STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BUI	A. BUILDING C			survey leted /2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630					
(X4) ID PREFIX TAG E 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg	conducted by the In accordance with 42 Survey Date: 02/25 Facility Number: 00 Provider Number: 1002 At this Emergency I Newburgh Health Compliance with En Requirements for M Participating Provid 483.73.	25 00245 155354 2890800 Preparedness survey, fare was found not in nergency Preparedness fedicare and Medicaid fers and Suppliers, 42 CFR certified beds. At the time of	E 00	00				
E 0004 SS=F Bldg	MET as evidenced by 403.748(a), 416.54 Develop EP Plan, Annually Based on record reversaled to develop and preparedness plan that least annually in a 483.73(a). This defersidents in the facil Findings include:	42 CFR, Subpart 483.73 is NOT by: 4(a), 418.113(a), 441.1 Review and Update iew and interview, the facility d maintain an emergency hat was reviewed and updated accordance with 42 CFR icient practice could affect all lity.	E 00	04	No residents were affected by tag. No other residents were affected and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station. Annual monitoring and updated	ted,	04/17/2025	
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(X6) DATE	
Emily Died	rich		ŀ	ΗFA			04/11/2025	

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JSDW21 Facility ID: 000245 If continuation sheet Page 1 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		104	EET ADDRESS, CITY, STATE, ZIP COD 166 POLLACK AVE WBURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE
E 0013 SS=F Bldg	Manual on 02/25/25 p.m. with the Admi Director present, the emergency prepared to been reviewed a twelve months. The the cover of the mainterview at the time confirmed there was Emergency Prepare reviewed and updat month period. This finding was reand Maintenance Diconference. 403.748(b), 416.5 Development of Emergency Development of Emergency Development of Emergency Prepare reviewed and update month period.	the Emergency Preparedness between 10:00 a.m. and 3:00 mistrator and Maintenance e facility did provide an dness manual, however, it has and updated during the past e most recent date of review on mual was 04/20/22. Based on e of review, the Administrator is no evidence that the dness Manual has not been ed within the past twelve wiewed with the Administrator irector during the exit 4(b), 418.113(b), 441.1 P Policies and Procedures		will be placed in the manual a needed.	
	failed to develop an preparedness policies and proced updated at least ann CFR 483.73(b). The all residents in the fall residents in	the Emergency Preparedness between 10:00 a.m. and 3:00 nistrator and Maintenance ere was documentation in the icies and procedures, however cedures have not been ility within the most recent date of the first of the manual was 04/20/22.	E 0013	No residents were affected by tag. No other residents were affected and the manual will be updated appropriately. Inservice staff to ensure awareness of updated manual each nurse's station. Annual monitoring and updated will be placed in the manual aneeded.	cted, ee als at

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 2 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BU	A. BUILDING B. WING			ETED 2025	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0025 SS=C Bldg	Administrator confir procedures within the Manual have not be within the past twelve. This finding was revand Maintenance Disconference. 403.748(b)(7), 418 Arrangement with Based on record rev failed to ensure eme and procedures incluarrangements with coproviders to receive limitations or cessat the continuity of ser accordance with 42 deficient practice coefficient practice coeffici	viewed with the Administrator frector during the exit	E 00	025	No residents were affected by tag. No other residents were affect and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station. Annual monitoring and update will be placed in the manual as needed.	ed, s at s	04/17/2025

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 3 of 31

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155354	B. W	B. WING 02/25/2025			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
E 0029 SS=F	and Maintenance Diconference. 403.748(c), 416.54	viewed with the Administrator irector during the exit 4(c), 418.113(c), 441.1 ommunication Plan					
Bldg	Based on record reversal failed to develop and preparedness common with Federal, State, and updated at least 42 CFR 483.73(c). affect all occupants. Findings include: Based on review of Manual on 02/25/25 p.m. with the Admin Director present, the preparedness plan dependent of the most recent twelf recent date of review as 04/20/22. Base review, the Administration Plan Preparedness Manual updated within the preparedness Manual updated within the preparedness Manual preparedness Ma	riew and interview, the facility d maintain an emergency unication plan that complies and local laws was reviewed annually in accordance with This deficient practice could	E 00	029	No residents were affected by tag. No other residents were affect and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station and communication plan. Annual monitoring and update will be placed in the manual as needed.	ed, ls at	04/17/2025

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 4 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BUILDING B. WING	COMPLETED 02/25/2025			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG E 0036	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 403.748(d), 416.54(d), 418.113(d), 441.1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
SS=F Bldg	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at the time of review, the Administrator confirmed the training and testing policy and procedure within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit	E 0036	No residents were affected by tag. No other residents were affect and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station and communication plan. Annual monitoring and update will be placed in the manual as needed.	red, Is at		
E 0039 SS=F Bldg	conference. 403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency	E 0039	No residents were affected by tag.			
	plan at least twice per year, including unannounced staff drills using the emergency		No other residents were affect by this tag.	rea		

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

Event ID:

