CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	LETED
		155535	B. W	ING		03/10	/2025
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENC N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	11E	DATE
E 0000							
Bldg	conducted by the Irl accordance with 42 Survey Date: 03/10 Facility Number: 0 Provider Number: 100 At this Emergency Crossing Health & found in complianc Preparedness Required Medicaid Participat CFR 483.73. The facility has 112 the survey, the cens	20/25 20/25 200572 207710 2077	E 0	000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the Statement of Deficiencies. The Plan of Correction is prepand submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Plefind enclosed this Plan of Correction for this survey. Duthe low scope and severity of survey findings, please find the sufficient documentation provevidence of compliance with the Plan of Correction. The documentation serves to confit the Community's allegation of compliance. Thus, the community respectfully requests the gran of paper compliance. Should additional information be necessary to confirm said compliance feel free to contain me.	on s. pared e ease ue to the ne riding the firm f nunity nting	
Bldg. 01							
	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 0	000	Submission of this Plan of Correction does not constitute admission or agreement by the		

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

483.90(a).

Alisha Miller

provider of the truth of facts

TITLE

03/24/2025

(X6) DATE

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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LQEF21 Facility ID: 000572 If continuation sheet Page 1 of 15

Administrator

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535 B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID PREFIX TAG Survey Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), SITREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203 (X5) PROVIDERS PLAN OF CORRECTION (AND CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) By PROVIDER PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICENCY) BY PROVIDER PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICENCY) COMPLETION DATE alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPI	ETED
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SURVEY Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203 ID PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION (RAGI CORRECTION ACTION SHOULD BE CORRECTION (RAGI CORRECTION ACTION SHOULD BE CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION (RAGI CORRECTION ACTION SHOULD BE COMPLETION (RAGI CORRECTION ACTION SHOULD BE COMPLETION (RAGI CORRECTION ACTION SHOULD BE CORRECTION (RAGI CORRECTION ACTION SHOULD BE COMPLETION (RAGIC CORRECTION ACTION ACTION SHOULD BE COMPLETION (RAGIC CORRECTION ACTION ACTI			155535	B. W	ING		03/10	/2025
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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Survey Date: 03/10/25 Burvey Date: 03/10/25 Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), PREFIX TAG PREFIX TAG	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION Survey Date: 03/10/25 Survey Date: 03/10/25 The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Provider Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), TAG DEFICIENCY) alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
Survey Date: 03/10/25 the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		16	DATE
Survey Date: 03/10/25 the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to						alleged or correction set forth	on	
Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710 At this Life Safety Code survey, Willow Crossing Health & Rehabilitation Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to		Survey Date: 03/10	0/25					
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Health & Rehabilitation Center was found not in compliance with Requirements for Participation find enclosed this Plan of Correction for this survey. Due to		At this Life Safety Code survey Willow Crossing				•		
compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), find enclosed this Plan of Correction for this survey. Due to		·					ase	
Medicare/Medicaid, 42 CFR Subpart 483.90(a), Correction for this survey. Due to						· ·		
		-	-				e to	
						the low scope and severity of		
National Fire Protection Association (NFPA) 101, survey findings, please find the		_				•		
Life Safety Code (LSC), Chapter 19, Existing sufficient documentation providing								
Health Care Occupancies and 410 IAC 16.2. evidence of compliance with the		• `					-	
Plan of Correction. The		Trouble Care Coup.					10	
This one story facility consists of two buildings. documentation serves to confirm		This one story facil:	ity consists of two buildings				rm	
Building 01, the original building, was determined the Community's allegation of			-					
to be of Type V (111) construction and was fully compliance. Thus, the community		-	-			-		
sprinklered. Building 02, the New Wing addition respectfully requests the granting			· ·				-	
added to the west end of the original building in of paper compliance. Should		-	-				g	
2022, was determined to be of Type V(111) additional information be			-			1		
construction and was fully sprinklered. Building necessary to confirm said			· · · · · · · · · · · · · · · · · ·					
02 consists of new occupational & physical compliance feel free to contact							t	
therapy rooms and a 32-bed locked unit in the new me.								
300 Hall. Building 01 was surveyed with Chapter						me.		
19, Existing Health Care Occupancies.			-					
127, 2.moning from the Goodpuncton		17, Emoning Houldi	care socupations.					
Building 01 has a fire alarm system with smoke		Building 01 has a fi	re alarm system with smoke					
detection in the corridors, in all areas open to		-						
corridor and hard-wired smoke detectors in all								
resident rooms. The facility has a capacity of 112								
and had a census of 93 at the time of the survey.								
			 - 					
All areas where residents have customary access		All areas where resi	dents have customary access					
were sprinklered. All areas providing facility								
services were sprinklered.								
Quality Review completed on 03/12/25		Quality Review cor	npleted on 03/12/25					
		, ,	•					

