Ally Lopp

PRINTED: 05/13/2025 FORM APPROVED OMB NO. 0938-039

05/12/2025

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPLETED	
		155354	<u> </u>		04/21/2025	
	PROVIDER OR SUPPLIER		10466 I	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
	·	L	INEVID	7 TOO		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
□ 0000						
Bldg						
g.	Preparedness Surve conducted by the In accordance with 42 Survey Date: 04/21 Facility Number: 0 Provider Number: AIM Number: 100 At this PSR to the I survey, Newburgh 1 compliance with Er Requirements for M	1/25 000245 155354	E 0000	By submitting the enclosed material we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance. We respectfully request a paper compliance/desk review.	fic serve s or	
E 0004 SS=F Bldg	The facility has 114 the survey, the censor Quality Review con The requirement at MET as evidenced 403.748(a), 416.5 Develop EP Plan, Annually Based on record revialed to develop an preparedness plan that least annually in 483.73(a). This determines residents in the facility findings include:	mpleted on 04/30/25  42 CFR, Subpart 483.73 is NOT by:  64(a), 418.113(a), 441.1  Review and Update  view and interview, the facility and maintain an emergency hat was reviewed and updated accordance with 42 CFR ficient practice could affect all	E 0004	-What corrective action(s) will accomplished for those reside found to have been affected b deficient practice?  No residents were affected by tag.	ents y the	

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.

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Administrator

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354		JILDING	ONSTRUCTION	(X3) DATE COMPI 04/21	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  10466 POLLACK AVE NEWBURGH, 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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	Manual on 04/21/2: of Nursing (DON) an emergency preparation of the past twelve months review on the cover Based on interview confirmed there was Preparedness Manu updated within the This finding was re Business Office Maconference. This deficiency was	Ithe Emergency Preparedness 5 at 1:15 p.m. with the Director present, the facility did provide aredness manual, however, it wed and updated during the . The most recent date of of the manual was 04/20/22. at 1:15 p.m., the DON is no evidence the Emergency all has not been reviewed and past twelve month period.  Wiewed with the DON and imager during the exit is cited on 02/25/25. The facility is a systemic plan of correction is existenced.			-How will other residents have the potential to be affected be same deficient practice be identified and what corrective action(s) will be taken? No cresidents were affected. The emergency manual was revie and updated as necessary of 5-12-2025What measures be put into place and what systemic changes will be man ensure that the deficient practices are the emergency preparedness manual with the interdisciplinate team at least annuallyHow will the corrective action be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place? The facility will ensure mergency preparedness plamanual is reviewed and update on an annual basis. The facili will maintain documentation annual review. Ongoing, the Administrator or designee with monitor and maintain documentation for the purpos surveyor verification to ensure continued compliance. Result the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	y the  chither  chith	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER A. BUILDING  155354  B. WING		ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  04/21/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG E 0013 SS=F	(EACH DEFICIEN REGULATORY OR 403.748(b), 416.5	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  4(b), 418.113(b), 441.1  P Policies and Procedures		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	failed to develop an preparedness policies and procedupdated at least ann CFR 483.73(b). The all residents in the fail residents in	the Emergency Preparedness 5 at 1:15 p.m. with the Director	E 0	013	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice?  No residents were affected by tag. How will other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken? No other sidents were affected. The emergency manual was review and updated as necessary on	nts y the  / this cted be her	05/12/2025
	documentation in the procedures, however have not been review most recent twelver recent date of review was 04/20/22. Based DON confirmed the and procedures with Preparedness Manual and updated within	the plan for facility policies and for the policies and procedures wed by the facility within the month period. The most we on the cover of the manual and on interview at 1:15 p.m., the fore was no proof the policies and the Emergency all have not been reviewed the past twelve month period.			5-12-2025. measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur? A checklist has been created for the Administrator/Designee to rev the emergency preparedness manual with the interdisciplinateam at least annually. How with the corrective action (sie be)	re s not iew plan ıry vill	
	Business Office Ma conference.  This deficiency was	viewed with the DON and nager during the exit secited on 02/25/25. The facility a systemic plan of correction see.			monitored to ensure the defici- practice will not recur, i.e., who quality assurance program wil put into place? The facility wil ensure the emergency preparedness policies and procedures within the plan are reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain	at I be I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIER		10466	FADDRESS, CITY, STATE, ZIP COD POLLACK AVE BURGH, 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
				documentation for the purpose surveyor verification to ensure continued compliance.¿ Result the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	Its of
E 0025 SS=C Bldg	403.748(b)(7), 418 Arrangement with	3.113(b)(5), 441.184(b) Other Facilities			
	failed to ensure eme and procedures incl arrangements with a providers to receive limitations or cessat the continuity of ser accordance with 42 deficient practice of Findings include:  Based on review of Manual on 04/21/25 of Nursing (DON) pemergency prepared including the development of the LTC facilities residents in the ever of operations was at the dates on the LTC was listed 2017 and Based on interview the documentation of facilities needs to be This finding was re-	riew and interview, the facility ergency preparedness policies ude the development of other LTC facilities and other residents in the event of cion of operations to maintain rvices to LTC residents in CFR 483.73(b)(7). This ould affect all occupants.  the Emergency Preparedness at 1:15 p.m. with the Director present, documentation of dness policies and procedures opment of arrangements with and other providers to receive at of limitations or cessation vailable for review, however, C facilities and other provider 2018 for the various facilities. at 1:15 p.m., the DON agreed of arrangements with other e updated.	E 0025	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice?  No residents were affected by tag. How will other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was review and updated as necessary on 5-12-2025. Mutual aid agreements have been sent to various vendors to be signed, updated, and placed back in the EP manual. measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur? A checklist has been created for the Administrator/Designee to review and with the interdisciplinate team at least annually. How with the corrective action(s be	nts y the y this cted be ner wed the ne put re s not sew plan ry

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to implement to prevent recurrent				monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place? The facility will ensure the emergency preparedness policies and procedures within the plan are reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purpose surveyor verification to ensure continued compliance. ¿ Resu the monitoring will be reviewed uring the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	at I be I es of et Its of	
E 0029 SS=F Bldg	Based on record refailed to develop a preparedness commutin Federal, State and updated at least 42 CFR 483.73(c). affect all occupants:  Findings include:  Based on review of Manual on 04/21/2 of Nursing (DON) emergency prepared	254(c), 418.113(c), 441.1 Communication Plan  view and interview, the facility and maintain an emergency annication plan that complies and local laws was reviewed at annually in accordance with This deficient practice could see.  If the Emergency Preparedness at 1:15 p.m. with the Director present, the facility's adness plan did include a plan intain an emergency	E 002	9	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice?  No residents were affected by tag. How will other residents having the potential to be affectly the same deficient practice identified and what corrective action(s) will be taken? No other residents were affected. The emergency manual was review and updated as necessary on 5-12-2025. measures will be into place and what systemic	onts y the y this cted be her	05/12/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/21/2025	
	ROVIDER OR SUPPLIER	10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	preparedness communication plan that complies with Federal, State, and local laws, however the communication plan 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 1:15 p.m., the DON confirmed there was no proof the Communication Plan within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period.  This finding was reviewed with the DON and Business Office Manager during the exit conference.  This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		changes will be made to ensure that the deficient practice does recur? A checklist has been created for the Administrator/Designee to revithe emergency preparedness manual with the interdisciplinateam at least annually. However, the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place? The facility will ensure the emergency preparedness communication is reviewed and updated on an annual basis. The facility will maintain documentation of the annual review. Ongoing, the Administrator or designee will monitor and maintain documentation for the purpose surveyor verification to ensure continued compliance. Result the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	es not  iew plan ry will ent at l be l plan n	
E 0036 SS=F Bldg	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing				
	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.	E 0036	What corrective action(s) will to accomplished for those reside found to have been affected by deficient practice?	nts	
	- -		No residents were affected by	this	