 $JSDW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000245$

If continuation sheet

Page 5 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ĺ ′			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED					
		155354	B. W	B. WING 02/25/2025				
NAME OF F	PROVIDER OR SUPPLIER	· }	-		ADDRESS, CITY, STATE, ZIP COD			
				10466 POLLACK AVE				
NEWBUF	RGH HEALTH CAR	E		NEWBU	URGH, IN 47630			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	_	TAG		DATE		
	_	C facility must do the			Inservice with Maintenance			
	following:	annual full-scale exercise that			Director will be completed to			
	is community-based				ensure proper protocol is followed.			
	-	ity-based exercise is not			Will review in QA meetings. a	nd		
		an annual individual,			staff interviews,	ilu		
	facility-based funct				July interviews,			
	_	y experiences an actual natural			E 0039			
		gency that requires activation			CORRECTIVE ACTION			
		lan, the LTC facility is exempt			No residents were affected by	the		
		ext required full-scale in a			alleged deficiency.			
		or individual, facility-based			RESIDENTS HAVING THE			
	full-scale functional exercise for 1 year following				POTENTIAL TO BE AFFECTE	ED		
	the onset of the actu	aal event.			All residents have the potentia	al to		
	(ii) Conduct an add	itional exercise that may			be affected.			
	include, but is not li	imited to the following:						
	a. A second full-sca	ale exercise that is			MEASURES PUT INTO			
	1	or an individual, facility-based			PLACE/SYSTEMIC CHANGE	S		
	functional exercise.				A table top exercise lead by a			
	b. A mock disaster				facilitator including a group			
	_	se or workshop that is led by a			discussion, using a narrated			
		des a group discussion, using			clinically – relevant emergenc	-		
		y-relevant emergency scenario,			scenario and a set of problem			
	_	n statements, directed			statements, directed message			
		red questions designed to			prepared questions designed			
	challenge an emerg				challenge an emergency plan			
		C facility's response to and ation of all drills, tabletop			be conducted for facility staff to			
		rgency events, and revise the			the Maintenance Director, Fac	anity		
		gency plan, as needed in			Administrator or designee. The facility's response will be			
	accordance with 42				analyzed and documented			
		ice could affect all occupants			including all drills, table top			
	in the facility.	all all occupants			exercises and emergency eve	ents.		
					The facility's Emergency Plan			
	Findings include:				be updated and or revised as			
					needed.			
	Based on review of	the Emergency Preparedness			The drill will be repeated the			
		5 between 10:00 a.m. and 3:00			following year unless there is	an		
	p.m. with the Admi	nistrator and Maintenance			actual event, then the drill will			
	_	e facility was able to provide			repeated and conducted every			

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BUILDING B. WING		COMPLETED 02/25/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	documentation of an actual event, a fire in the facility on 02/03/25, however, there was no documentation of a second exercise conducted by the facility during the past 12 month period. This was confirmed by the Administrator and Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			years and documented accord to the requirement. MONITORING The Maintenance Director and facility Administrator will monit the event and proceed with th appropriate follow up as soon practicable but not to exceed tweeks. The results of the Emergency Drills will be presented in the monthly Quality Assurance Performance Improvement Meeting. This monitor will be ongoing to reflect the various opportunitie action. Completion Date 4/17/2025	or e as wo		
E 0041 SS=F Bldg	, ,	(e), 485.542(e), 485.62 LTC Emergency Power					
ק נ	failed to implement inspection, testing, a found in the Health 110, and Life Safety CFR 483.73(e)(2). 1. Based on record facility failed to profor the testing of 1 c System in accordance for Emergency and Section 8.4.9, as required Facilities Code, Sec Section 8.4.9 states	iew and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA Code in accordance with 42 review and interview, the vide complete documentation of 1 Emergency Power Standby the with NFPA 110, Standard Standby Power Systems, uired by NFPA 99 Health Care tion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 1 be tested at least once within	E 0041	No residents were affected by tag. No other residents were affect by this tag. Maintenance Director will have system inspected as required. Proper documentation and logbook to be kept.	ed ethe		

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 7 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MUL A. BUIL B. WING	DING	NSTRUCTION	(X3) DATE : COMPL 02/25/	ETED	
	PROVIDER OR SUPPLIER			10466 P	DDRESS, CITY, STATE, ZIP COD POLLACK AVE IRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	assigned class is grepermitted to terminal NFPA 99 Section 6 Type 2 essential eleshall be classified a	6 months). Where the eater than 4 hours, it shall be ate the test after 4 hours. 4.1.1.6.1 states that Type 1 and extrical system power sources t Type 10, Class X, Level 1 s deficient practice could eccupants.					
	a.m. and 3:00 p.m. present, the facility documentation of a emergency generate 36 month period. This finding was re	view on 02/25/25 between 10:00 with the Maintenance Director was unable to provide four hour load test of the or conducted within the past this was confirmed by the for at the time of record review.					
	conference. 2. Based on record facility failed to ensimal maintenance and tengenerator was main NFPA 110, the Star Standby Powers Sylwritten schedule for operational testing destablished. 8.3.4 r the EPSS inspection and repairs shall be available. 8.3.4.1 r shall include the fol maintenance report servicing personnel unsatisfactory cond	review and interview, the sure a written record of routine sting for 1 of 1 emergency tained and available for review. Indeed of the EPSS and the EPSS shall be equires a permanent record of the EPSS shall be equires a permanent record of the steps, exercising, operation, maintained and readily equires the permanent record lowing: (1) The date of the (2) Identification of the (3) Notification of any ition and the corrective action the replaced (4) Testing of any					

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet

Page 8 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BUILDING B. WING	onstruction 	COMPLETED 02/25/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630					
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors.							
	a.m. and 3:00 p.m. v present, there was no show the emergency maintenance during recent routine maint emergency generato was over a month pa the time of record re Director said there is for the generator ven	iew on 02/25/25 between 10:00 with the Maintenance Director o documentation available to a generator has had routine the past 12 months. The most tenance report for the arr was dated 01/09/24, which ast due. Based on interview at eview, the Maintenance is currently no scheduled date andor to come to the facility to intenance service on the or.						
K 0000		viewed with the Administrator irector during the exit						
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000					
	Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C Care was found not	155354 290800 Code survey, Newburgh Health						

