PRINTED: 01/22/2024

	T OF HEALTH AND H R MEDICARE & MEDI					IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155363		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/08/2024	
NAME OF PROVIDER OR SUPPLIER WILLOWDALE VILLAGE		404 W	ADDRESS, CITY, STATE, ZIP COD WILLOW RD IN 47523			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000 Bldg	conducted by the accordance with 4 Survey Date: 01/6 Facility Number: Provider Number: AIM Number: 10 At this Emergency Willowdale Villag with Emergency F Medicare and Meand Suppliers, 42 The facility has 50 census of 29. Quality Review control The requirement at MET as evidenced 482.15(e), 483.7 Hospital CAH and \$482.15(e) Concontrol Control Contr	000254 155363 0266270 y Preparedness survey, ge was found not in compliance Preparedness Requirements for dicaid Participating Providers CFR 483.73 O certified beds, with a current completed on 01/09/24 at 42 CFR, Subpart 483.73 is NOT d by:	E 0000	/p> This provider respectfully req that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Compliand requests a desk review in of a post survey review on or 1/22/24.	iance n lieu	

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

(e) Emergency and standby power systems.

§483.73(e), §485.625(e)

TITLE (X6) DATE

Kristy Denton **HFA** 01/19/2024

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

PRINTED: 01/22/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155363	A. BUILDING B. WING	onstruction 	COM	IPLETED 08/2024
	PROVIDER OR SUPPLIER		404 W	address, city, state, zip WILLOW RD IN 47523	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requirement and TlA 12-5, and Code (NFPA 101 and TlA 12-4), and structure is built of structure or building 482.15(e)(2), §483 Emergency generator the [hospital, CAI-implement the eminspection, testing requirements foun Facilities Code, NIC Code. 482.15(e)(3), §483 Emergency generator the eminspection, testing requirements foun Facilities Code, NIC Code. 482.15(e)(3), §483 Emergency generator and LTC facilities] source to power enamergency, unless *[For hospitals at §5]	nd the CAH] must ency and standby power the emergency plan set (a) of this section. 33.73(e)(1), §485.625(e)(1) ator location. The clocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] d in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency erational during the	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	The standards inc this section are ap	orporated by reference in proved for incorporation by Director of the Office of the				

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Event ID:

PF9921

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				LETED
155363			B. WING 01/08/2024				
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	t		404 W V	WILLOW RD		
WILLOW	DALE VILLAGE			DALE, I	N 47523		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		n accordance with 5 U.S.C.					
		t part 51. You may obtain the sources listed below.					
		a copy at the CMS					
		a copy at the CiviS urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:	11 0 1, Gail 202 7 11 0000, Gi					
	•	es.gov/federal_register/code					
		ations/ibr locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Par	k,					
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
	(i) NFPA 99, Heal	th Care Facilities Code,					
	2012 edition, issue	ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued a	•					
	, ,	FPA 99, issued August 9,					
	2012.						
	, ,	FPA 99, issued March 7,					
	2013.						
	` '	PA 99, issued August 1,					
	2013.	TDA 00 income d 14 1. 0					
	` '	FPA 99, issued March 3,					
	2014.	fo Sofoty Code 2012					
	. ,	fe Safety Code, 2012					
	edition, issued Au	gust 11, 2011. IFPA 101, issued August					
	(VIII) TIA 12-1 to N 11, 2011.	IFFA 101, ISSUEU AUGUSI					
		FPA 101, issued October					
	30, 2012.	I A 101, ISSUEU OCIODEI					
		PA 101, issued October					
	22, 2013.						