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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 04/21/2025		
	PROVIDER OR SUPPLIEI			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)  tag	TE	(X5) COMPLETION DATE
	Based on review of Manual on 04/21/2 of Nursing (DON) documentation avainan emergency preparam, however program, however program has not be within the most recent date of manual was 04/20/2 p.m., the DON contraining and testing the Emergency Pressor Pressor (DON) and the state of the state	The Emergency Preparedness 5 at 1:15 p.m. with the Director present, there was ilable to show the facility had aredness training and testing the training and testing en reviewed by the facility ent twelve month period. The review on the cover of the 22. Based on interview at 1:15 firmed there was no proof the policy and procedure within paredness Manual has not updated within the past twelve			How will other residents havin potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?  No other residents were affect The emergency manual was reviewed and updated as necessary on 5-12-2025.		
	This finding was reviewed with the DON and Business Office Manager during the exit conference.  This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.				measures will be put into place and what systemic changes we be made to ensure that the deficient practice does not reconstruction.	ill	
					A checklist has been created the Administrator/Designee to review the emergency preparedness plan manual with the interdisciplinary team at leannually.	:h	
					How will the corrective action( monitored to ensure the defici practice will not recur, i.e., who	ent	

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION C	(X3) DATE SURVEY  COMPLETED  04/21/2025		
	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 R 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		
				quality assurance program will I put into place?  The facility will ensure the emergency preparedness training and testing program is reviewed and updated on an annual basis. The facility must maintain documentation of the annual review. Ongoing, the Administrator designee will monitor and maintain documentation for the purposes of surveyor verification ensure continued compliance. Results of the monitoring will be reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	ng d s. ator n to		
E 0039 SS=F Bldg	Based on record reversal failed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a communancessible, conduct facility-based functions.	view and interview, the facility dercises to test the emergency over year, including drills using the emergency of facility must do the annual full-scale exercise that drills, or ity-based exercise is not an annual individual,	E 0039	What corrective action(s) will be accomplished for those residen found to have been affected by deficient practice?  No residents were affected by the same deficient practice by the same	tts the his ted be er was		

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or man-made emergency that requires activation

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began on 5-7-2025, this exercise

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155354		A. BUILDING B. WING	E CONSTRUCTION  G	COMPLETED 04/21/2025	
NAME OF F	PROVIDER OR SUPPLIEF	3		EET ADDRESS, CITY, STATE, ZIP COD	
NEWBUF	RGH HEALTH CAR	E		VBURGH, IN 47630	
(X4) ID PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	DATE
	of the emergency p	lan, the LTC facility is exempt		is on-going. measures will	ре
		ext required full-scale in a		put into place and what syste	
		or individual, facility-based		changes will be made to ens	
		l exercise for 1 year following		that the deficient practice doe	es not
	the onset of the actu			recur? A checklist has been	
	1 1	itional exercise that may		created for the	
		imited to the following:		Administrator/Designee to re	
	a. A second full-sca			the emergency preparedness	
	functional exercise.	or an individual, facility-based		manual with the interdisciplin	- 1
				team at least annually. How the corrective action(s be	WIII
	<ul><li>b. A mock disaster drill; or</li><li>c. A tabletop exercise or workshop that is led by a</li></ul>			monitored to ensure the defic	siont
	facilitator that includes a group discussion, using			practice will not recur, i.e., where	
	a narrated, clinically-relevant emergency scenario,			quality assurance program w	
	and a set of problem statements, directed			put into place? The facility w	
		red questions designed to		ensure at least two emergence	
	challenge an emerg	-		preparedness exercises utiliz	-
		TC facility's response to and		the emergency preparedness	_
		ation of all drills, tabletop		are conducted on an annual	
		gency events, and revise the		The facility will maintain	
	LTC facility's emer	gency plan, as needed in		documentation of the exercis	es
	accordance with 42	CFR 483.73(d)(2).		and subsequent analysis.	
	This deficient pract	ice could affect all occupants		Ongoing, the Administrator o	r
	in the facility.			designee will monitor and ma	intain
				documentation for the purpos	ses of
	Findings include:			surveyor verification to ensur	
				continued compliance.¿ Resi	
		the Emergency Preparedness		the monitoring will be reviewed	ed
		5 at 1:15 p.m. with the Director		during the monthly Quality	
		present, the facility was able to		Assurance/Performance	
	_	tion of an actual event, a fire in		Improvement (QA/PI) meetin	g.
		3/25, however, there was no		Monitoring will be ongoing.	
		second exercise conducted by he past 12 month period. This			
		he DON at 1:15 p.m			
	was commined by the	ne DON at 1.13 p.III			
	This finding was re	viewed with the DON and			
		nager during the exit			
	conference.				

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	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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAU	This deficiency was	s cited on 02/25/25. The facility a systemic plan of correction		TAU			DATE
E 0041 SS=F Bldg	, ,	(e), 485.542(e), 485.62 LTC Emergency Power					
	failed to implement inspection, testing, found in the Health	the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42	E 0	041	What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice?	olished for those residents be have been affected by the	
	failed to ensure a w maintenance and te generator was main NFPA 110, the Star	riew and interview, the facility ritten record of routine sting for 1 of 1 emergency tained and available for review. Indard for Emergency and stems, at 8.3.3 requires a			No residents were affected by tag.	this	
	operational testing of established. 8.3.4 rd the EPSS inspection and repairs shall be available. 8.3.4.1 rd shall include the following the shall include the following shall be shall include the following shall be shall	routine maintenance and of the EPSS shall be equires a permanent record of as, tests, exercising, operation, maintained and readily equires the permanent record lowing: (1) The date of the (2) Identification of the			How will other residents having potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?	g the	
	servicing personnel unsatisfactory cond taken, including par repair for the time a	(3) Notification of any ition and the corrective action its replaced (4) Testing of any is recommended by the deficient practice could affect			No other residents were affect by this tag  The generator did have preventative maintenance on August 8th, 2024. The facility also renewed the contract for		
		riew on 04/21/25 at 3:00 p.m. Nursing (DON) and Business sent, there was no			maintenance to be performed 2025.	in	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025
	PROVIDER OR SUPPLIEF		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE SURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	generator has had repast 12 months. The maintenance report was dated 01/09/24 past due. Based on	lable to show the emergency outine maintenance during the see most recent routine for the emergency generator, which was over three months interview at 3:00 p.m., the mager said she contacted the		measures will be put into pla and what systemic changes we be made to ensure that the deficient practice does not re-	vill
	generator maintena report of emergency was not provided w This finding was re	nce vendor and they sent her a sy generator service, however, it with a date of service.  viewed with the DON and an ager during the exit		A checklist has been created the Maintenance Director to r with the Administrator/Design ensure routine maintenance a testing for the emergency generator is documented and maintained for review.	eview lee to and
	1	s cited on 02/25/25. The facility a systemic plan of correction ce.		How will the corrective action monitored to ensure the defic practice will not recur, i.e., wh quality assurance program will put into place?	ient nat
				The facility will ensure the emergency generator is maintained to ensure to a reasonable degree that the generator is capable of suppl emergency power within the specified and for the time dur specified within NFPA 110, Standard for Emergency and Standby Power Systems. ¿Th continuing reliability and integof the Emergency Power Sup System (EPSS) are depende an established program of romaintenance and operational	e grity oply nt on utine