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Event ID: LQEF21 Facility ID: 000572

If continuation sheet Page 2 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155535	B. WI	NG _		03/10/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER		COLUMBUS, IN 47203			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0100	NFPA 101						
SS=C	General Requirem	ents - Other					
Bldg. 01							
	Based on observation	on and interview, the facility	K 0	100	1 No residents, staff, or		03/18/2025
	failed to remove 1 o	f 2 essential electric system			visitors were affected. On 03/1	8/25	
	alarm remote annun	ciators which was in a location			the remote annunciator panel		
	readily observed by	operating personnel. LSC			without electricity at the main		
	4.6.12.3 requires ex	isting life safety features			entrance lobby nurse's station	has	
	obvious to the publi	c if not required by the Code,			been removed. (Attachment C)	
	shall be either main	tained or removed. This			2 All residents, staff, or		
	deficient practice co	ould affect all residents, staff			visitors have the potential to b	е	
	and visitors.				affected by the deficient practi	ce;	
					thus the following corrective		
	Findings include:				actions have been taken:		
					3 As a means of ongoing		
	Based on observation	ons with the Maintenance			compliance the Maintenance		
	Supervisor and the	Corporate Maintenance			Director has been educated in		
	Supervisor during a	tour of the facility from 12:30			regards to existing life safety		
	p.m. to 2:00 p.m. on	103/10/25, one of one remote			features shall either be mainta	ined	
	annunciator panels l	ocated at the nurse's station			or removed. (Attachment A)		
	at the main entrance	lobby for the facility's			4 As a means of quality		
		or had no electrical power and			assurance, the Maintenance		
	its warning lights fa	iled to illuminate when its test			Director or designee will review	w all	
	button was depresse	ed multiple times. Based on			existing life safety features		
	interview at the time	e of the observations, the			initially, then monthly thereafte	er to	
		nce Supervisor stated the			ensure that they are maintaine	ed	
	_	vas inoperable. The Corporate			and if not maintained, then		
	Maintenance Superv	visor stated the facility			removed. The results of the au	ıdits	
	-	ncy generator within the last			will be reviewed as part of the		
	few years and replace	ced the main entrance lobby			monthly quality assurance		
	nurse's station remo	te annunciator panel with a			meeting with the plan of action	1	
		nel located at the 300 Hall			adjusted accordingly, as		
		ed on interview at the time of			warranted.		
		e Corporate Maintenance			(Attachment H)		
		ne remote annunciator panel at			5 The above corrective act	tion	
		obby nurse's station had no			will be completed by 03/18/202	25	
	electrical power and	I should be removed.					
	These findings were	e reviewed with the Director of					
		enance Supervisor and the					

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

Event ID:

LQEF21 Facility ID: 000572

If continuation sheet Page 3 of 15

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				l ′	(3) DATE SURVEY COMPLETED	
MIDILAN	or conduction	155535					2025	
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Corporate Maintena conference.	nce Supervisor during the exit						
	3.1-19(b)							
K 0351	NFPA 101							
SS=E Bldg. 01	_	· Installation						
	failed to ensure the heads were not obst Library in accordan 2010 edition, Section be located so as to redischarge as defined 8.5.5.3 or additional ensure adequate cov 8.5.5.2 and 8.5.5.3 or noncontinuous obstance to the horizontal plane mosprinkler deflector to from fully developing could affect over 20 the vicinity of the Library within twelve inches sprinkler in the closwas part of the north	Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 2 closets in the Library in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Library. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:00 p.m. on 03/10/25, one of the two closets in the Library had box storage on shelving within twelve inches of the ceiling mounted sprinkler in the closet. The back wall of the closet was part of the north wall of the adjoining resident sleeping Room 114. Based on interview at the		351	1 No residents, staff, or visitors were affected. On 03/18/2025 the box storage or shelving within 12" of the ceilir mounted sprinkler in the close was removed. (Attachment E) 2 All residents, staff, or visitors have the potential to b affected; thus the following corrective action has been tak 3 As a means of ongoing compliance, the facility maintenance director has bee re-educated on not obstructing spray pattern of a sprinkler he (Attachment A). 4 As a means of quality assurance, the maintenance/director or designee will audit sprinkler heads for obstruction weekly for four weeks, then monthly thereafter. (Attachme Any concerns will be brought the attention of the Administral and will be addressed immediately. The results of the audits will be reviewed as part the monthly quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective according to the strength of the corrective according to the strength of the strength of action adjusted accordingly, as warranted.	e en; n g the ad. ss nt D) to tor e c of	03/18/2025	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	f '			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155535	B. W	ING		03/10/	2025
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
\A/!! I O\A/		THE OPENIADULT ATION OF SITE			ENTRAL AVE		
WILLOW	CROSSING HEAL	TH & REHABILITATION CENTER	.	COLUN	MBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		the sprinkler deflector in the			will be completed by 03/18/25		
	closet.						
	These findings were	e reviewed with the Director of					
	_	enance Supervisor and the					
	-	ance Supervisor during the exit					
	conference.	1					
	3.1-19(b)						
K 0355	NFPA 101						
SS=E Bldg. 01	Portable Fire Extir	nguishers				ļ	
ыug. U I	Rased on observation	on and interview, the facility	K 0	255	1 No residents, staff, or		03/18/2025
		f 11 portable fire extinguishers	KU	333	visitors were affected. The fire	ا ا	03/18/2023
		cordance with NFPA 10.			extinguisher was lowered on	•	
		for Portable Fire Extinguishers,			03/18/25 so that the top of it is	<u>.</u>	
	· ·	on 6.1.3.8.1 states fire			within five feet of the floor.	<u> </u>	
	· ·	g a gross weight not			(Attachment F)		
	-	all be installed so that the top			2 All residents, staff, or		
	-	her is not more than five feet			visitors have the potential to b	e	
	_	is deficient practice could			affected. Thus the following		
		ents, staff and visitors in the			corrective actions have been		
		apy Storage room by the			taken:		
	sprinkler riser room				3 The maintenance director	or	
	•				has been educated on the top		
	Findings include:				fire extinguisher cannot be mo	re	
					than five feet from the floor.		
		ons with the Maintenance			(Attachment G)		
	-	Corporate Maintenance			4 As a means of quality		
		tour of the facility from 12:30			assurance, the maintenance		
		n 03/10/25, the ABC type			director or designee will review	v all	
	-	uisher located in the Therapy			fire extinguishers as part of the	Э	
		e sprinkler riser room was			preventative maintenance pro	gram	
	mounted on the wal	-			to ensure that an inspection h	as	
		nes above the floor. Based on			been completed at least mont	nly	
		e of the observations, the			(see attachment H). The resul	ts of	
	_	visor and the Corporate			the audit will be reviewed as p	art	
	Maintenance Superv				of the monthly quality assuran	ce	
	aforementioned por	table fire extinguisher was			meeting with a plan of action	Į.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155535	B. WI	NG		03/10/	2025
			<u> </u>	CED FIELD	ADDRESS OF A STATE OF SOR		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
\A/II I \O\A/	CDOCCING LIEAL	THE DELIABILITATION CENTED			ENTRAL AVE		
WILLOW	CRUSSING HEAL	TH & REHABILITATION CENTER		COLUIV	MBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mounted on the wal	l with the top of the			adjusted accordingly, as		
	extinguisher greater	than five feet above the floor.			warranted.		
					5 The above corrective ac	corrective action	
	These findings were	e reviewed with the Director of			will be completed by 03/18/25		
	Nursing, the Mainte	enance Supervisor and the					
	Corporate Maintena	ance Supervisor during the exit					
	conference.						
	3.1-19(b)						
K 0918	NFPA 101						
SS=F	_	s - Essential Electric Syste					
