PRINTED: 02/10/2025

DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155363	B. W	NG		01/07	/2025
		<u> </u>	•	STREET	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	PROVIDER OR SUPPLIE	R			WILLOW RD		
WILLOW	DALE VILLAGE			DALE, IN 47523			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ORRECTION (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOU		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	D BE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION					DATE
E 0000							
Bldg							
	An Emergency Preparedness Survey was			E 0000 /p> This provider respectfu			
		ndiana Department of Health in			requests that this 2567 Plan o	f	
	accordance with 42	ccordance with 42 CFR 483.73.			Correction be considered the		
		- /0 -			Letter of Credible Allegation o		
	Survey Date: 01/0	7/25			Compliance and requests a de	esk	
	F '11', N 1 /	200254			review in lieu of a post survey		
	Facility Number: (Provider Number:				review on or after 1/31/25.		
		M Number: 100266270					
	Anvi Number. 100	7200270					
	At this Emergency	Preparedness survey,					
		e was found not in compliance					
	_	reparedness Requirements for					
		icaid Participating Providers					
	and Suppliers, 42 C						
	The facility has 50	certified beds, with a current					
	census of 23.						
	Quality Review con	mpleted on 01/10/25					
	_	42 CFR, Subpart 483.73 is NOT					
	MET as evidenced	by:					
E 0041	400 45(a) 400 70	0(a) 495 542(a) 495 62					
SS=F	, ,	8(e), 485.542(e), 485.62					
Bldg	HOSPILAI CAH AHC	d LTC Emergency Power					
ычу. 	Based on record re	view and interview, the facility	E 0	241	It is the intent of the facility to		01/31/2025
		t the emergency power system		J 4 1	It is the intent of the facility to conduct and document emergency 01/3		01/31/2023
	•	and maintenance requirements			power supply visual and audic	-	
		Care Facilities Code, NFPA			signals according to NFPA an		
		ry Code in accordance with 42			Life Safety Code.	~	
	CFR 483.73(e)(2).	-			What corrective action(s) wil	ı	
	· - ()(-)·				be accomplished for those		

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

Based on observation and interview, the facility

generator was provided with an operating alarm

failed to ensure 1 of 1 temporary emergency

TITLE (X6) DATE

residents found to have been

affected by the deficient

practice?

Kristy Denton **HFA** 01/31/2025

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.

Event ID: OIJE21 Facility ID: 000254

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			
		155363	B. W	VING		01/07/2025
NAME OF T	DROWNED OF CURPUSE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIER	C		404 W V	WILLOW RD	
WILLOW	DALE VILLAGE			DALE, IN 47523		
(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 APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		eation readily observed by			·Education provided to	
	operating personnel at a regular work station such				maintenance director related	
		. NFPA 99, 2012 Edition,			emergency power supply visu	ıal
		les Code, at 6.4.1.1.17 requires a			and audio signals.	
		that is storage battery			·Temporary generator was	
		rovided to operate outside of			removed and primary generat	
		n in a location readily observed			functioning with proper audio	
		anel at a regular work station.			visual signaling to annunciato	Г
		all be hard-wired to indicate			panel.	
	power source as fol	the emergency or auxiliary			How will you identify other	
	(1) Individual visual signals shall indicate:				How will you identify other residents having the potenti	
	a. When the emergency or auxiliary power source					ai
	is operating to supply power to load.				to be affected by the same deficient practice and what	
		y charger is malfunctioning.			corrective action will be take	n2
		al signals plus a common			·All residents in the facility h	
		arn of an engine-generator			the potential to be affected by	I
	alarm condition sha				alleged deficient practice.	uie
	a. Low lubricating				·Maintenance supervisor to	
	b. Low water temp				ensure that generator audio a	nd
	c. Excessive water				visual signaling is properly rel	
		he main fuel storage tank			to annunciator.	ayou
		4-hour operating supply.				
	e. Overcrank (faile				What measures will be put	
	f. Overspeed.	,			into place or what systemic	
	•				changes you will make to	
	6.4.1.1.17.1 A remo	ote, common audible alarm shall			ensure that the deficient	
		ified in 6.4.1.1.17.4 that is			practice does not recur?	
		rage battery and located			· Maintenance Director will	
	outside of the EPS	service room at a work site			educated on generator audio	and
	observable by perso	onnel.			visual signaling testing and	
					maintenance.	
	6.4.1.1.17.4 Individ	lual alarm indication to			·Monthly generator testing to	0
	annunciate any of the	he conditions listed in Table			include inspection of proper	
	6.4.1.1.16.2 shall ha	ave the following			signaling to annunciator pane	l.
	characteristics:					
	(1) It shall be batter				How the corrective action(s)	
	(2) It shall be visual	-			will be monitored to ensure	the
		litional contacts or circuits for			deficient practice will not	
	a common audible alarm that signals locally and				recur, i.e., what quality	