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/21/2025		
	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				testing. Ongoing, the Administrator or will monitor routine maintenance and operational testing program t ensure continued compliance Results of the monitoring will reviewed during the monthly Quality Assurance/Performal Improvement (QA/PI) meetin Monitoring will be ongoing.	o e.; be		
K 0000							
Bldg. 01	Code Recertification conducted on 02/25 Indiana Department 42 CFR 483.90(a).  Survey Date: 04/21 Facility Number: 0 Provider Number: 100/2 At this PSR to the LINewburgh Health Cowith Requirements Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (LINealth Care Occupation). This one story facility Type V (000) constitutions of the conduction o	200245 155354 290800 25 Safety Code survey, 26 Sare was found not compliance 26 For Participation in 26 42 CFR Subpart 483.90(a), 27 Sand the 2012 edition of the 28 Strion Association (NFPA) 101, 27 SC), Chapter 19, Existing 28 Sand 410 IAC 16.2. 28 Stry was determined to be of 29 Safety Code survey, 29 Safety Code survey, 20 Safety Code survey, 21 Safety Code survey, 22 Safety Code survey, 23 Safety Code survey, 24 Safety Code survey, 25 Safety Code survey, 26 Safety Code survey, 27 Safety Code survey, 28 Safety Code survey, 29 Safety Code survey, 20 Safety Code survey, 21 Safety Code survey, 22 Safety Code survey, 23 Safety Code survey, 24 Safety Code survey, 25 Safety Code survey, 26 Safety Code survey, 26 Safety Code survey, 27 Safety Code survey, 28 Safety Code survey, 29 Safety Code survey, 29 Safety Code survey, 29 Safety Code survey, 20 Safety Code survey, 20 Safety Code survey, 20 Safety Code survey, 20 Safety Code survey, 21 Safety Code survey, 22 Safety Code survey, 23 Safety Code survey, 24 Safety Code survey, 26 Safety Code survey, 26 Safety Code survey, 27 Safety Code survey, 28 Safety Code survey, 29 Safety Code survey, 29 Safety Code survey, 29 Safety Code survey, 29 Safety Code survey, 20 Safety Code surv	K 0000	By submitting the enclosed material we are not admitting truth or accuracy of any specifindings or allegations. We rether right to contest the finding allegations as part of any proceedings and submit thes responses pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance. We respectfully request a paper compliance/desk review.	eserve gs or e		
		ruction and was fully cility has a fire alarm system					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/21/2025		
	ROVIDER OR SUPPLIER		•	10466 F	DDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
	and spaces open to operated smoke deterooms. The facility a census of 58 at the	oke detectors in the corridors the corridors, plus battery ectors in all resident sleeping has a capacity of 114 and had et ime of this survey. residents have customary					
	facility services, inc for a maintenance si facility storage, wer detached wood fram	ered, and all areas providing cluding a detached garage used thop and maintenance and re sprinklered, except a small ned shed used for furniture in cooler outside the kitchen					
	Quality Review con	npleted on 04/30/25					
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lightir	ng					
	failed to ensure doc the testing of 1 of 1 light unit that was to during 3 of the past	riew and interview, the facility umentation was provided for battery powered emergency ested monthly for 30 seconds 12 months, and annually for the past 12 months to ensure	K 02	291	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice?	nts	05/14/2025
	power outages. LSG lighting shall be pro Section 7.9. Section	ride lighting during periods of C 19.2.9.1 requires emergency evided in accordance with n 7.9.3.1.1 (1) requires hall be conducted monthly,			No residents were affected by tag.	this	
	with a minimum of weeks between tests seconds, (3) Function conducted annually if the emergency lig powered and (5) With	3 weeks and a maximum of 5 s, for not less than 30 onal testing shall be for a minimum of 1 1/2 hours thing system is battery ritten records of visual s shall be kept by the owner			How will other residents having potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?	g the	
		eficient practice could affect all			No other residents were affect	ed.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155354		A. BUILDI B. WING		01	COMPL 04/21/	ETED	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD OLLACK AVE		
NEWBUF	RGH HEALTH CAR	≣			RGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	facility.	staff and visitors in the			The annual 90-minute testing of the emergency light has been performed.	of	
	a.m. and 3:00 p.m. of present, the facility emergency generated indicating emergency. There was no docur November and Dece 2025 that the emergiseconds. Furthermore documentation available powered emergency for 90 minutes during Based on interview the Maintenance Dispattery powered emigenerator during each have forgotten to do for November and I of 2025. He further of a 90 minute test demergency light unit.	iew on 02/25/25 between 10:00 with the Maintenance Director did have a line item on the or monthly load testing form by lighting was tested monthly. In the entation on the form for ember of 2024 and January of ency light was tested for 30 ore, there was no lable to show the battery of light unit was tested annually not the past 12 month period. The past 12 month period at the time of record review, rector said he does test the ergency light unit at the ch monthly load test, but must become the 30 second tests obecomber of 2024 and January said there is no documentation of the battery powered the available for review.			A checklist has been created for the Maintenance Director to rewith the Administrator/Designer ensure routine maintenance are testing for the emergency generator is documented and maintained for review.  MEASURES TO PREVENT REOCCURRENCE:  The facility will use the current form to document the testing of the battery-operated emergence light. A 30-second monthly log and 90-minute annual log is seand itemized to include the	view ee to and  f cy et up	
	Director of Nursing Maintenance Direct today and she was r	on 04/21/25 at 3:00 p.m., the said the Administrator and or were not in the facility ot able to locate the Plan of show this deficiency has been			battery-powered emergency lig by the emergency generator. T battery backup light will be test monthly, and findings document in the logbook.	he ted	
		viewed with the DON and nager during the exit			measures will be put into plac and what systemic changes wi		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       01       COMPLETED         B. WING       04/21/2025			TED	
	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 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	
	conference.  3.1-19(b)  This deficiency was	s cited on 02/25/25. The facility		be made to ensure that the deficient practice does not rec	eur?		
	-	a systemic plan of correction		The itemized log/documentation will be reviewed by the Administrator/Designee for completion as required and with presented by the Maintenance Supervisor/designee to the Administrator monthly. Any arror areas of concern will be reviewed and addressed as necessary at this time. Results will be reviewed at the monthly Quality Assurance/Performant Improvement (QA/PI) meeting Monitoring will be ongoing.	ill be e ea s y		
				How will the corrective action( monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place?	ent at		
				The audit will be reviewed by QA/PI Committee with subsequence plans of correction developed implemented as deemed necessary to ensure compliant is maintained.	quent and		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155354	B. WI	NG		04/21/	2025
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		_			POLLACK AVE		
NEWBUR	RGH HEALTH CAR	Ė		NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	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
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Trotoction Other						
Bidg. 01	1 Rased on record	review and interview, the	K 0.	200			05/14/2025
	facility failed to ens		K U.	500	Mhat carractive action(a) will b		03/14/2023
	-	-			What corrective action(s) will be		
		battery operated smoke alarms			accomplished for those reside		
		as conducted according to			found to have been affected by		
	-	ished instructions. NFPA 101			deficient practice? No resider	าเร	
		isting life safety features			were affected How will other		
		c, if not required by the Code,			residents having the potential		
		NFPA 72, 29.10 Maintenance			be affected by the same defici		
		rning equipment shall be			practice be identified and what		
		ed in accordance with the			corrective action(s) will be		
	-	ished instructions and per the			taken? All residents have the		
		apter 14. NFPA 72, 14.2.1.1.1			potential to be affected. A smo		
		and maintenance programs			detector battery test check has		
		uirements of this Code and			been performed according to t	he	
		pment manufacturer's			devices manufacturers' guideli	nes,	
	-	ns. This deficient practice			please see attachment Q. The		
	could affect all resid	dents.			smoke detectors will continue	to	
					be tested weekly per manufac	turer	
	Findings include:				guidelines.		
					All residents have the potentia	l to	
	Based on record rev	view on 02/25/25 between 10:00			be affected. The Maintenance		
	a.m. and 3:00 p.m. v	with the Administrator and the			Director/ Designee has replace	ed	
		or present, the "Maintenance			all batteries for the resident sm		
		oom Smoke Detector Test"			alarms and has documented to	)	
	-	sting of the battery operated			indicate battery replacement a		
	•	manufacturer's published			5-12-2025. This documentation		
		back side of each smoke alarm			remain documented in the	********	
		quire weekly testing. Based			logbook.		
		time of record review, the			logbook.		
		or stated the smoke alarms are			measures will be put into place		
		agreed the alarms should be			and what systemic changes wi		
		ding to manufacturer's			be made to ensure that the	111	
	published instruction	_					
	paonished instruction	113.			deficient practice does not	Sm.	
	This finding was	viewed with the Administrator			recur? A smoke detector batte	ei y	
	-	viewed with the Administrator			test check will be performed	_	
		irector during the exit			weekly according to the device		
	conference.				manufacturers' guidelines. The	•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155354	B. WI	NG	<del></del>	04/21/	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
		_			POLLACK AVE		
NEWBU	RGH HEALTH CAR	E		NEWBU	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Maintenance Director/Designe	e	
	Based on interview	on 04/21/25 at 3:00 p.m., the			has completed the weekly bat	tery	
	Director of Nursing said the Administrator and				checks for all residents' rooms	3	
	Maintenance Director were not in the facility				and will continue to do per		
	today and she was not able to locate the Plan of				manufacturer guidelines. A		
	Correction folder to show this deficiency has been				checklist has been created for	the	
	corrected.				Maintenance Director to review	N	
					with the Administrator/Designe	ee to	
	This finding was reviewed with the DON and				ensure weekly tests of the		
	Business Office Ma	nager during the exit			battery-operated smoke alarm	s is	
	conference.				documented and maintained for		
					review and corrections will be		
	3.1-19(b)				made as soon as possible if		
					necessary. See attachment		
	This deficiency was	s cited on 02/25/25. The facility			E. The testing dates and resul	ts	
	failed to implement	a systemic plan of correction			will be documented in the for		
	to prevent recurrence	ce.			review.		
					The Maintenance Director/		
	2. Based on record	review and interview, the			Designee has replaced all		
