STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155745	A. BUILDING -- B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS VILLAGE AT NOTRE DAME INC	54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/24/2023 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990 At this Emergency Preparedness survey, Holy Cross Village at Notre Dame, Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 52 certified beds. 30 beds are dually certified for Medicare and Medicaid. 22 beds are certified only for Medicare. At the time of the survey, the census was 43 Quality Review completed on 03/29/23	E 0000	Holy Cross Village at Notre Dame Inc., (the "Provider") submits this plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by then Centers for Medicare and Medicaid Services, ("CMS"), the state of Indiana or any other entity; or (2) serve, in anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jack Mueller	Administrator	04/10/2023

Any defiencystatement 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 disclo days 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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			that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on March 24, 2023.. We respectfully ask for a desk review and opportunity for paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/24/2023 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990 At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 2019 Therapy Room and dining facility addition to the Murphy Wing were surveyed under Chapter 18, New Health Care Occupancies.. This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the	K 0000	Holy Cross Village at Notre Dame Inc., (the "Provider") submits this plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by then Centers for Medicare and Medicaid Services, ("CMS"), the state of Indiana or any other entity; or (2) serve, in	

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	Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. A Therapy Room and dining facilities were added to the existing Murphy Wing in 2019. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The building is partially protected by a 200 kW diesel-powered emergency generator. The facility has 52 certified beds. 30 beds are dually certified for Medicare and Medicaid. 22 beds are certified for Medicare only. The facility had a census of 43 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered Quality Review completed on 03/29/23		anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on March 24, 2023.. We respectfully ask for a desk review and opportunity for paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all staff and residents in 100 hall. Findings include:	K 0211	1.) The scale that was in the hallway has been moved to a shower room. The hallways will be added to the Preventive Maintenance checklist to check for any obstructions or impediments are not in the hallway. Attachment #2. All	04/07/2023

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	Based on an observation during a tour of the facility with the Maintenance Technician #1 on 03/24/23 between 1:30 p.m. and 3:10 p.m., a weight scale was stored in the 100 hall exit corridor which took up half of the corridor. Based on an interview at the time of observations, the Maintenance Technician #1 agreed there was storage in the corridor and removed the scale upon observation. The findings was reviewed with the Administrator, Maintenance Technician #1 and Maintenance Director during the exit conference. 3.1-19(b)		personnel will be Inserviced as to keeping the hallways clear of storage in the halls. Attachment #1. 2.) Preventative Maintenace daily checks will prevent any storage in the hallway. 3.) Preventative Maintenace checks will be instituted and report to the QAPI committee for the next six month .	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 2 of 2 battery operated smoke alarms in the main dining room were complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the	K 0300	1.) Battery operated smoke detectors will be added to our Corrigo Preventative Maintenace daily list to check on these detectors are in working order. All smoke detectors will be checked on a monthly basis and the test and cleaning noted. (Attachment # 3) 2.) No residents have been affected by this deficient practice. 3.) Smoke Detectors added to	04/10/2023

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	equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Technician #1 on 03/24/23 between 10:22 a.m. and 1:20 p.m., no completed itemized list for preventative maintenance of battery operated smoke alarms were available for review. Based on interview at the time of review, the Maintenance Technician #1 stated the alarms are tested monthly but the test are not recorded and was unaware when the last cleaning was conducted. On observation during a tour of the facility between 1:34 p.m. and 3:10 p.m., it was confirmed that two battery operated smoke detectors were installed in the main dining area near the front entrance. Findings were discussed with the Maintenance Technician #1, Maintenance Director and Administrator at exit conference. 3.1-19(b)		daily list and monthly recording of smoke detector will assure compliance. 4.) The Plant Operations Director will report to QAPI the result for six months of the Daily Preventative to assure daily checks have been performed.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 8.3.1.2 electric motor-driven fire pumps shall be operated monthly. Findings include: Based on record review with the Maintenance Director and the Maintenance Technician #1 on 03/24/23 between 10:22 a.m. and 1:20 p.m., the facility was able to produce documentation for monthly fire pump inspections, but did not fulfill and list all of the necessary requirements for a monthly inspection. Based on interview at the time of record review, the Maintenance Technician #1 stated they were only documenting the run time. This finding was reviewed with the Maintenance Director, Maintenance Technician #1 and Administrator at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire pump systems in accordance with NFPA 25, 2011 edition. NFPA	K 0353	1.) All testing of the Fire Pump system will be performed monthly and needed documentation will be noted at the time of the testing. A test of the Electric Motor Driven Fire Pump system was performed on March 29, 2023. Attachment #4 2.) All resident and staff could have been effected. 3.) The Plant Operations Director will report to the QAPI committee for six(6) months to assure all needed records of the monthly test are maintained. New Monthly Testing form implemented. (Attachment #10)	04/07/2023