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

PRINTED: 02/10/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155363			ILDING	INSTRUCTION	COMPL 01/07/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD WILLOW RD		
WILLOW	DALE VILLAGE				N 47523		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		of the itemized conditions		1710	assurance program will be po	ut	DITTE
	occurs				into place?		
		imp test switch(es) to test the			·Executive Director/ designe		
	operation of all alar	m tamps.			will review pm audit results related to generator and annunciator	ated	
	This deficient pract	ice could affect all residents,			function and monitor complian	ce	
	as well as visitors as	nd staff in the facility.			and report to QAPI.		
	T' 1' ' 1 1				·If 100% threshold is not		
	Findings include:				achieved, an action plan will be developed to ensure complian		
	Based on interview	during record review on			developed to endure compilari	· · ·	
	01/07/25 between 10:00 a.m. and 2:00 p.m. with the						
	Maintenance Director and Regional Support						
	present, the Maintenance Director said the facility has been using a temporary generator for the past						
	_	nechanical/electrical issues					
	with the natural gas						
		or also said the temporary					
		generator. Based on					
		en 2:00 p.m. and 4:00 p.m.					
		facility with the Maintenance nal Support there was no					
		panel for the temporary					
		mporary generator was not					
		rrent annunciator panel					
		Nurse's Station. This was					
	_	faintenance Director at the time					
		further said he has been in nerator vendor and is hoping					
	_	fixed as soon as possible.					
	This finding was re-	viewed with the Administrator,					
	Maintenance Superduring the exit conf	visor, and Regional Support Perence.					
K 0000							
Bldg. 01							
		Recertification and State ras conducted by the Indiana	K 00	000	/p> This provider respectfully requests that this 2567 Plan of	f	

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

Event ID:

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

PRINTED: 02/10/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155363			ILDING	01	COMPL 01/07/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD WILLOW RD		
WILLOW	DALE VILLAGE				N 47523		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	483.90(a). Survey Date: 01/07				Correction be considered the Letter of Credible Allegation of Compliance and requests a de review in lieu of a post survey review on or after 1/31/25.		
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	155363					
	Village was found in Requirements for Pa Medicare/Medicaid, Life Safety from Fin National Fire Protect Life Safety Code (L	Code survey, Willowdale not in compliance with articipation in 42 CFR Subpart 483.90(a), we and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Type V (000) constructions sprinklered. The fact with hard wired smooth and spaces open to the operated smoke detections.	ty was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors the corridors, plus battery ectors in all resident sleeping has a capacity of 50 and had a time of this survey.					
	access were sprinkle facility services wer detached wood fram	residents have customary ered and all areas providing re sprinklered except one ned garage and one detached both used for facility storage.					
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lightir						
Diag. 01	Based on record rev interview; the facilit	iew, observation, and by failed to ensure	K 02	291	It is the intent of the facility to provide emergency lighting		01/31/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155363	B. WING		01/07/2025	
					, 	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF T	NO VIDER OR SOLVER		404 W	WILLOW RD		
WILLOW	DALE VILLAGE		DALE,	IN 47523		
(V4) ID	CUMMADV	STATEMENT OF DEFICIENCIE	ID	I	(V5)	
(X4) ID				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE	
		provided for the testing of 3		documentation according to Li	ife	
	• •	d emergency light units that		Safety Code.		
		y for 30 seconds during 11 of		What corrective action(s) wil	I	
	-	to ensure the light would		be accomplished for those		
		ring periods of power outages.		residents found to have beer	1	
	_	res emergency lighting shall be		affected by the deficient		
	provided in accorda	nce with Section 7.9. Section		practice?		
	7.9.3.1.1 (1) require	es functional testing shall be		·Education provided to the		
	conducted monthly,	with a minimum of 3 weeks		maintenance director related to	О	
	and a maximum of	5 weeks between tests, for not		emergency lighting testing and	d b	
	less than 30 seconds	s, (3) Functional testing shall		documentation.		
	be conducted annually for a minimum of 1 1/2			·Testing documentation upd	ated	
hours if the emergency lighting system is battery			to include documentation of th			
powered and (5) Written records of visual			additional unit located in the			
inspections and tests shall be kept by the owner			kitchen on emergency lighting			
	for inspection by the			monthly testing. Testing		
		eficient practice could affect all		conducted and passed on all		
	-	staff and visitors in the		I -		
	facility.	starr and visitors in the		emergency lighting.		
	lacility.			Harrist was identify athen		
	Fig. 41			How will you identify other		
	Findings include:			residents having the potentia	ai	
	D 1 1	. 01/07/251 . 10.00		to be affected by the same		
		view on 01/07/25 between 10:00		deficient practice and what		
	-	with the Maintenance Director		corrective action will be take		
		ort present, the facility did		·All residents in the facility h		
	•	maintenance report that 2 of 3		the potential to be affected by	the	
		ergency light units were		alleged deficient practice.		
	-	90 minutes on 04/10/24,		·Light in kitchen removed as		
		no documentation to show a		longer needed due to full capa	acity	
	<u> </u>	test was performed on the 3		emergency generator.		
		ergency light units for 11 of		·Maintenance supervisor to		
	the past 12 months.	Based on observations		ensure that monthly testing an	nd	
	between 2:00 p.m. a	and 4:00 p.m., the 2 battery		documentation occurs on each	n	
	powered emergency	light units tested were		emergency lighting unit in		
		ator and transfer switch.		accordance with Life Safety		
		ttery powered emergency light		codes.		
		itchen that had not been				
		nnually. Based on an		What measures will be put		
	•	e of record review, the		into place or what systemic		
		or confirmed there were no		changes you will make to		
	iviamichance Difect	or commined mere were no		Changes you will make to		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155363	B. WING 01/07/2025				2025
			<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2					
\^/!! ! \\					WILLOW RD		
VVILLOVV	DALE VILLAGE			DALE, I	N 47523		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	monthly 30 second	tests performed during 11 of			ensure that the deficient		
	the past 12 months,	and no 90 minute test			practice does not recur?		
	performed during th	ne past 12 month period for the			·Maintenance Director educa	ated	
	-	ergency light unit in the			on emergency lighting testing		
kitchen.				documentation requirements.			
					·Monthly emergency lighting		
	This finding was re	viewed with the Administrator,			testing occurred and was prop		
Maintenance Director, and Regional Support during the exit conference.				documented.	,		
				accamented.			
	uming the thin toni				How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure t	he	
	3.1 17(0)				deficient practice will not		
					recur, i.e., what quality		
				assurance program will be p			
					into place?	ut	
					·Executive Director/ designe	_	
					· · · · · · · · · · · · · · · · · · ·		
					will review pm audit results rel	ateu	
					to emergency lighting testing		
					monthly.		
					·If 100% threshold is not		
					achieved, an action plan will b		
					developed to ensure complian	ce.	
K 0353	NFPA 101						
SS=F		Maintenance and Testina					
Bldg. 01	Sprinkler System -	- Maintenance and Testing					
ыug. U I	Dogod on mooned nor	view and interview, the facility	17.00	2.52	K 252 Consideration Constant		01/21/2025
			K 03	333	K 353 Sprinkler System-		01/31/2025
		backflow prevention device in			Maintenance Testing		
		n piping was properly			It is the intent of the facility to		
		dance with NFPA 25. NFPA			perform sprinkler maintenance		
	·	Inspection, Testing, and			testing according to Life Safet	y	
		ter-Based Fire Protection			Code.	_	
		ion, Section 13.6.2.1 states all			What corrective action(s) wil	1	
	•	s installed in fire protection			be accomplished for those		
		be tested annually by			residents found to have beer	1	
	_	rd flow test of the system at			affected by the deficient		
		ate, including hose stream			practice?		
		rants or inside hose stations			·Education provided to		
		eam of the backflow preventer.			maintenance director related t		
	This deficient practi	ice could affect all residents,			sprinkler system maintenance	and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155363	B. W	ING	_	01/07/	2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 404 W WILLOW RD DALE, IN 47523				
(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 CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	staff, and visitors in Findings include: Based on record revalues a.m. and 2:00 p.m. and Regional Support documentation of an inspection/test reposprinkler inspection. In the comments set stated "Test cock #2 leaking very bad duacknowledged by the time of record reviet test cocks have not this finding was revenue."	riew on 01/07/25 between 10:00 with the Maintenance Director ort present, there was a annual backflow prevention rt dated 10/28/24 from the vendor available for review. Cotion of the report it was 2 and #3 need replaced and are ring testing device." This was the Maintenance Director at the w who further said the the two yet been replaced.			testing. Sprinkler testing occurred of 1-14-25 with no deficits or lead noted. Test cock 2 and 3 were replaced by IEI on 1-14-25. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents in the facility he potential to be affected by alleged deficient practice. Maintenance supervisor to ensure that sprinkler testing occurs addressing any concer areas in accordance with Life Safety codes. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance Director eduction sprinkler testing and maintenance requirements. Preventative maintenance I send reminder and maintenance director to document proper sprinkler maintenance and test quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pointed.	n? ated og to ce sting	
			1		into place?		