Bldg. 01	,						
· ·	Based on observation	on and interview, the facility	K 09	918	1 No residents, staff, or		03/18/2025
	failed to ensure over	rcurrent protective devices in			visitors were affected. On		
	Emergency Power S	Supply Systems (EPSS) circuits			03/18/2025 locks have been		
	were accessible only	y to authorized persons.			placed on the two emergency		
	NFPA 110, Standar	d for Emergency and Standby			generator switches. (Attachme	ent I	
	Power Systems, 201	10 Edition, Section 6.5.4 states			and J)		
	overcurrent devices	in EPSS circuits shall be			2 All residents, staff, or		
	accessible to author	ized persons only. This			visitors have the potential to be		
	deficient practice co	ould affect all residents, staff			affected thus the following		
	and visitors.				corrective action has been take	en;	
					3 The maintenance director	r	
	Findings include:				has been educated on ensurin	ıg	
					that over current protective de	vices	
	Based on observation	ons with the Maintenance			in EPSS circuits were accessit	ole	
	Supervisor and the	Corporate Maintenance			only to authorized personnel.		
	Supervisor during a	tour of the facility from 12:30			(Attachment G).		
	p.m. to 2:00 p.m. or	n 03/10/25, two of two			4 As a means of quality		
	emergency generate	or transfer switches located			assurance, the maintenance		
	outside the facility of	on the north side of the			director or designee will condu	ıct a	
	building outside the	main dining room for Building			monthly audit of over current		
	01 were in an unloc	ked detached weatherproof			protective devices (Attachmen	t H)	
	storage cabinet. Ba	sed on interview at the time of			to ensure that over current		
	the observations, the	e Maintenance Supervisor			protective devices in EPSS		
	and the Corporate M	Maintenance Supervisor			circuits were accessible only to)	
	_	wo emergency generator			authorized persons. Any conce	erns	
	transfer switches wa	as in an unlocked detached			will be brought to the administ	rator	
	weatherproof storag	ge cabinet outside the facility.			and fixed immediately. The res	sults	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535 NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC	Ν
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE O3/10/2025 STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203 (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)N
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC)N
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC)N
WILLOW CROSSING HEALTH & REHABILITATION CENTER COLUMBUS, IN 47203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.))N
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC)N
PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC)N
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC	Ν
PRETIA (EACH DEPICIENCE WOST BE PRECEDED BY POLE PRETIA CROSS-REFERENCED TO THE APPROPRIATE CONFEDERAL	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
of the audits will be reviewed as	
These findings were reviewed with the Director of part of the monthly quality	
Nursing, the Maintenance Supervisor and the assurance meeting with the plan	
Corporate Maintenance Supervisor during the exit of action adjusted accordingly, as	
conference.	
5 The above corrective action	
3.1-19(b) will be completed by 03/18/25.	
will be completed by 03/10/23.	
K 0921 NFPA 101	
SS=F Electrical Equipment - Testing and	
Bldg. 01 Maintenanc	
Based on record review, observation and K 0921 1 No residents, staff, or 03/21/20	25
interview; the facility failed to conduct the visitors were affected. On	23
required maintenance and maintain complete 03/21/2025 inspections for all	
Related Electrical Equipment (PCREE). NFPA 99, (Attachment L)	
Health Care Facilities Code, 2012 edition, sections 2 All residents, staff, or	
10.3 and 10.5 states the physical integrity, visitors have the potential to be	
resistance, leakage current, and touch current affected; thus the following	
tests for fixed and portable PCREE is performed as corrective actions have been	
required in 10.3. Testing intervals are established taken:	
with policies and protocols. All PCREE used in 3 The maintenance director	
patient care rooms is tested in accordance with has been educated to ensure that	
10.3.5.4 or 10.3.6 before being put into service and all PCREE is tested prior to being	
after any repair or modification. Any system put into use and after any repair or	
consisting of several electrical appliances modification. (Attachment B)	
demonstrates compliance with NFPA 99 as a 4 As a means of Quality	
complete system. Service manuals, instructions, Assurance, the maintenance	
and procedures provided by the manufacturer director or designee will audit the	
include information as required by 10.5.3.1.1 and PCREE in 10 resident rooms	
are considered in the development of a program monthly ensuring that it has been	
for electrical equipment maintenance. Electrical inspected. (Attachment H) The	
equipment instructions and maintenance manuals results of the audits will be	
are readily available, and safety labels and reviewed as part of the monthly	
condensed operating instructions on the quality assurance meeting with	
appliance are legible. A record of electrical the plan of action adjusted	
equipment tests, repairs, and modifications is accordingly, as warranted.	
maintained for a period of time to demonstrate 5 The above corrective action	
compliance in accordance with the facility's will be completed by 03/21/25.	
policy. Personnel responsible for the testing,	