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 9 of 31

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION 01	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	COMPLETED			
		155354	B. WING 02/25/2025				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD POLLACK AVE			
NEWBUF	RGH HEALTH CAR	E		URGH, IN 47630			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR Requirements for Pa	LISC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE		
	•	, 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the					
	_	ction Association (NFPA) 101,					
	Life Safety Code (L	SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
		ity was determined to be of					
	· · ·	ruction and was fully					
	_	cility has a fire alarm system					
	with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had						
	a census of 55 at the	e time of this survey.					
	All areas where the	residents have customary					
	_	ered, and all areas providing					
	-	cluding a detached garage used					
		hop and maintenance and					
		re sprinklered, except a small ned shed used for furniture					
		in cooler outside the kitchen					
	service hall exit.	in cooler outside the knotten					
	Quality Review con	npleted on 02/28/25					
K 0291	NFPA 101						
SS=C Bldg. 01	Emergency Lightir	ng					
	Based on record rev	view and interview, the facility	K 0291	No residents were affected by	this 04/17/2025		
		umentation was provided for		tag.			
	_	battery powered emergency		No other residents were affect			
		ested monthly for 30 seconds		Maintenance Director has beg	jun		
	-	12 months, and annually for he past 12 months to ensure		logbook and proof of testing. MCORRECTIVE ACTION			
	_	vide lighting during periods of		No residents were affected by	the		
		C 19.2.9.1 requires emergency		alleged deficiency.			
lighting shall be provided in accordance with							
		n 7.9.3.1.1 (1) requires		RESIDENTS HAVING THE			

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 10 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	·			COMPLETED
		155354	B. WING 02/25/2025			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI ANI OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	functional testing sl	nall be conducted monthly,			POTENTIAL TO BE AFFECTE	ĒD
		3 weeks and a maximum of 5			Residents may have the poter	ntial
		s, for not less than 30			to be affected but are not	
	seconds, (3) Function	_			identified.	
	· ·	for a minimum of 1 1/2 hours				
		ghting system is battery			MEASURES PUT INTO PLAC	CE /
		ritten records of visual			SYSTEMIC CHANGES	
	_	s shall be kept by the owner			The Maintenance Director or	
	for inspection by th	•			designee will perform the 30	
	l -	eficient practice could affect all			second monthly test has been	
	facility.	s staff and visitors in the			completed. The 90 minute and	
	lacility.				test by 4/17/2025 utilizing the	
	Findings include:				current logging tool including t time frame for the month as	ne
	Tilidings include.				scheduled.	
	Based on record rev	view on 02/25/25 between 10:00			scrieduled.	
		with the Maintenance Director			MONITORING	
	_	did have a line item on the			ı	
		or monthly load testing form			The Maintenance Director will monitor the competition of the	
		cy lighting was tested monthly.			testing and document on the	
		nentation on the form for			monitoring tool.	
		ember of 2024 and January of			The Maintenance Director will	
		gency light was tested for 30			follow up on it's completion be	
	seconds. Furthermo	· ·			the end of the month it is	
	documentation avai	lable to show the battery		scheduled to ensure completion of		
	powered emergency	light unit was tested annually			the check and the documenta	
		ng the past 12 month period.			A report or copy of the results	will
	Based on interview	at the time of record review,			be given to the facility	
		rector said he does test the			Administrator. Any area or	
		ergency light unit at the			areas of concern will be revie	
		ch monthly load test, but must			and addressed as necessary	at
		ocument the 30 second tests			this time.	
		December of 2024 and January			The results will be reviewed	
		said there is no documentation			monthly at the Quality Assura	· · · · · · · · · · · · · · · · · · ·
		of the battery powered			Performance Committee Meet	-
	emergency light un	it available for review.			for 6 month . Afterwards it will	
					reviewed for patterns requiring	
		viewed with the Administrator			changes.	
		irector during the exit				
1	conference.		1		Completion Date 4/17/2025	l l

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	COMPLETED	
		155354	B. WI	B. WING 02/25/202			/2025	
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	1						
NEWBLIE	RGH HEALTH CAR	F		10466 POLLACK AVE NEWBURGH, IN 47630				
NEWBOI	CONTIE ALTHOUGH			INLVIBO				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
	3.1-19(b)							
K 0300	NEDA 404							
K 0300 SS=F	NFPA 101							
	Protection - Other							
Bldg. 01	1 Dagad an maa1	raviaty and interview the	IZ O	200	No regidente viere effected by	thic	04/17/2025	
		review and interview, the sure the preventative	K 0	300	No residents were affected by	นแร	04/17/2025	
	•	battery operated smoke alarms			tag. No other residents were affect	od		
		as conducted according to				.c u		
		ished instructions. NFPA 101			by this tag. Maintenance Director will have	a the		
	•	isting life safety features			smoke detectors inspected as			
		ic, if not required by the Code,			required.	•		
	-	NFPA 72, 29.10 Maintenance			Prop			
		rning equipment shall be			1 100			
		ed in accordance with the			K 0300			
		ished instructions and per the			CORRECTIVE ACTION			
	_	apter 14. NFPA 72, 14.2.1.1.1			No residents were affected by	the		
		and maintenance programs			alleged deficiency.			
		uirements of this Code and			,			
		pment manufacturer's			RESIDENTS HAVING THE			
		ns. This deficient practice			POTENTIAL TO BE AFFECTE	D		
	could affect all resid	dents.			All residents have the potentia	l to		
					be affected.			
	Findings include:							
					MEASURES PUT INTO PLAC	E/		
	Based on record rev	view on 02/25/25 between 10:00			SYSTEMIC CHANGES			
		with the Administrator and the			The Maintenance Director and	l or		
	Maintenance Direct	or present, the "Maintenance			Designee has begun the batte	ry		
	Log for Resident Ro	oom Smoke Detector Test"			checks for residents rooms.			
	-	sting of the battery operated			A smoke detector battery test			
		manufacturer's published			check will be performed weekl	у		
		back side of each smoke alarm			thereafter according to the dev	/ices		
		quire weekly testing. Based			manufacturers guidelines.			
		time of record review, the			Corrections will be made as so	oon		
		or stated the smoke alarms are			as possible.			
	tested monthly, and agreed the alarms should be				The testing dates and results			
		ding to manufacturer's			be documented in the log boo	k.		
	published instructio	ns.						