	facility failed to ens	sure documentation for the			batteries for the resident smok	ке	
	preventative mainte	enance of battery operated			alarms and has documented to	0	
	smoke alarms in all	resident rooms was complete.			indicate battery replacement a	s of	
	NFPA 72 14.2.1.1.	1 states to ensure operations			5-12-2025. This documentation	on	
	integrity, the systen	n shall have an inspection,			will remain documented in the		
	testing, and mainter	nance program. NFPA 72 29.10			logbook.		
	states fire-warning	equipment shall be maintained					
	and tested in accord	lance with manufacturer's			A checklist has been created f	or	
	published instruction	ons and per the requirements			the Maintenance Director to re	eview	
		s deficient practice could affect			with the Administrator/Designe	ee to	
	all residents, staff a	nd visitors.			ensure the batter-operated sm	noke	
					alarms batteries are replaced		
	Findings include:				annually and is documented a	nd	
					maintained for review and		
	Based on record rev	view on 02/25/25 between 10:00			corrections will be made as so	on	
	a.m. and 3:00 p.m.	with the Maintenance Director			as possible if necessary.		
	present, the battery	operated smoke alarm			How will the corrective action	(s be	
	maintenance docum	nentation failed to indicate			monitored to ensure the deficient	ent	
	battery replacement	t during the past 12 month			practice will not recur, i.e., who	at	
	. –	e most recent battery			quality assurance program wil		
		ocumented on 01/18/24, which			put into place? The Maintena		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155354	B. W	ING	<del></del>	04/21/	/2025
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
		_			POLLACK AVE		
NEWBUF	RGH HEALTH CAR	E		NEWBU	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	is over a month pas	t due. Based on interview at			Director and facility Administra	ator	
	the time of record re	eview, the Maintenance			will monitor the testing dates a	and	
	Director confirmed	the batteries in the resident			log for consistency and procee	ed	
	room smoke alarms have not been replaced in the				with the appropriate follow-up	as	
	past 12 month perio	od.			soon as possible. The results	of	
					the smoke detector checks wil		
	This finding was re	viewed with the Administrator			presented in the monthly Qual	ity	
	and Maintenance Director during the exit				Assurance / Performance		
	conference.				Improvement Meeting. The		
					monitoring will be ongoing to		
	Based on interview on 04/21/25 at 3:00 p.m., the				reflect the various opportunitie	s for	
	Director of Nursing said the Administrator and				action.		
	Maintenance Direct	tor were not in the facility					
	today and she was r	not able to locate the Plan of			The facility will ensure		
	Correction folder to	show this deficiency has been		battery-operated smoke alarms			
	corrected.				within the facility are maintaine		
					accordance with NFPA 72,		
	This finding was re	viewed with the DON and			National Fire Alarm and Signa	ling	
	Business Office Ma	nager during the exit			Code, 2010 edition. NFPA 72,	-	
	conference.				29.10 states that fire-warning		
					equipment shall be maintained	t	
	3.1-19(b)				and tested in accordance with	the	
					manufacturer's published		
	This deficiency was	s cited on 02/25/25. The facility			instructions and per the		
	failed to implement	a systemic plan of correction			requirements of Chapter 14.¿		
	to prevent recurrence	ce.			NFPA 72, 14.2.1.1.1 states that	at	
					inspection, testing, and		
					maintenance programs shall		
					satisfy the requirements of this	5	
					Code and conform to the		
					equipment manufacturer's		
					published instructions. Ongoin	ıg,	
					the Administrator or will monitor	or	
					the battery-operated smoke		
					alarms to ensure continued		
					compliance.¿ Results of the		
					monitoring will be reviewed du	ıring	
					the facility's monthly Quality	-	
					Assurance meeting; monitorin	g	
					will be ongoing.	-	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-03	59
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155354	B. WING		04/21/2025	
			CTREET	ADDRESS OWN STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD POLLACK AVE		
NEWBUI	RGH HEALTH CAR	E	NEWB	URGH, 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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC	ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
K 0324	NFPA 101					
SS=F	Cooking Facilities					
Bldg. 01	Cooking Facilities					
Diag. 01	Raced on observation	on and interview, the facility	K 0324	What corrective action(s) will be	05/12/20	25
		approved method for	K 0324	` '		123
	_	ppliances to where they were		accomplished for those reside		
				found to have been affected b		
		ood extinguishing equipment		deficient practice? No residen	S	
	_	nstalled for 1 of 1 kitchen hood		were affected by this tag		
		m. NFPA 96, Standard for				
		and Fire Protection of				
		ng Operations Section 2011		How will other residents havin	g the	
		1.2.2, states cooking appliances		potential to be affected by the		
		shall not be moved, modified,		same deficient practice be		
	_	out prior re-evaluation of the		identified and what corrective		
		ystem by the system installer		action(s) will be taken?		
		unless otherwise allowed by				
	the design of the fir	e extinguishing system.				
	Section 12.1.2.3 sta	tes the fire-extinguishing				
	system shall not rec	quire reevaluation where the		No other residents were affect	ed.	
	cooking appliances	are moved for the purposes of				
	maintenance and cl	eaning, provided the		The Maintenance Director has		
	appliances are retur	ned to approved design		taped the specific area the		
	location prior to coo	oking operations, and any		equipment needs to be placed		
	disconnected fire-ex	xtinguishing system nozzles		back into after been moved fo	the	
	attached to the appl	iances are reconnected in		purposes of maintenance and		
	accordance with the	e manufacturer's listed design		cleaning to ensure in compliar	ice	
	manual. Section 12.	.1.2.3.1 states an approved		with the manufacture guideline		
		ovided that will ensure that the		Ĭ		
	_	d to an approved design				
		ient practice could affect				
	mostly kitchen staff	-		measures will be put into place	e l	
				and what systemic changes w		
	Findings include:			be made to ensure that the		
				deficient practice does not rec	ur?	
	Based on observation	ons on 02/25/25 between 3:00		delicioni practice dece not rec	~···	
		during a tour of the facility with		Residents who are in the area	of	
	_	nd Maintenance Director, the		the dining room have the pote		
		the range hood in the kitchen		to be affected. The Maintenan		
		rith an approved method that		Director has taped the specific		
	_	the appliance was returned to				
	I would clisule that th	ne appliance was returned to	I	area the equipment needs to I	, <del>c</del>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  04/21/2025	
	ROVIDER OR SUPPLIER		10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE BURGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ed location after it had been	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  placed back into after been m	DATE
	moved for maintena on interview at the Administrator and I were not aware an a	ince and/or cleaning. Based ime of observation, the Maintenance Director said they approved method had to be the appliances were returned gned location after		for the purposes of maintenar and cleaning to ensure in compliance with the manufact guidelines. The kitchen staff h been in- on this update.	ture
	and Maintenance D conference.  Based on interview Director of Nursing Maintenance Direct	on 04/21/25 at 3:00 p.m., the said the Administrator and or were not in the facility not able to locate the Plan of		How will the corrective action monitored to ensure the defic practice will not recur, i.e., wh quality assurance program wi put into place?	ent at
	corrected.  This finding was re Business Office Ma conference.  3.1-19(b)  This deficiency was	viewed with the DON and nager during the exit  s cited on 02/25/25. The facility a systemic plan of correction see.		The facility will ensure kitcher suppression systems within the facility are maintained in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Comme Cooking Operations, 2011 ¿N 96, Section 4.1.2 states all sure equipment and its performance shall be maintained in accord with the requirements of this standard during all periods of operation of the cooking equipment. ¿Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearrange without prior re-evaluation of fire-extinguishing system by the system installer or servicing	rol ercial IFPA ch ee ance
				agent, unless otherwise allow by the design of the fire extinguishing system. Section	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155354	B. WI	NG		04/21	/2025
	PROVIDER OR SUPPLIE			10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630	•	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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  12.1.2.3 states the fire-extinguishing system shal require reevaluation where the cooking appliances are moved the purposes of maintenance cleaning, provided the applian are returned to approved desi location prior to cooking operations, and any disconnective-extinguishing system nozz attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location.  Ongoing, the Administrator or monitor the kitchen fire suppression system to ensure continued compliance.; Resu	I not e d for and aces gn cted zles e ith gn ates the will	(X5) COMPLETION DATE
K 0346 SS=C Bldg. 01	Based on record re failed to provide a protection of all oc to be followed in that to be placed or more in a twenty for	m - Out of Service  view and interview, the facility complete written policy for the cupants indicating procedures the event the fire alarm system at of service for four hours or our hour period in accordance 9.6.1.6. This deficient practice to in the facility.	K 03	346	the monitoring will be reviewe during the facility's Quality Assurance meeting; monitorin will be ongoing.  What corrective action(s) will I accomplished for those reside found to have been affected be deficient practice?  No residents were affected by tag	d g ents y the	05/14/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/21/2025	
	ROVIDER OR SUPPLIEF		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Findings include:				
	a.m. and 3:00 p.m. Maintenance Direct provide fire watch of Emergency Prepare incomplete. The pl the IDOH with the Incident Reporting	with the Administrator and with the Administrator and for present, the facility did documentation from the dness Manual, however, it was an failed to include contacting web link for contacting the System located on the IDOH at an interview at the time of		How will other residents having potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?  A checklist has been created	e e
	record review, this Administrator.  This finding was re	was confirmed by the viewed with the Administrator irector during the exit		the Administrator/Designee treview the emergency preparedness plan manual withe interdisciplinary team at annually.	o vith
	Based on interview Director of Nursing Maintenance Direct today and she was r Correction folder to corrected. This finding was re	on 04/21/25 at 3:00 p.m., the said the Administrator and for were not in the facility not able to locate the Plan of show this deficiency has been viewed with the DON and mager during the exit		measures will be put into pla and what systemic changes be made to ensure that the deficient practice does not re	will
	_	s cited on 02/25/25. The facility a systemic plan of correction ee.		The policy & procedure was updated to include contacting IDOH with the web link for contacting the Incident Repo System located on the IDOH Gateway and includes containformation for the facilities insurance carrier.	rting