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

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		A. BUILDING 01 COMPL B. WING 03/10/					
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CI	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(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 APPROPRIAT	ΓE	(X5) COMPLETION
TAG	maintenance and us	e of electrical appliances training. This deficient		TAG	DEFICIENCY)		DATE
	practice affects all r	residents in the facility.					
	Findings include: Based on review of "SAFE-TEST 50 Electrical						
	Safety Analyzer Bed-Test NFPA 99"						
	documentation date						
		visor and the Corporate					
	_	visor during record review 2:30 p.m. on 03/10/25, PCREE					
		on for the facility only					
	-	eeping room beds. Additional					
		umentation was not available					
		on interview at the time of					
		Corporate Maintenance					
		dditional PCREE testing er than that conducted for					
		om beds, was not available for					
		of the survey. Based on					
		ne Maintenance Supervisor					
		Maintenance Supervisor during					
	•	from 12:30 p.m. to 2:00 p.m. on					
		er was noted in resident					
		and oxygen concentrators					
		xygen storage and transfilling					
	room.						
	These findings were	e reviewed with the Director of					
	_	enance Supervisor and the					
		ance Supervisor during the exit					
	conference.						
	3.1-19(b)						
K 0930	NFPA 101						
SS=A	Gas Equipment - I	Liguid Oxygen Equipment					
Bldg. 01	Based on observation	on and interview, the facility	K 09	930	No plan of correction is require	ed.	03/18/2025