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 12 of 31

CT ATEL CO	IT OF DEFICIENCIES	W1) DROVIDED (CURRY IER (CULA	(V2) 2.5	III TIDI E CO	NICTRICTION	(V2) DATE	CLIDVEY
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155354	B. W	ING		02/25	/2025
NAME OF D	ROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF P	NO VIDER OR SUPPLIED			10466 F	POLLACK AVE		
NEWBUF	RGH HEALTH CAR	E	NEWBURGH, IN 47630				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator			MONITORING		
		virector during the exit			The Maintenance Director and		
	conference.				facility Administrator will moni	tor	
					the testing dates and log for		
	3.1-19(b)				consistency and proceed with		
					appropriate follow up as soon	as	
		review and interview, the			possible.		
	facility failed to ensure documentation for the				The results of the smoke dete		
	-	enance of battery operated			checks will be presented in th	е	
		resident rooms was complete.			monthly Quality Assurance		
	· ·	1 states that to ensure			Performance Improvement		
		, the system shall have an			Meeting.		
	_	and maintenance program.			This monitor will be ongoing to		
		tes fire-warning equipment shall			reflect the various opportunitie	es for	
		tested in accordance with			action.		
	_	lished instructions and per the			Competition Date 4/17/2025		
	_	apter 14. This deficient					
	-	et all residents, staff and					
	visitors.				er documentation and logboo	k to	
					be kept.		
	Findings include:						
	Based on record rev	view on 02/25/25 between 10:00					
	a.m. and 3:00 p.m.	with the Maintenance Director					
	present, the battery	operated smoke alarm					
	maintenance docum	nentation failed to indicate					
	battery replacement	t during the past 12 month					
	period or prior. The	e most recent battery					
	replacement was do	ocumented on 01/18/24, which					
	is over a month pas	t due. Based on interview at					
	the time of record re	eview, the Maintenance					
	Director confirmed	the batteries in the resident					
	room smoke alarms	s have not been replaced in the					
	past 12 month perio	od.					
	This finding was re	viewed with the Administrator					
		virector during the exit					
	conference.	nector during the exit					
	conference.						
	3.1-19(b)						

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet

Page 13 of 31

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIEF		10466	FADDRESS, CITY, STATE, ZIP COD S POLLACK AVE BURGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N (X5) SE COMPLETION DATE	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities					
Bldg. 01	facility failed to ensure proper use of the U system in 1 of 1 kit Ventilation Control Commercial Cooking states instruction share garding the proper extinguishers and the fire-extinguishing extinguishing extinguishing system conspicuously in the reviewed with empressidents while in the Findings include: Based on observational properties of the system of the syst	e kitchen and shall be loyees by management. This buld affect kitchen staff plus all the adjoining main dining room. Ons on 02/25/25 between 3:00	K 0324	No residents were affected by tag. No other residents were affected by Maintenace Director will have class with kitchen staff and directions will also be posted An in-service sheet will be known prove compliance. CORRECTIVE ACTION No residents were affected by alleged deficiency. RESIDENTS HAVING THE POTENTIAL TO BE AFFECT Residents who are in the area the dining room have the poto be affected.	ected. Ve a d. Sept by the	
	the Administrator a kitchen was provide Based on interview Manager and a cool would do first if the range hood and the system had not auto said they would gra (and pointed to it). activating the pull s suppression system knew where it was acknowledged by the system of the pull of t	during a tour of the facility with and Maintenance Director, the ed with a UL 300 hood system. with the Assistant Kitchen k, when asked what they ere was a fire underneath the range hood suppression omatically activated, they both ab the silver fire extinguisher. They did not mention station for the range hood until they were asked if they located. This was the Maintenance Director at the land interview with the kitchen		MEASURES PUT INTO PLA SYSTEMIC CHANGES The Maintenance Director w provide in-service to the kite staff regarding the proper u the UL 300hood fire suppres system. Instructions for use of the po fire extinguisher wil posted in a conspicuous are The content of the informatic provided including staff sign will be documented and filed the appropriate area. Aside from routine cleaning appliances must be removed	vill chen use of ssion ortable II be ea. on uatures d int , if	