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155354		A. BUILDING  B. WING	01	COMPLETED 04/21/2025	
	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)	DATE
				How will the corrective action(s monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place?	ent at
				The facility will ensure that a complete facility-specific writter fire safety plan for the protecticall residents is established. The facility will ensure all health can occupancy personnel are periodically instructed all asperof the written fire safety plan. Emphasis must be placed on addressing evacuation of the smoke compartments and identifying where the smoke barriers were located in the fact and evacuation in detail as we addressing staff response to the activation of abattery powered smoke alarms in the resident rooms, training staff to sound fire alarm, to rescue residents needed), and to close all doors.	on of e re cts the cility ll as ne the (as
				Ongoing, the Administrator or monitor training documentation ensure all employees of health care occupancies have received instruction in life safety procedures and devices to ensure continued compliance. Result the monitoring will be reviewed during the facility's monthly	n to n ed sure ts of

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155354	B. WI	NG		04/21	/2025
	ROVIDER OR SUPPLIER		<u>.                                      </u>	10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Quality Assurance/Performand Improvement (QA/PI) meeting Monitoring will be ongoing.		
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System -	- Maintenance and Testing					
Didg. 01	failed to ensure 1 of system was inspected accordance with NF the Inspection, Test Water-Based Fire P Edition, Section 14. piping and branch liconducted every 5 y connection at the enremoving a sprinkle line for the purpose of foreign organic a Alternative nondest shall be permitted. required to be inspestates records shall tests, and maintenar components and sha authority having jur deficient practice af visitors.  Findings include:  Based on record revalum, and 3:00 p.m. we present, documentate of the sprinkler syst recent five year period.	riew and interview, the facility a automatic sprinkler piping and every five years in and Maintenance of rotection Systems, 2011 2.1 states an inspection of ine conditions shall be rears by opening a flushing and of one main and by ar toward the end of one branch of inspecting for the presence and inorganic material. ructive examination methods Non-metallic pipe shall not be cted internally. Section 4.3.1 be made for all inspections, ance of the system and its all be made available to the insdiction upon request. This arefects all residents, staff and are won 02/25/25 between 10:00 with the Maintenance Director tion of an internal inspection em performed within the most and was not available for attention for the most recent	K 0.	353	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice?  No residents were affected by tag. How will other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken? No offer residents were affected. measures will be purinto place and what systemic changes will be made to ensure that the deficient practice does recur? A checklist has been created for the Maintenance Director to review with the Administrator/Designee to ensure the automatic sprinkler piping system is inspected every five years in accordance with NFP 25 and is documented and maintained for review. The Maintenance Director will reviet the schedule / log with the fact Administrator. A summary of the report will be reviewed at the remonthly Quality Assurance/Performance Improvement (QA/PI) meeting	nts y the  y this cted be ther t re s not cure A	05/14/2025