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	25 8.3.3.1 states an annual test of each pump assembly shall be conducted by qualified personnel under minimum, rated, and peak flows of the fire pump by controlling the quantity of water discharged through approved test devices. This deficiency practice could affect all residents and staff in the facility. Findings include Based on record review with Maintenance Technician #1 on 03/24/23 between 10:22 a.m. and 1:20 p.m., no documentation could be found for an annual fire pump inspection. Upon interview at the time of record review, the Maintenance Technician #1 stated that they were unaware of a required annual inspection and did not have any documentation at the time of survey. Findings were discussed with the Maintenance Director, Maintenance Technician #1 and Administrator at exit conference.			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain			

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	flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 3 of 40 corridor doors on the southwest wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 30 staff and residents in two smoke compartments Findings include: Based on observation with the Maintenance Director and Maintenance Technician #1 on 03/24/23 between 1:34 p.m. and 3:10 p.m., the	K 0363	1.) The three doors referred to doors will all be outfitted with a positive latching mechanism. 2.) All doors in the facility will be evaluated to assure they have a positive locking mechanism. Any doors identified without a positive locking latch will have a positive locking latch installed. Lazzaro Door Company and Holy Cross Village signed agreement on April 10 to perform	04/28/2023

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	storage room double doors in the Quinn Unit did not positively latch into the frame. Furthermore, the storage room in the 100 hall also did not close and latch into the frame. The 100 hall storage door was not designed to positively latch. Based on interview at the time of the observations, the Maintenance Director acknowledged that both storage room doors did not properly positively latch. The finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician #1 during the exit conference. 3.1-19(b)		this work. Attachment #5.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 5 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection	K 0761	1.) All smoke/ Fire barrier doors will be added to the Annual Door inspection list. Attachment #9 Doors were inspected April 10, 2023 by Lazzaro Door Company. Attachment #6. 2.) All residents have potential to be affected by the practice. All Smoke/Fire doors were inspected April 10th, 2023 and added to the yearly testing schedule. 3.) Director of Plant Operations will report status of smoke/ Fire barrier doors and any new doors that nee to be added to the list for the next 12 months.	04/10/2023

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	by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Technician #1 on 03/24/23 between 10:22 a.m. and 1:20 p.m., no documentation of an annual inspection for the oxygen storage/transfilling room was provided. Based on observation during			

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	the tour between 1:30 p.m. and 3:10 p.m., the fire rated tag on the oxygen room door stated it was a 3/4 hour rated fire door. Based on interview at the time of observation, the Maintenance Director stated that they did not do annual fire door inspections for that door. Findings were discussed with the Maintenance Director, Maintenance Technician #1 and Administrator at exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions			

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	as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 20 residents and staff in one smoke compartment. Findings include: Based on observation during the tour of the facility with the Maintenance Director and Maintenance Technician #1 on 03/24/23 between 1:30 p.m. and 3:10 p.m., four cardboard boxes	K 0923	1.) Oxygen Room was inspected and all cardboard was removed. Nursing Personnel was educated concerning no cardboard in the Oxygen room. Attachment # 7. 2.) The cardboard was removed from the oxygen room. 3.) The weekly inspection of the Preventive Maintenance list was added to inspect for cardboard in the Oxygen room. Attachment # 8.	04/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155745	A. BUILDING 01 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS VILLAGE AT NOTRE DAME INC	54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	containing supplies were stored within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Based on interview at the time of observation, the Maintenance Director agreed combustible materials were stored within five feet of stationary liquid oxygen containers and removed the boxes upon observation. Findings were discussed with the Maintenance Director, Maintenacne Technician #1 and Administrator at exit conference. 3.1-19(b)			
K 0000 Bldg. 06	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/24/2023 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990 At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 2019 Therapy Room and dining facility addition to the Murphy Wing were surveyed under Chapter 18, New Health Care Occupancies..	K 0000	Holy Cross Village at Notre Dame Inc., (the "Provider") submits this plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155745	A. BUILDING 06 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS VILLAGE AT NOTRE DAME INC	54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556

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	This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. A Therapy Room and dining facilities were added to the existing Murphy Wing in 2019. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The building is partially protected by a 200 kW diesel-powered emergency generator. The facility has 52 certified beds. 30 beds are dually certified for Medicare and Medicaid. 22 beds are certified for Medicare only. The facility had a census of 43 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered Quality Review completed on 03/29/23		whether such remedies are imposed by then Centers for Medicare and Medicaid Services, ("CMS"), the state of Indiana or any other entity; or (2) serve, in anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on March 24, 2023.. We respectfully ask for a desk review and opportunity for paper compliance.	