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025	
	OF PROVIDER OR SUPPLIES			10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	_	viewed with the Administrator irector during the exit			proper installment and verifica will be professionally complete by Koorsen Environmental.		
	facility failed to pro- returning cooking a when the kitchen h was designed and i extinguishing syste Ventilation Control Commercial Cooki Edition Section 12. requiring protection or rearranged withe fire-extinguishing s or servicing agent, the design of the fir Section 12.1.2.3 sta system shall not rec cooking appliances maintenance and cl appliances are returned in the cooking appliances attached to the appliance of the disconnected fire-e attached to the appliance is returned in the cooking include: Based on observation of the cooking is returned in the cooking include: Based on observation of the cooking is returned in the cooking include: Based on observation of the cooking is returned in the cooking is re	ration and interview, the ovide an approved method for appliances to where they were cood extinguishing equipment installed for 1 of 1 kitchen hood im. NFPA 96, Standard for and Fire Protection of the section 2011 1.2.2, states cooking appliances a shall not be moved, modified, but prior re-evaluation of the system by the system installer unless otherwise allowed by the extinguishing system. Ites the fire-extinguishing quire reevaluation where the are moved for the purposes of eaning, provided the med to approved design oking operations, and any extinguishing system nozzles iances are reconnected in the manufacturer's listed design and 1.2.3.1 states an approved ovided that will ensure that the end to an approved design ient practice could affect for a province of the facility with and Maintenance Director, the			MONITORING The Maintenance Director, face Administrator will ensure follow up for the instruction, content, staff signatures including legit and updated posting. A summary will be provided in next Quality Assurrance / Performance Improvement Meeting. A summary will be submitted thereafter with new hires. This monitor will be ongoing to reflect changes in staffing. Completion Date 4/17/2025	wing and olle the	

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 15 of 31

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/25/2025
	ROVIDER OR SUPPLIER		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0346 SS=C Bldg. 01	was not provided we would ensure that the an approved designs moved for maintenation interview at the fadministrator and Mere not aware an approvided to ensure to an approved designaintenance or clear to an approved a conference. 3.1-19(b) NFPA 101 Fire Alarm System Based on record reversity for a twenty for with LSC, Section 9 affects all occupants. Findings include: Based on record reversity and 3:00 p.m. of Maintenance Direct provide fire watch of Emergency Prepare incomplete. The platter incomplete incomplete. The platter incomplete incomplete. The platter incomplete incomplete. The platter incomplete incomplete incomplete incomplete incomplete incomplete incomplete.	ning. viewed with the Administrator irector during the exit n - Out of Service view and interview, the facility complete written policy for the rupants indicating procedures e event the fire alarm system of service for four hours or ur hour period in accordance 0.6.1.6. This deficient practice	K 0346	No residents were affected by tag. No other residents were affected and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station. Annual monitoring and update will be placed in the manual aneeded. CORRECTIVE ACTION No residents were affected by alleged deficiency.	ted,

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 16 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPI 02/25	LETED
	PROVIDER OR SUPPLIER		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	record review, this Administrator. This finding was re	n an interview at the time of was confirmed by the viewed with the Administrator firector during the exit		RESIDENTS HAVING THE POTENTIAL TO BE AFF All residents have the porbe affected. The policy for Firewalks the essential elements will reviewed for revisions. The revisions will include personnel to continuously the affected area. Ready to fire extinguishers and to promptly notify the fire department. The person not only be looking for the making sure that the other protection features of the such as egress routes an systems are functioning. The event will be reported Indiana Stated Department Health reporting systems are reportable guidelines. The policy for the sprinkle will be reviewed for revisions will include personnel to continuously the affected area. Ready to fire extinguishers and to promptly notify the fire department. The person not only be looking for the making sure that the other protection features of the such as egress routes an systems are functioning in the event the sprinkler is out of service for 10 or hours in a 24- hour period that portion of the building the portion of the building the sure of the protection of the building that portion are portion to the building that portion are protection and the portion of the building that portio	trained y patrol y access the ability should effect of the ability system more dithen	

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

Event ID:

JSDW21

Facility ID: 000245

If continuation sheet

Page 17 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155354	A. BUILDING B. WING	01	COMPLETED 02/25/2025
	ROVIDER OR SUPPLIER		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				evacuated or an approved fire watch will be provided until the sprinkler system has returned service. The event will be reported to the Indiana State Department Of Health reporting system. Facility staff will be in serviced ensure knowledge of the update the Facility New Hire Packets. Policies will be reviewed annument of the Emergency / Disaster Markill be updated to include the changes. MONITORING The Maintenance Director and facility Administrator or design will monitor the event and promit the appropriate follow upon the facility Staff Development Coordinator will ensure New Hand annual inservices are provided. The results will be presented the monthly Quality Assurance Performance Improvement Meeting. This monitor will be ongoing to reflect the various opportunities action. Completion Date 4/17/2025	e to the to the dito ates. ed in ally anual diee ceed dities dires
K 0351 SS=F	NFPA 101 Sprinkler System -	- Installation			

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet

Page 18 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155354	B. WI	NG		02/25/	/2025
					_		
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD		
		_			S POLLACK AVE		
NEWBUF	RGH HEALTH CAR	Ē		NEW	BURGH, IN 47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWINEDIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
Bldg. 01							
Ü	Based on observation	on and interview, the facility	K 0.	351	No residents were affected by	this	03/18/2025
		sprinkler system piping was	10.	551	tag.	4.10	03/10/2023
		1 of 1 attic area throughout			No other residents were affect	-pd	
		13, 2010 Edition, Installation of			This tag has been corrected.	.cu.	
	Sprinkler Systems, Section 9.2.3.7 states Sprigs 4				Annually visualize system.		
	feet or longer shall be restrained against lateral				Aillidally visualize system.		
		ficient practice could affect all					
	residents, staff, and	•					
	residents, starr, and	visitors.			CORRECTIVE ACTION		
	Findings include:				The bracing for the attic sprink	dor	
	rindings include.					(ICI	
	D 1 1 2 02/25/251 4 10.00				sprigs has been corrected by		
	Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. the Maintenance Director				Tristate Fire Protection. No		
	_				residents were affected.		
		1 dated 10/01/24 from the			DECIDENTS 1141/11/0 THE		
		endor to add seismic bracing			RESIDENTS HAVING THE		
		ing in the attic. The proposal			POTENTIAL TO BE AFFECTE		
		and vertical sprig sprinkler			All residents have the potentia	ıl to	
		erview at the time record			be affected by the alleged		
		ance Director said there is no			deficiency.		
		he sprinkler vendor to start					
		observations between 3:00			MEASURES PUT INTO PLAC	Ε/	
	_	during a tour of the facility with			SYSTEMIC CHANGES		
		nd Maintenance Director,			The system will be manually		
		50 or more sprinkler pipe			visualized by the Maintenance		
		ace that were not restrained			Director annually and as the n	eed	
	_	ement. The sprinkler pipe			may arise. The facility will		
		5 feet in length. This was			continue the Services of Trista	ite	
		e Maintenance Director at the			Fire Protection.		
	time of observations	5.			Monitoring		
					The Maintenance Director wil	l	
		viewed with the Administrator			monitor and follow up with the		
		irector during the exit			facility Administrator annually	and	
	conference.				as needed.		
					A summary of reports will be		
	3.1-19(b)				included in the next Quality		
					Assurance Performance Meet	ing	
					and annually thereafter.		
					Competition Date 4/17/2025		

