updated to check all hard wired smoke detectors to ensure none are installed to where air flow would adversely affect its operation. 4. The Administrator, director of maintenance or designee will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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			responsible to monitor (Attachment D) all hard wired smoke detectors in the facility to ensure none 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.	
K 0347 SS=E Bldg. 02	NFPA 101 Smoke Detection Smoke Detection 2012 NEW 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 101 in 4.6.12.3 states existing life safety features	K 0347	K347 requires battery operated smoke detectors be tested monthly for functionality including the location of the smoke detectors. 1. No residents were harmed by	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all 300 Hall residents, as well as 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 available to show resident room battery operated smoke detectors were tested for functionality on a monthly basis during the past twelve months, however, the documentation was incomplete. It was not an itemized list of where the smoke detectors were located, it was only a form that stated "Fire Alarms Checked" with a check mark by each month. Based on interview at the time of record review, the facility Maintenance Director confirmed the lack of proper documentation for monthly testing of all 300 Hall resident room battery operated smoke detectors during the past 24 months. Based on observations between 2:00 p.m. and 4:45 p.m. during a tour of the facility with both Maintenance Director's, battery operated smoke alarms were observed in all resident sleeping rooms in the 300 Hall. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)		the alleged deficient practice. The director of maintenance has been educated (Attachment A) to the requirement that all battery operated smoke detectors be tested for functionality including the location of each smoke detector monthly. The battery operated smoke detectors have been tested and documentation completed for all battery operated smoke detectors located on the 300 hall. (Attachment S). 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated to the requirement that all battery operated smoke detectors be tested for functionality including the location of each smoke detector monthly. The battery operated smoke detectors have been tested and documentation completed for all battery operated smoke detectors located on the 300 hall. 3. The facility's battery operated smoke detector policy was reviewed with no changes needed. 4. The Administrator, director of maintenance, or designee will be responsible to monitor (Attachment D) all documentation for the battery operated smoke detectors on 300 hall monthly to ensure they have been tested for functionality, including the location of the smoke detectors.	

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	155535	A. BUILDING 02 B. WING	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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			(Attachment D). 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.	
K 0761 SS=F Bldg. 02	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 set of separation fire doors assembly between the New and Existing portions of the Skilled Care Units was completed in accordance with LSC 18.1.1.4.1.1. Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	K761 requires maintenance, testing, and inspection of all fire doors 1. No residents were harmed by the alleged deficient practice. The director of maintenance has been educated on the fire door inspections, testing and maintenance to include all fire doors. (Attachment A) The facility map has been updated to include all fire doors that need inspected, tested, and maintained. The director of maintenance has completed the fire door assembly maintenance, 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 N). 2. No residents were harmed by this alleged deficient practice. All residents had the potential to be affected. The director of	04/07/2023

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	NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as 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, the facility was unable to provide documentation for an annual inspection of the set of separation fire doors assembly between the		maintenance has been educated regarding the annual maintenance, testing, and inspection of all fire doors. 3. The facility's annual maintenance, inspection, and testing form was reviewed with no changes needed. The facility's map was updated to include all doors that need maintenance, testing, and inspection. 4. The Administrator, director of maintenance, or designee will be responsible to check all fire doors to ensure all have been maintained, inspected, and tested annually. (Attachment D) 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.	

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	New and Existing portions of the Skilled Care Units during the past 12 month period. Based on interview at the time of record review, the facility Maintenance Director confirmed there were no fire door assembly inspection 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 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or 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 monthly test, a process shall be provided to annually confirm this capability for the life safety and critical 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 once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

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	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent	K 0918	K918 requires that the facility implement Emergency Generator inspection, testing, and maintenance. 1. No residents were harmed by this alleged deficient practice. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual minimum 30 minute run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspection. (Attachment A) picture of light	04/07/2023

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	of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. 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 no documentation on the emergency generator monthly test form for a 30-minute run time during the monthly load tests during the past 12 months. The information provided for run time was based on a counter number from the generator panel. Based on interview at the time of record review, the facility Maintenance Director agreed the actual run time was not properly documented on the monthly generator load test form. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency		(Attachment E) 2. No residents were harmed by this alleged deficient practice. All resident had the potential to be affected. The director of maintenance has been educated on the documentation requirements for the emergency generator including how to properly document the actual minimum 30 minute run time, how to complete the monthly load testing for the generator including the proper cool down time, and the requirement to have battery powered light set at the emergency generator with functional testing conducted monthly for not less than 30 seconds, functional testing annually for a minimum of 90 minutes, visual inspections and tests shall be kept for inspetion. 3. The facility's emergency generator logs were reviewed with no changes needed. The director of maintenance or designee will be responsible for completing the emergency generator logs with the actual start and stop times for the minimum 30 minute run time, completing the monthly load testing with the proper cool down time, and completing the visual inspection and testing of the battery powered light set located at the emergency generator. 4. The Administrator, director of maintenance or designee will be responsible to review the	

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	electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, 6.4.2.1.5.9 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime 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 test, however, it was documented for a 2-minute cool down time only for the past 3 months (when the facility's new generator was installed). Based on interview at the time of record review, the facility Maintenance Director said the cool down time for the new generator was at least 10 minutes but was confused by the monthly generator load test form and wrote the wrong time down. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b) 3. Based on observation and interview, the		emergency generator documentation weekly to ensure the required documentation has been completed as required. Any negative findings will be immediately corrected. Monitoring logs will be reviewed monthly during the quality assurance meetings and will remain ongoing for compliance. (Attachment D) 5. The above corrective measures will be completed on or before April 7th, 2023.	

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	facility failed to ensure 1 of 1 emergency task generator was provided with a battery backup light set. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. 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, there was no battery powered light set at the emergency generator. The emergency generator was located at least 100 feet from the rear parking lot. Based on an interview at the time of record review, the facility Maintenance Director confirmed there was no battery powered light set at the emergency generator. This finding was reviewed with both Maintenance Director's during the exit conference. 3.1-19(b)			