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/10/2025	
		100000	D. W			03/10/	2020
	PROVIDER OR SUPPLIED	R .TH & REHABILITATION CENTER		3550 CE	DDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S BLANGE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to protect 6 of the use of liquid ox patient bed location 99, Health Care Far Section 11.7.4 state liquid oxygen permater bed location 120 L (31.6 gallons location or patient separated from the barriers and horizon minimum fire resist accordance with the Section 7.2.4.3.10 in horizontal exits a automatic-closing. affect 6 residents, s Findings include: Based on observati Supervisor and the Supervisor during a p.m. to 2:00 p.m. o container was store sleeping Room 102	of over 40 resident rooms from exygen containers stored in a container of a conta			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	separated from the barriers and horizon minimum fire resist corridor door to the automatic closing a equipped with a fire to the door. Based observations, the Mothe Corporate Mair liquid oxygen contact the rooms and each	remainder of the facility by fire intal assemblies having a stance rating of 1 hour. The erooms was not self-closing or and each door was not eresistance rating label affixed on interview at the time of the Maintenance Supervisor and intenance Supervisor agreed ainers were stored and in use in a room was not maintained with distance rating of 1 hour.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	` ´			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155535	B. WI	NG		03/10/	2025
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	These findings were reviewed with the Director of Nursing, the Maintenance Supervisor and the Corporate Maintenance Supervisor during the exit conference.						
K 0000							
Bldg. 02	Licensure Survey w Department of Heal 483.90(a). Survey Date: 03/10 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety O Health & Rehabilita compliance with Re Medicare, 42 CFR S from Fire and the 20 Protection Associati Code (LSC), Chapte Occupancies and 41 This one story facili Building 01, the orig to be of Type V (11 sprinklered. Buildin added to the west er 2022, was determine construction and wa 02 consists of new of	200572 155535 267710 Code survey, Willow Crossing ation Center was found not in equirements for Participation in Subpart 483.90(a), Life Safety 2012 edition of the National Fire ion (NFPA) 101, Life Safety er 18, New Health Care	K 00	000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the Statement of Deficiencies. The Plan of Correction is prep and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Plea find enclosed this Plan of Correction for this survey. Du the low scope and severity of survey findings, please find the sufficient documentation provi evidence of compliance with th Plan of Correction. The documentation serves to confit the Community's allegation of compliance. Thus, the commu respectfully requests the grant of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	e on ared ase e to the e ding he irm unity ting	
		02 was surveyed with Chapter					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				r í	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	02	COMPL	
		155535	B. WI	NG		03/10/	2025
	PROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203			
			1		1.200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0293 SS=E	Building 02 has a findetection in the correction. Building 02 connected to the bunew 300 Hall reside backup which reportstation. The facility a census of 93 at the All areas where residence were sprinklered. Asservices were sprinklered.	re alarm system with smoke ridors and in all areas open to 02 has smoke detectors ilding electrical system in the ent sleeping rooms with battery to the 300 Hall nurse's has a capacity of 112 and had the time of the survey.		IAU			DATE
Bldg. 02	failed to ensure 1 of the facility in the 30 mistaken as a facilit states any door, pas neither an exit nor a located or arranged mistaken for an exit that reads as follow sign shall have the high, with a stroke word EXIT below t is an approved exist practice could affect visitors in the 300 F. Findings include: Based on observation Supervisor and the Supervisor during a	on and interview, the facility of 1 door sets to the outside of the Hall Activity Room was not the exit. LSC Section 7.10.8.3.1 sage, or stairway that is a way of exit access and that is so that it is likely to be a shall be identified by a sign so NO EXIT. The NO EXIT word NO in letters 2 inches width of 3/8ths inch, and the the word NO, unless such sign ting sign. This deficient t over 10 residents, staff and Hall Activity Room. The months with the Maintenance Corporate Maintenance tour of the facility from 12:30 to 103/10/25, the exit door to the	K 02	293	1 No residents, staff, or visitors were affected. On 03/1 a "Not an Exit" sign was place the door to the outside of the facility in the 300 hall activity room. (Attachment K) 2 All residents, staff and visitors have the potential to b affected, thus the following corrective actions have been taken: 3 The maintenance director has been educated that all exit and directional signs are displin accordance with 7.10 (see attachment B). 4 As a means of quality assurance, the maintenance director or designee will audit exit signage monthly as part of preventative maintenance products.	d on e or it ayed all f the gram.	03/18/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED
		155535	B. WI	NG		03/10/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ENTRAL AVE		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	CDOSSING HEAL	TH & DEHABILITATION CENTED					
VVILLOVV	CRUSSING REAL	TH & REHABILITATION CENTER		COLUM	IBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	outside of the facilit	ty in the 300 Hall Activity			audit will be reviewed as part o	of	
	Room was not mark	red as a facility exit with an exit			the monthly quality assurance		
	sign. The exit door	was also not equipped with			meeting with a plan of action		
	signage affixed to the	ne door stating it was "Not an					