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 19 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155354	B. W	NG		02/25/	/2025	
	ROVIDER OR SUPPLIER		•	10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEAR OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Based on record rev failed to ensure 1 of system was inspecte accordance with NF the Inspection, Test Water-Based Fire P Edition, Section 14. piping and branch li conducted every 5 y connection at the en removing a sprinkle line for the purpose of foreign organic a Alternative nondest shall be permitted. required to be inspe states records shall t tests, and maintenar components and sha authority having jur deficient practice af visitors. Findings include: Based on record rev a.m. and 3:00 p.m. v present, documentat of the sprinkler syst recent five year peri review. Documenta	- Maintenance and Testing Tiew and interview, the facility To automatic sprinkler piping Ed every five years in TPA 25. NFPA 25, Standard for ing and Maintenance of rotection Systems, 2011 2.1 states an inspection of tine conditions shall be rears by opening a flushing and of one main and by the toward the end of one branch of inspecting for the presence and inorganic material. Tructive examination methods Non-metallic pipe shall not be cted internally. Section 4.3.1 be made for all inspections, face of the system and its all be made available to the disdiction upon request. This effects all residents, staff and Tiew on 02/25/25 between 10:00 with the Maintenance Director tion of an internal inspection em performed within the most ind was not available for attion for the most recent tion performed was dated	KO		No residents were affected by tag. No other residents were affect This tag has been corrected. 5 year visualize system. K 353 CORRECTIVE ACTION The sprinkle system has been assessed and completed by Tristate Fire Protection. RESIDENT'S HAVING THE POTENTIAL TO BE AFFECTE All residents have the potential be affected by the alleged deficiency. MEASURES / SYSTEMIC CHANGES The Maintenance Director will maintain a 5 year schedule or for inspection and visualization the sprinkler system. MONITORING The Maintenance Director will review the schedule / log with facility administrator. A summa of the report will be reviewed a next Quality Assurance	ED log n of the ary	03/18/2025	
		s over a month past due.			Performance Improvement Me	acting		
		at the time of record review,			and as needed.	Journa		
			1		ana ao mooada.		I	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		1046	T ADDRESS, CITY, STATE, ZIP COD 6 POLLACK AVE BURGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
	scheduled date for t the internal pipe ins will contact and sch possible. This finding was re-	rector said there is no he sprinkler vendor to perform pection/investigation, but he edule them as soon as viewed with the Administrator irector during the exit		Completion Date 4/17/2025		
K 0354 SS=C Bldg. 01	failed to provide a containing procedur protection of all resautomatic sprinkler out-of-service for 10 period in accordance 9.7.6 requires sprinkler comply with NFPA for the Inspection, 7 Water-Based Fire P 15.5.2 requires nine impairment coordin (b) states a fire water personnel who contarea. Ready access ability to promptly important items to the area, the person for fire, but making protection features or routes and alarm syfunctioning properly	riew and interview, the facility complete written policy res to be followed for the idents in the event the system has to be placed 0 hours or more in a 24-hour e with LSC, Section 9.7.5. LSC kler impairment procedures 25, 2011 Edition, the Standard Testing and Maintenance of rotection Systems. NFPA 25, procedures that the ator shall follow. A.15.5.2 (4) ch should consist of trained inuously patrol the affected to fire extinguishers and the notify the fire department are consider. During the patrol of should not only be looking sure that the other fire of the building such as egress stems are available and y. This deficient practice apants in the facility.	K 0354	No residents were affected by tag. No other residents were affer Policy will be written to ensustaff are in-serviced. Conduct random questions was staff to ensure understanding.	cted. re are	

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 21 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155354	l i		COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER		10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0711 SS=F Bldg. 01	Based on record revalum. and 3:00 p.m. v. Maintenance Direct provided fire watch Emergency Prepared incomplete. The plathe Indiana Departm web link for contact System located on the furthermore, the platinformation for the contact information time of record reviet the fire watch policy mentioned informat. This finding was revalum Maintenance Disconference 3.1-19(b) NFPA 101 Evacuation and Revaluation and Re	n failed to include contact facilities insurance carrier with Based on an interview at the w, the Administrator agreed v lacked the previously ion. Viewed with the Administrator frector during the exit elocation Plan iew and interview, the facility complete facility specific fan for the protection of all ely address all life safety em addressing all items 01, 2012 edition, Section 2.2 requires a written health care y plan that shall provide for alarm to fire department the call to fire department	K 0711	No residents were affected by tag. No other residents were affect and the manual will be update appropriately. Inservice staff to ensure awareness of updated manual each nurse's station and communication plan. Annual monitoring and update will be placed in the manual as needed.	ed, s at	