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/21/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		tion performed was dated			as needed. The sprinkler sys	stem	
		s over a month past due.			has been assessed and		
		at the time of record review, rector said there is no			completed by Tristate Fire		
					Protection. How will the		
		he sprinkler vendor to perform pection/investigation, but he			corrective action(s be monitor		
		redule them as soon as			ensure the deficient practice	WIII	
	possible.	ledule them as soon as			not recur, i.e., what quality assurance program will be pu	ıt into	
	possible.				place? The facility will ensure		
	This finding was re	viewed with the Administrator			sprinkler system operates as	e uie	
	_	irector during the exit			designed, receives an		
	conference.	are the control of th		unobstructed flow of water, and i		nd is	
					maintained in accordance wit		
	Based on interview	on 04/21/25 at 3:00 p.m., the			NFPA 25, Standard for the		
		said the Administrator and	Inspection, Testing, and				
		for were not in the facility			Maintenance of Water-Based	Fire	
		not able to locate the Plan of			Protection Systems.; The fac		
	1 -	show this deficiency has been			will ensure issues are addres		
	corrected.	,			promptly when identified. If		
					evidence of the presence of		
	This finding was re	viewed with the DON and			sufficient material to potential	lv	
	_	nager during the exit			obstruct pipe or sprinklers is	-,	
	conference.				noted, a complete flushing		
					program shall be conducted by	ру	
	3.1-19(b)				qualified personnel.¿Inspection	•	
					test, and maintenance record		
	This deficiency was	s cited on 02/25/25. The facility			be available for review. Ong	oing,	
	failed to implement	a systemic plan of correction			the Administrator or designed	will	
	to prevent recurrence				monitor the sprinkler system		
					inspection, tests, and		
					maintenance documentation	to	
					ensure continued compliance	.;	
					Results of the monitoring will	be	
					reviewed during the facility's		
					monthly Quality		
					Assurance/Performance		
					Improvement (QA/PI) meeting	g.	
					Monitoring will be ongoing.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/21/2025	
NAME OF PROVIDER OR SUPPLIER NEWBURGH HEALTH CARE			10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630		
PREFIX (EACH DEFICIENC	TATEMENT 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)	ΤE	(X5) COMPLETION DATE
SS=C Sprinkler System -	Out of Service					
Based on record revifailed to provide a containing procedure protection of all residuationatic sprinkler sout-of-service for 10 period in accordance 9.7.6 requires sprink comply with NFPA for the Inspection, Towater-Based Fire Professional for the Inspection for fire watch for fire, but making a protection features or routes and alarm system for fire, but making a protection features or routes and alarm system for fire and alarm system for fire watch for the Indiana Department for the Indiana Department for contaction for the Indiana Department for contaction for cont	attor shall follow. A.15.5.2 (4) h should consist of trained nuously 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 atems are available and or. This deficient practice pants in the facility.  The deficient practice pants in the facility documentation from the dness Manual, however, it was an failed to include contacting tent of Health (IDOH) with the ling the Incident Reporting	K 0	354	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice?  No residents were affected by tag. How will other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken? No other residents were affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does recur? The policy & procedur was updated to include contact the IDOH with the web link for contacting the Incident Report System located on the IDOH Gateway and includes contact information for the facilities insurance carrier. How will the corrective action(s be monitored ensure the deficient practice whot recur, i.e., what quality assurance program will be put place? The facility will ensure sprinkler system operates as designed, receives an unobstructed flow of water, an maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Inspection Systems. The facility will ensure issues are address.	nts y the  y this  ted be ther  t es not esting ing into the d is	05/14/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	COMPLETED	
		155354	B. WING		04/21/2025
	ROVIDER OR SUPPLIER		104	EET ADDRESS, CITY, STATE, ZIP COD 466 POLLACK AVE WBURGH, IN 47630	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINEBIG DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE
	information for the	facilities insurance carrier with		promptly when identified. If	
	contact information	. Based on an interview at the		evidence of the presence of	
		w, the Administrator agreed		sufficient material to potentia	lly
		y lacked the previously		obstruct pipe or sprinklers is	
	mentioned informat	ion.		noted, a complete flushing	
				program shall be conducted I	•
		viewed with the Administrator		qualified personnel.¿Inspecti	I
		irector during the exit		test, and maintenance record	
	conference			be available for review. Ong	<b> </b>
	Događ on interni	on 04/21/25 at 2,00 41-		the Administrator or designed	; WIII
		on 04/21/25 at 3:00 p.m., the said the Administrator and		monitor the sprinkler system	
	_	for were not in the facility		inspection, tests, and maintenance documentation	to
		not able to locate the Plan of		ensure continued compliance	
	_	show this deficiency has been		Results of the monitoring will	-
	corrected.	show this deficiency has been		reviewed during the facility's	
	conceicu.			monthly Quality	
	This finding was re	viewed with the DON and		Assurance/Performance	
		nager during the exit		Improvement (QA/PI) meeting	a.
	conference.			Monitoring will be ongoing.	
	3.1-19(b)				
	This deficiency was	s cited on 02/25/25. The facility			
	•	a systemic plan of correction			
	to prevent recurrence				
K 0711	NFPA 101				
SS=F	Evacuation and R	elocation Plan			
Bldg. 01					
-	Based on record rev	view and interview, the facility	K 0711		05/14/2025
	failed to provide a c	complete facility specific		What corrective action(s) will	
	written fire safety p	lan for the protection of all		accomplished for those resid	ents
		ely address all life safety		found to have been affected	by the
		em addressing all items		deficient practice?	
		101, 2012 edition, Section			
		.2.2 requires a written health care			
		ty plan that shall provide for			
	the following:			No residents were affected by	y this
	(1) Use of alarms		1	tag	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 04/21/2025	
	PROVIDER OR SUPPLIER		1046	ET ADDRESS, CITY, STATE, ZIP COD 6 POLLACK AVE /BURGH, IN 47630	•
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION SHOULD	
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO	PRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	BEFERENT	DATE
	* *	Calarm to fire department ne call to fire department			
	(4) Response to ala				
	(5) Isolation of fire	iiiis		How will other residents ha	wing the
	(6) Evacuation of ir	mmediate area		potential to be affected by	_
	(7) Evacuation of si			same deficient practice be	uie
	* *	loors and building for		identified and what correct	ive
	evacuation	tools and building for		action(s) will be taken?	ive
	(9) Extinguishment	of fire		action(s) will be taken:	
	` '	states any required aisle or			
	` '	e less than 48 inches in clear			
width where serving as means of egress from			No other residents were af	fected	
	patient sleeping rooms. Projections into the			The strict residents were an	loctod
		be permitted for wheeled			
	-	I the relocation of wheeled			
		fire or similar emergency is		measures will be put into	olace
		itten fire safety plan and	and what systemic changes will		
		r the facility. The wheeled		be made to ensure that the	
	equipment is limite			deficient practice does not	
	i. Equipment in use			<u>'</u>	
		ncy equipment not in use			
	iii. Patient lift and t	ransport equipment			
		ice could affect all occupants		The plan was updated to	
	in the event of an er	mergency.		address:	
	Findings include:			-evacuation of the smoke compartment	
	Based on a review of	of the facility's Fire Procedure			
	plan on 02/25/25 be	etween 10:00 a.m. and 3:00 p.m.			
	with the Administra	ntor and Maintenance Director		·-to identify where the sm	noke
		d not address the following:		barriers the facility and eva	acuation
	a. The plan did not	address evacuation of the		in detail	
		t, furthermore, the plan did not			
	-	moke barriers were located in			
	the facility and evac			·-staff response to the ac	tivation
	•	address staff response to the		of battery powered smoke	alarms
	activation of batter	y powered smoke alarms in the		in the resident rooms (i.e.,	staff
	resident rooms.			are alerted to smoke alarm	l,
		at the time of record review,	1	rescues resident, shuts do	or and
	the Administrator a	nd Maintenance Director		then pulls fire alarm)	

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	OF CORRECTION	IDENTIFICATION NUMBER  155354	, ,	UILDING	01	COMPL 04/21/	ETED
	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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	acknowledged the Finclude the previous This finding was re and Maintenance Diconference.  Based on interview Director of Nursing Maintenance Direct today and she was re Correction folder to corrected.  This finding was re Business Office Maconference.  3.1-19(b) This deficiency was	Fire Procedure plan did not sly mentioned items.  viewed with the Administrator irector during the exit  on 04/21/25 at 3:00 p.m., the said the Administrator and for were not in the facility not able to locate the Plan of show this deficiency has been viewed with the DON and mager during the exit  s cited on 02/25/25. The facility a systemic plan of correction		TAG	How will the corrective action( monitored to ensure the defici- practice will not recur, i.e., who quality assurance program will put into place?  The facility will ensure a comp facility-specific written fire safe plan for the protection of all residents is established. The facility will ensure all health ca occupancy personnel are periodically instructed all aspe of the written fire safety plan. Emphasis must be placed on addressing evacuation of the smoke compartments and	ent at I be lete ety	DATE
	to prevent recurrent				identifying where the smoke barriers were located in the far and evacuation in detail as we addressing staff response to the activation of battery powered smoke alarms in the resident rooms, training staff to sound fire alarm, to rescue residents needed), and to close all doors.  Ongoing, the Administrator or monitor training documentation ensure all employees of health care occupancies have received instruction in life safety	ell as the the (as s.; will n to	