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OT ATEL CO	IT OF DEDICIEN CIES	V1) PROVIDED (CLIPPI IED (CLI	(V2) MILERINE C	ONICTRICTION	(V2) DATE CURVEY	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		155363	B. WING		01/07/2025	
	PROVIDER OR SUPPLIER	t	404 W	ADDRESS, CITY, STATE, ZIP COD WILLOW RD		
WILLOW	DALE VILLAGE		DALE,	IN 47523		
(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	
V 0046	NEDA 404			·Executive Director/ designed will review sprinkler testing and maintenance documents and to ensure compliance. ·If 100% threshold is not achieved, an action plan will be developed to ensure compliance.	d logs e	
K 0916 SS=F	NFPA 101	- Facantial Flactuic Cyata				
	Electrical Systems	s - Essential Electric Syste				
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 temporary emergency generator was provided with an operating alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common		K 0916	It is the intent of the facility to conduct and document emerg power supply visual and audic signals according to NFPA an Life Safety Code. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Education provided to maintenance director related to emergency power supply visuand audio signals. ·Temporary generator was removed and primary generate functioning with proper audio a visual signaling to annunciator panel.	d I o o al or is and	
	alarm condition sha			How will you identify other		
	a. Low lubricating			residents having the potential	al	
	b. Low water temp			to be affected by the same		
	c. Excessive water	-		deficient practice and what		
		he main fuel storage tank		corrective action will be take		
		4-hour operating supply.		·All residents in the facility h		
	e. Overcrank (faile	d to start).		the potential to be affected by	the	
	f. Overspeed.			alleged deficient practice.		

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Event ID:

OIJE21

Facility ID: 000254

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·Maintenance supervisor to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			
		155363	B. WI	NG		01/07/2025	
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			WILLOW RD		
WILLOW	DALE VILLAGE				IN 47523		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ote, common audible alarm shall			ensure that generator audio a		
	be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located				visual signaling is properly rela	ayed	
		-			to annunciator.		
	observable by person	service room at a work site			NA/Ib a 4 man a second a secilla la consta		
	observable by perso	onnei.			What measures will be put		
	(L1 -1 ididi			into place or what systemic		
		lual alarm indication to he conditions listed in Table			changes you will make to		
	1				ensure that the deficient		
	6.4.1.1.16.2 shall have characteristics:	ave the following			practice does not recur?		
	(1) It shall be batter	m; m avviage d			·Maintenance Director will		
	1 1				educated on generator audio	and	
	(2) It shall be visually indicated.				visual signaling testing and maintenance.		
	(3) It shall have additional contacts or circuits for						
	a common audible alarm that signals locally and remotely when any of the itemized conditions				·Monthly generator testing to	3	
	occurs	of the itemized conditions			include inspection of proper	1	
		amp test switch(es) to test the			signaling to annunciator panel	i.	
	operation of all alar				How the competitive action(a)		
	operation of all alai	in lamps.			How the corrective action(s) will be monitored to ensure t		
	This deficient proct	ice could affect all residents,			deficient practice will not	.ne	
	_	nd staff in the facility.			recur, i.e., what quality		
	as well as visitors a	nd starr in the facility.			assurance program will be p	+	
	Findings include:				into place?	ut	
	i manigs metade.				·Executive Director/ designe	20	
	Based on interview	during record review on			will review pm audit results rel	l l	
		0:00 a.m. and 2:00 p.m. with the			to generator and annunciator	atou	
		tor and Regional Support			function and monitor complian	nce	
		nance Director said the facility			and report to QAPI.		
	1 *	mporary generator for the past			If 100% threshold is not		
	_	nechanical/electrical issues			achieved, an action plan will b	ne.	
		LP generator. The			developed to ensure complian		
		tor also said the temporary					
		l generator. Based on					
	_	en 2:00 p.m. and 4:00 p.m.					
		facility with the Maintenance					
		nal Support there was no					
	_	panel for the temporary					
		emporary generator was not					
	_	rrent annunciator panel					
		Nurse's Station. This was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155363		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 01/07/2025			
	PROVIDER OR SUPPLIEI	?	404 W	ADDRESS, CITY, STATE, ZIP COD WILLOW RD IN 47523	
(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)	(X5) COMPLETION DATE
K 0921	of observation who contact with the ger to get the generator. This finding was re Maintenance Super during the exit confidence of the second				
SS=F Bldg. 01	interview; the facili required maintenant documentation of in Related Electrical I 2012 edition, section physical integrity, in touch current tests is performed as require established with PCREE used in patter accordance with 10 into service and after Any system consist appliances demonstructions, and promanufacturer including a condensed operappliance are legible and condensed operappliance are legible.	view, observation, and ity failed to conduct the ce and maintain complete inspections for Patient Care Equipment (PCREE). NFPA 99 ons 10.3 and 10.5 states the resistance, leakage current, and for fixed and portable PCREE uired in 10.3. Testing intervals in policies and protocols. All itent care rooms is tested in 10.3.5.4 or 10.3.6 before being put ter any repair or modification. Sing of several electrical trates compliance with NFPA restem. Service manuals, occdures provided by the de information as required by considered in the development electrical equipment maintenance. In instructions and maintenance of available, and safety labels rating instructions on the lee. A record of electrical pairs, and modifications is	K 0921	K 921- Electrical Equipment Testing and Maintenance It is the intent of the facility to perform electrical function test on PCREE in accordance with Safety standards. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Education provided to maintenance director related to PCREE testing. ·PCREE testing to occur on February 18th by Medical Dev inspection company. How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take ·All residents in the facility ha the potential to be affected by	Life I o rice n? ave

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maintained for a period of time to demonstrate

Event ID:

OIJE21

Facility ID: 000254

alleged deficient practice.

If continuation sheet

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

PRINTED: 02/10/2025 FORM APPROVED OMB NO. 0938-039

CENTERSTON	MEDICINE & MEDIC	THE SERVICES				O	B 110. 0700 007
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		155363	B. WI	NG		01/07/	/2025
							-
NAME OF P	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP COD			
			404 W WILLOW RD				
WILLOW	DALE VILLAGE			DALE, I	N 47523		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	compliance in acco	rdance with the facility's			·Maintenance supervisor to		
	policy. Personnel r	responsible for the testing,			ensure that electrical testing		
		se of electrical appliances			occurs on all PCREE in reside	ent	
		training. This deficient			rooms in accordance with Life		
	practice could affect	_			Safety codes.		
	F				24.01, 00400.		
	Findings include:				What measures will be put		
					into place or what systemic		
	Based on record review on 01/07/25 between 10:00				changes you will make to		
		with the Maintenance Director			ensure that the deficient		
	•	ort present, there was no			practice does not recur?		
		the testing of PCREE, such as			·Maintenance Director educ	hate	
		izers, oxygen concentrators, air			on PCREE testing requiremen		
		resses, vital sign monitors, and			PCREE testing and verifica		
		dical equipment. Based on			_	ilion	
		ne of record review, the			to be added to preventative		
					maintenance log ensure ongo	ing	
		tor and Regional Support said			compliance.		
	_	aware PCREE items had to be nted. Based on observation			Ham the same street and		
					How the corrective action(s)		
	_	to 4:00 p.m. during a tour of the			will be monitored to ensure	ine	
	-	nintenance Director and			deficient practice will not		
		it was revealed the facility			recur, i.e., what quality		
	-	uch as electric beds, oxygen			assurance program will be p	ut	
	_	umps for air mattresses, and			into place?		
		dical equipment was present in			·Executive Director/ designe		
	the facility.				will review PCREE testing and	t	
					maintenance logs.		
	This finding was re	viewed with the Administrator,			·If 100% threshold is not		
	Maintenance Direct	tor, and Regional Support			achieved, an action plan will b	e	
	during the exit conf	ference.			developed to ensure compliar	ice.	
					·		
	3.1-19(b)						

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