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

Event ID:

JSDW21 Facility ID: 000245

Page 22 of 31 If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	 JILDING	nstruction 01	(X3) DATE COMPL 02/25 /	ETED
	PROVIDER OR SUPPLIEI		10466 F	DDRESS, CITY, STATE, ZIP COD POLLACK AVE IRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
TAG	(5) Isolation of fire (6) Evacuation of in (7) Evacuation of is (8) Preparation of five evacuation (9) Extinguishment Section 19.2.3.4(4) corridor shall not be width where serving patient sleeping roor required width shall equipment provided equipment during a addressed in the writaining program for equipment is limited in Equipment in used ii. Equipment in used iii. Medical emergendiii. Patient lift and to the third the event of an experiment of the event of an experiment of the plan did not smoke compartment identify where the state of the facility and evant but the Administrator and acknowledged the lacknowledged	mmediate area moke compartment loors and building for of fire states that any required aisle or e less than 48 inches in clear g as means of egress from oms. Projections into the l be permitted for wheeled of fire or similar emergency is eitten fire safety plan and or the facility. The wheeled d to: e and carts in use may equipment not in use transport equipment dice could affect all occupants mergency. of the facility's Fire Procedure etween 10:00 a.m. and 3:00 p.m. ator and Maintenance Director d not address the following: e address evacuation of the out, furthermore, the plan did not smoke barriers were located in	TAG	DEPRIENCT		DATE

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 23 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BU	A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025	
	ROVIDER OR SUPPLIER			10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0712	This finding was re-	viewed with the Administrator irector during the exit					
SS=F Bldg. 01	Fire Drills 1. Based on record facility failed to ensincluded complete of transmission of a firmonitoring companion past twelve months drills in health care transmission of the simulation of emergence.	review and interview, the sure 4 of 12 fire drill reports documentation of the re alarm signal to the y/fire department during the LSC 19.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This bull affect all residents.	K 0'	712	No residents were affected by tag. No other residents were affect Monthly times will be changed Monthly fire book will be upda accordingly.	ted. I.	04/17/2025
	Findings include: Based on review of on 02/25/25 betwee the Maintenance Di shift fire drill report month period were adocumentation for the monitoring commonthe time of record redirector confirmed included with 4 of 1 transmission of the monitoring compan. This finding was recorded.	the facility's fire drill reports n 10:00 a.m. and 3:00 p.m. with rector present, all four third is performed during the past 12 not provided with the transmission of the alarm to pany. Based on interview at eview, the Maintenance there was no information 2 fire drill reports to verify that alarm was received by the			CORRECTIVE ACTION The fire Drill Log will be updat include the activation of the al system and the variance in the times of the drills. No residents were affected by alleged deficiency. RESIDENT'S HAVING THE POTENTIAL TO BE AFFECTE All residents have the potential be affected. MEASURES / SYSTEMIC CHANGES The fire Drill Log will be updat include the activation of the al system and the variance in the times of the drills for each shift.	arm e the ED al to ed to arm e	

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 24 of 31

i '		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 B. WING		COMPLETED	
					02/25/	02/25/2025	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NEWBURGH HEALTH CARE					POLLACK AVE JRGH, IN 47630		
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID	, ·		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	IE.	DATE
	3.1-51(c)				The Maintenance Director will		
	2 D11				review the log with the facility		
		review and interview, the sure fire drills were held at			administrator. A summary of the report will be reviewed at the record at		
	1	f 3 employee shifts during 4 of			Quality Assurance Performan		
		ficient practice could affect all			Improvement Meeting and as		
	residents in the faci	lity.			needed.		
	Findings include:				Completion Date 4/17/2025		
	Based on review of the facility's fire drill reports						
		en 10:00 a.m. and 3:00 p.m. with					
	the Maintenance Director present, the following						
	was noted:						
		(day) fire drills were performed					
	between 10:15 a.m.						
		ift (evening) fire drills were 2:30 p.m. and 3:15 p.m.					
	1 ~	(night) fire drills were					
		10:00 p.m. and 10:40 p.m.					
	_	at the time of record review,					
		rector acknowledged the times					
		drills were performed and					
	agreed the times we	ere not varied enough.					
	1	viewed with the Administrator					
		irector during the exit					
	conference.						
	3.1-19(b)						
	3.1-51(c)						
K 0741	NFPA 101						
SS=E Bldg. 01	Smoking Regulati	ons					
		on and interview, the facility	K 0	741	No residents were affected by	this	04/17/2025
	_	arette butts were properly			tag.		
	_	l area where cigarettes were			No other residents were affect	ed	
	allowed to be smok practice could affec	ed by staff. This deficient			by this tag.	act	
	practice could affect	i stati olliy.			Maintenance Director will expe	J Ul	l

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155354		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/25/2025			
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Findings include:			grounds daily. In-service on properly exposin cigarettes.	g		
	p.m. and 5:30 p.m. of the Administrator and designated staff smokkitchen exit door has scattered on the ground metal self-closing as full of cigarette butt cigarette butt can with the staff smoking artime of observation, Administrator acknowledge of the cigarette butts on the dispose of the cigare	during a tour of the facility with and Maintenance Director, the oking area outside the rear d hundreds of cigarette butts and, along with two small sh trays on a table and both s. There was no metal ith self-closing lid provided at ea. Based on interview at the the Maintenance Director and owledged the issues with the e ground and lack of ways to ette butts properly.					
K 0918 SS=F Bldg. 01	•	s - Essential Electric Syste					
	facility failed to profor the testing of 1 c System in accordance for Emergency and Section 8.4.9, as req Facilities Code, Sec Section 8.4.9 states Power Systems shall every three years (3 assigned class is gree permitted to terminal	review and interview, the vide complete documentation of 1 Emergency Power Standby the with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care tion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency 1 be tested at least once within 6 months). Where the eater than 4 hours, it shall be note that after 4 hours. 4.1.1.6.1 states that Type 1 and	K 0918	No residents were affected by tag. No other residents were affect by this tag. Maintenance Director will mair logbook. Will place on calendar every 3 years for reminder.	ed ntain		