	Exit". The exit discharge for the 300 Hall Activity Room was a gated courtyard with one				warranted.		
					5 The above corrective act	ion	
	magnetically secure	d gate which required a code			will be completed by 03/18/202	<u>2</u> 5.	
	at a keypad to releas	se the gate to open. The code					
	was not posted beca	use the 300 Hall is a					
	dedicated wing for i	residents with the clinical					
	-	secure wing. Based on					
		e of the observations, the					
	_	visor and the Corporate					
	-	visor stated they were not					
		s an exit door or not an exit					
	_	door was not currently					
		exit with an exit sign and was					
	also not currently m	arked as not an exit.					
	TTI (* 1'	: 1 :1 d B:					
	_	e reviewed with the Director of					
	-	enance Supervisor and the					
	-	ince Supervisor during the exit					
	conference.						
	3.1-19(b)						
K 0921	NEDA 101						
SS=F	NFPA 101 Electrical Equipme	ent - Testing and					
Bldg. 02		ent - Testing and					
Diug. 02	Maintenanc	riew, observation and	17.00	221	1 No regidente eteff er		02/21/2025
		ty failed to conduct the	K 09	921	 No residents, staff, or visitors were affected. On 		03/21/2025
		ce and maintain complete			03/21/2025 inspections for all		
	-	spections for all Patient Care			PCREE was completed.		
		quipment (PCREE). NFPA 99,			(Attachment L)		
		es Code, 2012 edition, sections			2 All residents, staff, or		
		the physical integrity,			visitors have the potential to be	ے	
		current, and touch current			affected; thus the following	,	
	_	ortable PCREE is performed as			corrective actions have been		
	-	sting intervals are established			taken:		
	-	otocols. All PCREE used in			3 The maintenance director	ır	
	man poneres and pr	otocolo, Tili i Civili useu III	I		The maintenance unecto	'	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155535		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2025	
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE		
IAG	patient care rooms in 10.3.5.4 or 10.3.6 be after any repair or no consisting of several demonstrates complete system. So and procedures provinclude information are considered in the for electrical equipment instructionare readily available condensed operating appliance are legible equipment tests, reparameters and us receive continuous practice affects all representation of the process of the	s tested in accordance with efore being put into service and modification. Any system il electrical appliances liance with NFPA 99 as a service manuals, instructions, vided by the manufacturer as required by 10.5.3.1.1 and e development of a program ment maintenance. Electrical cons and maintenance manuals e, and safety labels and g instructions on the e. A record of electrical coairs, and modifications is riod of time to demonstrate redance with the facility's esponsible for the testing, e of electrical appliances training. This deficient residents in the facility. "SAFE-TEST 50 Electrical d-Test NFPA 99"	IAG	has been educated to ensure all PCREE is tested prior to be put into use and after any reprodification. (Attachment B) 4 As a means of Quality Assurance, the maintenance director or designee will audit PCREE in 10 resident rooms monthly ensuring that it has be inspected. (Attachment H) The results of the audits will be reviewed as part of the month quality assurance meeting with the plan of action adjusted accordingly, as warranted. 5 The above corrective act will be completed by 03/21/25	that eing air or the een le ly h	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155535	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 03/10/2025	
	ROVIDER OR SUPPLIER	TH & REHABILITATION CENTER		3550 CE	ADDRESS, CITY, STATE, ZIP COD ENTRAL AVE IBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	HOULD BE COMPLET	
K 0930 SS=A Bldg. 02	a tour of the facility 03/10/25, a nebulize sleeping Room 202 were stored in the oroom. These findings were Nursing, the Mainter Corporate Maintena conference. 3.1-19(b) NFPA 101 Gas Equipment - I Based on observation failed to protect 2 or use of liquid oxygen bed location or patient Care Faciliti 11.7.4 states the man oxygen permitted in bed location or patient (31.6 gallons), provolocation or patient care from the interpretation of the partiers and horizon minimum fire resist accordance with the Section 7.2.4.3.10 min horizontal exits a sautomatic-closing. affect 2 residents, stated in the same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers and horizontal exits a sautomatic-closing. The same of the partiers are partiers and horizontal exits a sautomatic-closing. The same of the partiers are partiers and horizontal exits a sautomatic-closing. The partiers are partiers and horizontal exits a sautomatic-closing. The partiers are partiers and horizontal exits a sautomatic-closing. The partiers are partiers and horizontal exits a sautomatic-closing. The partiers are partiers and horizontal exits a sautomatic-closing.	Maintenance Supervisor during from 12:30 p.m. to 2:00 p.m. on er was noted in resident and oxygen concentrators xygen storage and transfilling ereviewed with the Director of enance Supervisor and the ance Supervisor during the exit Liguid Oxygen Equipment on and interview, the facility from 16 resident rooms from the containers stored in a patient ent care room. NFPA 99, es Code, 2012 Edition, Section eximum total quantity of liquid a storage and in use in a patient ent care room shall be 120 L ided that the patient bed eare room, or both, are remainder of the facility by fire ental assemblies having a sance rating of 1 hour in a adopted building code. LSC equires all fire door assemblies hall be self-closing or This deficient practice could eaff and visitors.	K 0º	930	No plan of correction is require	ed.	03/18/2025

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

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
155535		B. WING			03/10/2025		
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3550 CENTRAL AVE COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL						

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