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	OF CORRECTION	IDENTIFICATION NUMBER  155354	A. BU	A. BUILDING <u>01</u>		COMPL 04/21/	ETED
	PROVIDER OR SUPPLIER			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 LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					procedures and devices to enscontinued compliance.¿ Resulthe monitoring will be reviewed during the facility's monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	ts of	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						l
	facility failed to ensincluded complete of transmission of a fir monitoring company past twelve months. drills in health care transmission of the simulation of emerg deficient practice confirmed included with 4 of 1 transmission of the simulation of emerged efficient practice confirmed included with 4 of 1 transmission of the simulation for the monitoring company	he 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	K 0	712	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice?  No residents were affected. How will other residents having the potential be affected by the same deficient practice be identified and what corrective action(s) will be taken? All others with potential be affected: The Maintenance Supervisor/designee will ensure the monthly fire drills are completed and documented (including but not limited to data and time) retained in the LSC Binder to meet set standards. Measures to prevere reoccurrence: When the Maintenance Supervisor condumonthly fire drills for 3 shift between the hours of 10pm and 6am, the maintenance director pull the fire alarm the following morning to verify the monitoring company has received	nts y the to ent in al to re te te te d will	05/14/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155354	B. W	NG		04/21/2025
				CEDELET	ADDRESS STEW STATE SID COD	
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD	
NEWDIE		_			POLLACK AVE	
NEWBUR	RGH HEALTH CAR	E		NEWBO	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	and Maintenance D	irector during the exit			transmission of the alarm. This	s
	conference.				completed documentation will	be
					placed in the facility's logbook	as
	Based on interview	on 04/21/25 at 3:00 p.m., the			a part of the facility's Emergen	
	Director of Nursing	said the Administrator and			Preparedness Program. If any	-
	Maintenance Direct	or were not in the facility			issues are discovered, they wi	
	today and she was r	not able to locate the Plan of			addressed and resolved. The	
	1 -	show this deficiency has been			Maintenance Director/designe	e
	corrected.				will review with the Administra	
					the fire drill reports to ensure t	here
	This finding was re-	viewed with the DON and			is documentation of the	
	_	nager during the exit			transmission of the alarm to th	e
	conference.				monitoring company.	
	3-1.19(b)				All others with potential to be	
	3.1-51(c)			affected: On 5-12-2025 the		
					Maintenance Supervisor/desig	inee
	This deficiency was	s cited on 02/25/25. The facility			was in-serviced on the require	
	failed to implement	a systemic plan of correction			that monthly fire drills must be	
	to prevent recurrence	ee.			completed and documentation	
					(including but not limited to da	
	2. Based on record	review and interview, the			and time) retained in the LSC	
	facility failed to ens	sure fire drills were held at			Binder to meet set standards.	
	varied times for 3 of	f 3 employee shifts during 4 of			Measures to prevent recurren	ce:
	4 quarters. This def	ficient practice could affect all			Maintenance Supervisor will	
	residents in the faci	lity.			conduct monthly fire drills and	
					place completed documentation	on in
	Findings include:				the facility's log Binder as a pa	rt of
	-				the facility's Emergency	
	Based on review of	the facility's fire drill reports			Preparedness Program. If any	
	on 02/25/25 betwee	n 10:00 a.m. and 3:00 p.m. with			issues are discovered, they wi	
	the Maintenance Di	rector present, the following			addressed and resolved. The	
	was noted:	- <del>-</del>			maintenance director/designee	e will
	a. 3 of 4 first shift (	(day) fire drills were performed			review with the Administrator t	
	between 10:15 a.m.				fire drill reports to ensure there	e is
	b. 4 of 4 second shi	ift (evening) fire drills were			documentation of the transmis	
		2:30 p.m. and 3:15 p.m.			of the alarm to the monitoring	
	_	(night) fire drills were			company. measures will be p	ut
		10:00 p.m. and 10:40 p.m.			into place and what systemic	
	_	at the time of record review,			changes will be made to ensur	re

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	OF CORRECTION	IDENTIFICATION NUMBER  155354	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01		COMPLETED 04/21/2025	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD POLLACK AVE		
NEWBUF	RGH HEALTH CAR	E		URGH, IN 47630		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)  COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		rector acknowledged the times		that the deficient practice doe	<b>I</b>	
		Irills were performed and re not varied enough.		recur? The Administrator will monitor adherence to the fire		
		-		schedule and validate the		
		viewed with the Administrator		Emergency Preparedness		
	conference.	irector during the exit		documentation in place. Monitoring corrective		
	comerciee.			action: The fire drill report will	be	
	Based on interview	on 04/21/25 at 3:00 p.m., the		presented by the Maintenance	<b>I</b>	
	_	said the Administrator and		Supervisor/designee to the		
		or were not in the facility		Administrator monthly and the	;	
	-	not able to locate the Plan of		Administrator will present the		
		show this deficiency has been		inspection results at the mont	-	
	corrected.			Quality Assurance/Performan Improvement (QA/PI) meeting	<b>I</b>	
	This finding was rev	viewed with the DON and		fire drill reports will be presen	•	
		nager during the exit		by the Maintenance	lou	
	conference.			Supervisor/designee monthly	to	
				the Administrator and the		
	3.1-19(b)			Administrator will present the		
	3.1-51(c)			inspection results at the mont	-	
	TEL: 1 CC:	'. 1 02/25/25 TI C 'I'.		Quality Assurance/Performan		
	_	a systemic plan of correction		Improvement (QA/PI) meeting every month for 6 months. Th	•	
	to prevent recurrence	•		audit will be reviewed by the (	<b>I</b>	
	as provent recurrence	· <del></del> :		Committee with subsequent p	<b>I</b>	
				of correction developed and		
				implemented as deemed		
				necessary to ensure compliar	nce	
				is maintained. How will the		
				corrective action(s be monitor	<b>I</b>	
				ensure the deficient practice was not recur, i.e., what quality	VIII	
				assurance program will be pu	t into	
				place? The facility will ensure		
				drills are held at expected and	<b>I</b>	
				unexpected times under varyi		
				conditions, at least quarterly of		
				each shift. Documentation sha	all be	
				maintained for review by the		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  04/21/2025
	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 APPROPRI DEFICIENCY)	5.112
				authority having jurisdiction a include documenting the transmission of the alarm sign Ongoing, the Administrator or designee will maintain fire dril documentation to ensure continued compliance. ¿ Resuthe monitoring will be reviewed uring the facility's monthly Quality Assurance/Performan Improvement meeting. Monito will be ongoing.	nal. Il ults of ed
K 0741 SS=E Bldg. 01	failed to ensure ciga disposed of at 1 of 1	on and interview, the facility arette butts were properly area where cigarettes were ed by staff. This deficient	K 0741	What corrective action(s) will accomplished for those reside found to have been affected to deficient practice?	ents
		ons on 04/21/25 at 1:45 p.m. facility with the Director of		No residents were affected.	
	Nursing (DON), the outside the rear kitc cigarette butts scatte with two small meta table and both full cinterview at the time acknowledged the is on the ground and la	designated staff smoking area then exit door had hundreds of ered on the ground, along al self closing ash trays on a of cigarette butts. Based on the of observation, the DON essues with the cigarette butts ack of ways to dispose of the		How will other residents havir potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken?	,
		erly. viewed with the DON and nager during the exit		No other residents were affect measures will be put into pla	ce
				and what systemic changes v	VIII

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	OF CORRECTION	IDENTIFICATION NUMBER  155354	A. BUILDING B. WING	01	COMPLETED 04/21/2025
	ROVIDER OR SUPPLIER		10466 I	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
		cited on 02/25/25. The facility a systemic plan of correction e.		be made to ensure that the deficient practice does not rec	ur?
				A designated smoking area is established with self-closing ashtray/smoking tower receptacles of noncombustible material and safe design provi Signage is prominently display with instructions for the disposing cigarette butts. A smoking polas been updated, with an addendum included on how to dispose of cigarette butts once self-closing device is full.	e ided. yed sal of licy
				Staff will continue to be in-served on the Smoking Protocol by the Staff Development Coordinator/designee until compliance with the policy and then annually after.	e
				How will the corrective action( monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place?	ent at
				The facility will ensure staff, residents and visitors adhere testablished smoking policies a	

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	A. BUILDING  B. WING	<u>01</u>	COMPLETED 04/21/2025	
	ROVIDER OR SUPPLIER	≣	STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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	
				procedures.¿ Smoking materia are discarded properly in area where smoking is permitted ar not permitted.	s	
				Ongoing, the Administrator or monitor smoking areas and nonsmoking areas to ensure proper disposal of discarded smoking materials to ensure continued compliance. Result the monitoring will be reviewed during the facility's monthly Quality Assurance meeting. Monitoring will be ongoing.	its of	
K 0918 SS=F Bldg. 01	Based on record rev failed to ensure a wr maintenance and tes generator was maint NFPA 110, the Stan Standby Powers Sys written schedule for operational testing of established. 8.3.4 re the EPSS inspection and repairs shall be available. 8.3.4.1 re shall include the follomaintenance report servicing personnel unsatisfactory conditions.	- Essential Electric Syste  iew and interview, the facility itten record of routine ting for 1 of 1 emergency ained and available for review. dard for Emergency and tems, at 8.3.3 requires a routine maintenance and if the EPSS shall be equires a permanent record of s, tests, exercising, operation, maintained and readily quires the permanent record lowing: (1) The date of the (2) Identification of the (3) Notification of any tion and the corrective action as replaced (4) Testing of any	K 0918	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice? No resident were affected by this tag. How other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No other residents were affected by this tag. The generator did have preventative maintenance on August 8th, 2024. The facility I also renewed the contract for maintenance to be performed 2025. measures will be put into	nts y the ats v will  her s	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY  COMPLETED  04/21/2025
	PROVIDER OR SUPPLIER RGH HEALTH CARE	10466 F	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE JRGH, IN 47630	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors.  Findings include:		place and what systemic chan will be made to ensure that the deficient practice does not recur? A checklist has been created for the Maintenance	-
	Based on record review on 04/21/25 at 3:00 p.m. with the Director of Nursing (DON) and Business Office Manager 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 three months past due. Based on interview at 3:00 p.m., the Business Office Manager said she contacted the generator maintenance vendor and they sent her a report of emergency generator service, however, it was not provided with a date of service.  This finding was reviewed with the Administrator and Maintenance Director during the exit		Director to review with the Administrator/Designee to ensity routine maintenance and testing for the emergency generator is documented and maintained for review. How will the corrective action(s be monitored to ensure the deficient practice will not recur, i.e., what quality assurated program will be put into place? The facility will ensure emergency generator is maintained to ensure to a reasonable degree that the generator is capable of supply emergency power within the tispecified and for the time durate.	ng s or re nce the ing me
	Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and Maintenance Director were not in the facility today and she was not able to locate the Plan of Correction folder to show this deficiency has been corrected.  This finding was reviewed with the DON and Business Office Manager during the exit conference.  This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		specified within NFPA 110, Standard for Emergency and Standby Power Systems.; The continuing reliability and integr of the Emergency Power Supp System (EPSS) are dependent an established program of rout maintenance and operational testing. Ongoing, the Administrator or will monitor the routine maintenance and operational testing program to ensure continued compliance. Results of the monitoring will the reviewed during the monthly Quality Assurance/Performance Improvement (QA/PI) meeting Monitoring will be ongoing.	rity bly t on tine de