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet

Page 26 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			ETED	
		155354	B. W	NG		02/25/	/2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					POLLACK AVE		
NEWBURGH HEALTH CARE					JRGH, IN 47630		
							<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROS		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCT		DATE
		ctrical system power sources t Type 10, Class X, Level 1					
		s deficient practice could					
	affect all building o	-					
	arreet air building 0	ecupants.					
	Findings include:						
	1 managa merawa						
	Based on record rev	view on 02/25/25 between 10:00					
	a.m. and 3:00 p.m.	with the Maintenance Director					
	-	was unable to provide					
		four hour load test of the					
	emergency generate	or conducted within the past					
	36 month period. This was confirmed by the						
	Maintenance Direct	or at the time of record review.					
	_	viewed with the Administrator					
		irector during the exit					
	conference.						
	2.1.10(1)						
	3.1-19(b)						
	2 Dogad on massand	review and interview, the					
		sure a written record of routine					
	-	sting for 1 of 1 emergency					
		tained and available for review.					
		ndard for Emergency and					
		stems, at 8.3.3 requires a					
		routine maintenance and					
		of the EPSS shall be					
	-	equires a permanent record of					
		ns, tests, exercising, operation,					
	_	maintained and readily					
	available. 8.3.4.1 re	equires the permanent record					
		lowing: (1) The date of the					
	maintenance report	(2) Identification of the					
	_	(3) Notification of any					
	unsatisfactory cond	ition and the corrective action					
	taken, including par	ts replaced (4) Testing of any					
	repair for the time a	s recommended by the					
	manufacturer. This	deficient practice could affect					

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 27 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/25/2025			
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION and visitors.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 01/09/24, which was over a month past due. Based on interview at the time of record review, the Maintenance Director said there is currently no scheduled date for the generator vendor to come to the facility to perform routine maintenance service on the emergency generator. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)						
K 0920 SS=D Bldg. 01	Extens Based on observation failed to ensure power were not used as a sof 64 resident room to comply with Sectelectrical wiring and NFPA 70, National NFPA 70, Article 4 specifically permitted shall not be used as	on and interview, the facility over strips and extension cords substitute for fixed wiring in 1 s. LSC 19.5.1 requires utilities tion 9.1. LSC 9.1.2 requires d equipment to comply with Electrical Code, 2011 Edition. 00.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ficient practice could affect	K 0920	No residents were affected by tag. No other residents were affect by this tag. Maintenance Dir will remove a extensions and power strips o resident rooms. Visual inspection monthly.	ed II		

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

Event ID:

 $JSDW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000245$

If continuation sheet

Page 28 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED	
		155354	B. WIN	B. WING 02/25/2			2025	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
	Findings include:							
K 0921	p.m. and 5:30 p.m. of the Administrator and resident room 19 has trips. One was plug but had nothing plug least two unidentifiad. Those items could in partially obscured by there was a string of (approximately 100 window curtains and observation. When Director said the Changing over the wind acknowledged by the Maintenance Director.	ons on 02/25/25 between 3:00 during a tour of the facility with and Maintenance Director, d two unapproved power gged into the wall receptacle, gged into it, the other had at able items plugged into it. not be determined due to being y storage items. Furthermore, f white Christmas lights to 200 lights) hanging over the d turned on at the time of asked, the Maintenance wistmas lights are always andow curtains. This was not at the time of observation.						
SS=F	Electrical Equipme	ent - Testing and						
Bldg. 01	Maintenanc	•						
	interview; the facilit required maintenand documentation of in Related Electrical E 2012 edition, section physical integrity, re touch current tests for is performed as requare established with	riew, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care quipment (PCREE). NFPA 99 ans 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE aired in 10.3. Testing intervals policies and protocols. All ent care rooms is tested in	K 09	21	No residents were affected by tag. No other residents were affected by this tag. Will ensure PCREE testing is completed as required. Will maintain a logbook for documentation.		04/17/2025	

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet Page 29 of 31

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025		
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE					10466 F	NDDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		into service and after Any system consists appliances demonst 99 as a complete sy instructions, and promanufacturer included 10.5.3.1.1 and are coff a program for electrical equipmer manuals are readily and condensed oper appliance are legible equipment tests, reproduced in accomposition of the program for a percompliance in accomposition of the produced for a percompliance in accomposition of the produced for a percondition of the produced for the produced	view on 02/25/25 between 10:00 with the Maintenance Director to documentation for the such as electric beds, concentrators, air pumps for air er electrical medical on interview at the time of Maintenance Director said the ed and documented the PCREE ware of the requirement. On between 3:00 p.m. to 5:30 of the facility with the Maintenance Director, it was a provided PCREE such as an concentrators, air pumps for other electrical medical					

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

Event ID:

JSDW21 Facility ID: 000245

If continuation sheet

Page 30 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	ľ	ILDING	onstruction 01	(X3) DATE COMPL 02/25 /	ETED
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE				10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
	· ·	viewed with the Administrator irector during the exit					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: $JSDW21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000245$ Page 31 of 31 If continuation sheet