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	WIEDICAKE & MEDIC				ONIB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE Co	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
155363		B. WING		01/08/2024	
	PROVIDER OR SUPPLIER		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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	(xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Stincluding TIAs to 2009. Based on record reversal failed to implement inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2). Based on record reversal failed to provide contesting of 1 of 1 Em System in accordant for Emergency and Section 8.4.9, as record failed to provide contesting of 1 of 1 Em System in accordant for Emergency and Section 8.4.9 states Power Systems shadevery three years. Sugreater than 4 hours terminate the test afformation of the system point of the s	tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system and maintenance requirements. Care Facilities Code, NFPA y Code in accordance with 42 view and interview, the facility mplete documentation for the tergency Power Standby ce with NFPA 110, Standard Standby Power Systems, quired by NFPA 99 Health Care extion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency II be tested at least once within Where the assigned class is so, it shall be permitted to the 4 hours. NFPA 99 Section at Type 1 and Type 2 essential ower sources shall be classified at Type 1 and Type 2 essential ower sources shall be classified at Level 1 generator sets. This bould affect all building view on 01/08/24 between 9:30 with the Maintenance gional Support person present, ble to provide documentation test of the emergency d within the past 36 month excent four hour load test	E 0041	It is the intent of the facility to conduct and document emerge power supply load tests accord to NFPA and Life Safety Code What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice? Education provided to maintenance director related emergency power supply load tests. 4- Hour emergency power supply load tests. 4- Hour emergency power supply load tests was successfund according to policy moving for at least every 36 months. How will you identify other residents having the potentiation be affected by the same deficient practice and what corrective action will be taken. All residents in the facility if the potential to be affected by alleged deficient practice. Maintenance supervisor to ensure that 4- hour emergence power supply load tests are conducted according to policy least every 36 months.	gency riding e. II n to did fully cted rward al en? nave of the

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	OF CORRECTION	IDENTIFICATION NUMBER 155363	A. BUILDING B. WING		COMPLETED 01/08/2024
	PROVIDER OR SUPPLIER		404 W	ADDRESS, CITY, STATE, ZIP COD WILLOW RD IN 47523	
(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	
K 0000	confirmed by the M Regional Support poreview. This finding was rev	was dated 12/21/20. This was aintenance Supervisor and erson at the time of record viewed with the Administrator, visor, and Regional Support cit conference.		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 will educated on 4- hour emerge power supply load tests on 1/17/24. ·Four- hour emergency por supply load tests audit to be added to pm tasks and will b monitored by Executive Direct designee to ensure continued compliance. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? ·Executive Director/ design will review pm audit results reto 4- hour emergency power supply load tests to ensure a monitor compliance and report QAPI. ·If 90% threshold is not achieved, an action plan will developed to ensure compliance.	ncy ver e ctor/ d) the put ee elated nd ort to
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	/p> This provider respectfully rec that this 2567 Plan of Correc be considered the Letter of	

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Event ID:

PF9921

Facility ID: 000254

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155363		ì í	JILDING	nstruction 01	(X3) DATE : COMPL 01/08/	ETED	
NAME OF PROVIDER OR SUPPLIER WILLOWDALE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 404 W WILLOW RD DALE, IN 47523				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	Survey Date: 01/08/24				Credible Allegation of Complia and requests a desk review in of a post survey review on or a 1/22/24.		
	Facility Number: 000254 Provider Number: 155363 AIM Number: 100266270				1/22/24.		
	Village was found r Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L	Code survey, Willowdale not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Type V (000) constructions sprinklered. The factorial with hard wired smooth and spaces open to the operated smoke determined to the specific speci	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 0040	Quality Review con	npleted on 01/09/24					
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the					

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Event ID:

PF9921

Facility ID: 000254

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
155363		155363	B. WING 01/08			01/08/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WILLOW RD		
\\/\ \ \ \\\\\	DALE VILLAGE						
VVILLOVV	DALE VILLAGE			DALE, I	IN 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	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	10-second criterio	on is not met during the					
	monthly test, a pro	ocess shall be provided to					
	annually confirm t	his capability for the life					
	safety and critical	branches. Maintenance					
	and testing of the	generator and transfer					
	switches are perfo	ormed in accordance with					
	NFPA 110.						
	Generator sets ar	e inspected weekly,					
	exercised under lo	oad 30 minutes 12 times a					
	year in 20-40 day	intervals, and exercised					
	once every 36 mo	onths for 4 continuous hours.					
	Scheduled test un	nder load conditions include					
	a complete simula	ated cold start and					
	automatic or man	ual transfer of all EES					
	loads, and are co	nducted by competent					
	-	nance and testing of stored					
	energy power sou	irces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
	· ·	tablished according to					
		uirements. Written records					
		nd testing are maintained					
	_	ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the					
		source is a design					
	consideration for i						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10 (NFPA 70)						
		view and interview, the facility	K 0	918	It is the intent of the facility to		01/19/2024
	failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby				conduct and document emerge	-	
					power supply load tests accord	•	
	_	ice with NFPA 110, Standard			to NFPA and Life Safety Code		
		Standby Power Systems,			What corrective action(s) will	l	
		quired by NFPA 99 Health Care			be accomplished for those		
	· · · · · · · · · · · · · · · · · · ·	etion 6.4.1.1.6.1. NFPA 110			residents found to have beer	1	
		that all Level 1 Emergency			affected by the deficient		
Power Systems shall be tested at least once within					practice?		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>01</u>		COMPLETED		
155363		B. WING 01/08/2024			2024		
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8					
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\					WILLOW RD		
WILLOW	DALE VILLAGE			DALE, I	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
	every three years. V	Where the assigned class is			·Education provided to		
	greater than 4 hours	s, it shall be permitted to			maintenance director related t	to	
	terminate the test af	fter 4 hours. NFPA 99 Section			emergency power supply load	l	
	6.4.1.1.6.1 states th	at Type 1 and Type 2 essential			tests.		
		ower sources shall be classified			·4- Hour emergency power		
		, Level 1 generator sets. This			supply load test was successf	ullv	
		ould affect all building			conducted on 1/17/24.	,	
	occupants.	5			·4- Hour emergency power		
	1				supply load tests to be conduc	cted	
	Findings include:				according to policy moving for		
					at least every 36 months.	wara	
	Based on record rev	view on 01/08/24 between 9:30			at loadt overy of mentile.		
		with the Maintenance			How will you identify other		
	-	gional Support person present,			residents having the potential	al	
		ble to provide documentation			to be affected by the same	uı	
	-	test of the emergency			deficient practice and what		
		d within the past 36 month			corrective action will be take	n2	
	-	ecent four hour load test			·All residents in the facility h		
	-	was dated 12/21/20. This was			the potential to be affected by		
	_	Iaintenance Supervisor and			alleged deficient practice.	uic	
		erson at the time of record			·Maintenance supervisor to		
	review.	erson at the time of record			ensure that 4- hour emergence	V	
	10 / 10 // .				power supply load tests are	У	
	This finding was re	viewed with the Administrator,			conducted according to policy	at	
	_	visor, and Regional Support			least every 36 months.	at	
	person during the ex				least every so months.		
	1				What measures will be put		
	3.1-19(b)				into place or what systemic		
	2.1 17(0)				changes you will make to		
					ensure that the deficient		
					practice does not recur?		
					·Maintenance Director will		
					educated on 4- hour emergen	CV	
					power supply load tests on	∪y .	
					1/17/24.		
						or	
					Four- hour emergency pow	CI CI	
					supply load tests audit to be		
					added to pm tasks and will be		
					monitored by Executive Direct		
					designee to ensure continued		

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155363		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/08/2024			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 404 W WILLOW RD DALE, IN 47523				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE ((X5) COMPLETION DATE	
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place? Executive Director/ designe will review pm audit results relet to 4- hour emergency power supply load tests to ensure an monitor compliance and report QAPI. If 90% threshold is not achieved, an action plan will be developed to ensure compliant.	ut ee ated d t to		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PF9921 Facility ID: 000254 Page 9 of 9 If continuation sheet