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155354		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/21/2025	
			10466	ADDRESS, CITY, STATE, ZIP COD POLLACK AVE URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure extension cords were not used as a substitute for fixed wiring in 1 of 64 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident.  Findings include:  Based on observations on 04/21/25 at 1:35 p.m. during a tour of the facility with the Director of Nursing (DON), a string of white Christmas lights (approximately 100 to 200 lights) hanging over the window curtains and turned on at the time of observation. This was acknowledged by the DON at 1:35 p.m  This finding was reviewed with the DON and Business Office Manager during the exit conference.  3.1-19(b)  This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		K 0920	What corrective action(s) will accomplished for those resider found to have been affected by deficient practice? No resident were affected by this tag. How will other residents have the potential to be affected by same deficient practice be identified and what corrective action(s) will be taken? No otheresidents were affected by this tag. The resident's family remether the Christmas lights from the resident's room. The Maintens director has audited all other residents' rooms to remove extension cords, power strips, and/or Christmas lights out of resident rooms if they do not comply with NFPA 70, National Electrical Code, 2011 measu will be put into place and what systemic changes will be made ensure that the deficient practice does not recur? A checklist has been created for the Maintens Director to review with the Administrator/Designee to ensure that the deficient practice of the maintained of the review. How will the correction cords are not used substitute for fixed wiring and documented and maintained of the deficient practice will not recur, i.e., what quality assurations are not used? The facility will ensure program will be put into place? The facility will ensure program will be put into place? The facility will ensure the second of the facility will ensure the facility will ensure the second of the facility will ensure the facility will ensure the facility will ensure the facility will ensure the second of the facility will ensure the facility will ensu	ents by the ats ing the her s loved ance  al res t de to tice as ance sure as a is for we lire ance

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155354		IDENTIFICATION NUMBER	l í	JILDING	ONSTRUCTION  01	(X3) DATE : COMPL 04/21/	ETED
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 APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
					compliance with power cord are extension cord requirements. Ongoing, the Administrator or monitor the facility to ensure continued compliance with powered and extension cord requirements. ¿ Results of the monitoring will be reviewed duthe facility's Quality Assurance meeting; monitoring will be ongoing.	will ver ring	
K 0921 SS=F Bldg. 01	interview; the facili required maintenand documentation of in Related Electrical E 2012 edition, section physical integrity, respectively. The section are established with PCREE used in patriac accordance with 10 into service and after Any system consists appliances demonst 99 as a complete syinstructions, and promanufacturer included 10.5.3.1.1 and are confused of a program for electrical equipment manuals are readily and condensed oper appliance are legible.	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 resistance, leakage current, and for fixed and portable PCREE aired in 10.3. Testing intervals policies and protocols. All rent care rooms is tested in 13.5.4 or 10.3.6 before being put er any repair or modification. The importance with NFPA restem. Service manuals, recedures provided by the de information as required by considered in the development rectrical equipment maintenance available, and safety labels rating instructions on the read of electrical reads, and modifications is	K 0	921	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice? No resident were affected by this tag.  How will other residents having potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? No oth residents were affected by this tag. The company "" was contacted on 5/11/2025 and 5/12/2025 to request them to perform an assessment of the building equipment to be tested accordingly. The facility has requested this company to tested equipment such as electric been nebulizers, oxygen concentrate air pumps for air mattresses, and other electrical medical equipment.	nts y the s g the er d ds, ors,	05/16/2025

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155354	A. Bl	MULTIPLE CONSTRUCTION BUILDING 01 WING		(X3) DATE SURVEY COMPLETED 04/21/2025	
NAME OF PROVIDER OR SUPPLIER  NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE NEWBURGH, IN 47630				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	maintained for a period of time to demonstrate						
	-	rdance with the facility's					
	policy. Personnel responsible for the testing, maintenance and use of electrical appliances			measures will be put into place			
		training. This deficient		and what systemic changes wil			
	practice could affect	_			be made to ensure that the		
	praetice coura arree	v un residents.			deficient practice does not rec	cur?	
	Findings include:				A checklist has been created for		
	C				the Maintenance Director to re		
	Based on record rev	view on 02/25/25 between 10:00			with the Administrator/Design		
	a.m. and 3:00 p.m.	with the Maintenance Director			ensure the required maintena	nce	
	present, there was n	no documentation for the			is maintained of complete		
	testing of PCREE, such as electric beds,				documentation of inspections		
	nebulizers, oxygen concentrators, air pumps for air			Patient Care Related Electrical Equipment (PCREE) is			
	mattresses, and other electrical medical						
	equipment. Based on interview at the time of				documented and maintained f	or	
	record review, the Maintenance Director said the facility has not tested and documented the PCREE items and was not aware of the requirement.  Based on observation between 3:00 p.m. to 5:30				review.		
		of the facility with the			How will the corrective action(	's bo	
	_				monitored to ensure the defici	•	
	Administrator and Maintenance Director, it was revealed the facility provided PCREE such as				practice will not recur, i.e., wh		
	electric beds, oxygen concentrators, air pumps for				quality assurance program will be		
	air mattresses, and other electrical medical equipment was present in the facility.				put into place?		
	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.						
					The facility will ensure patient		
					care-related electrical equipm		
	Raced on intervious	on $04/21/25$ at $3.00$ n m the			(PCREE) is tested at intervals established by the facility's ow		
	Based on interview on 04/21/25 at 3:00 p.m., the Director of Nursing said the Administrator and				policy and procedures. (based		
	Maintenance Director were not in the facility				manufacturer's guidelines)	4 OH	
	today and she was not able to locate the Plan of				Inspection and testing will incl	ude	
	Correction folder to show this deficiency has been corrected.				the following for fixed and por		
					PCREE:	=	
	_	viewed with the DON and anager during the exit			Physical integrity		

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STATEMENT C	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
	155354		B. WING			04/21/2025		
NAME OF PROVIDER OR SUPPLIER  NEWBURGH HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 10466 POLLACK AVE					
NEWBURG	IN NEALTH CAR	=	NEWBURGH, IN 47630					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG:		TE	COMPLETION		
TAG	conference.	LSC IDENTIFYING INFORMATION		TAG			DATE	
	onterence.				Resistance			
3	3.1-19(b)				Leakage current			
	This deficiency was cited on 02/25/25. The facility				Touch current tests			
	This deficiency was cited on 02/25/25. The facility failed to implement a systemic plan of correction to prevent recurrence.				All PCREE used in resident rooms shall be tested before being put service and after any repairs or modification. Service manuals and manufacturer's guidelines must be considered in the development of an electrical equipment maintenance program. Instructions and maintenance manuals shall be readily available. Safety labels and condensed operating instructions shall be legible. Documentation is maintained of all tests, repairs, and modifications in accordance with the facility's PCREE policy and procedure.  Personnel responsible for the testing, maintenance and use of electrical appliances shall receive continuing training.			

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