		X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155519	B. W	ING		05/15/	/2025
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
GENTLE	CARE STRATEGII	ES			16TH ST NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	MATION TAG DEFICIENCY)			DATE	
□ 0000							
Bldg							
J	An Emergency Pre	paredness Survey was	E 00	000	By submitting the following		
	conducted by the Ir	ndiana Department of Health in			material, we are not admitting	ງ the	
	accordance with 42	CFR 483.73.			truth or accuracy of any spec	ific	
					findings or allegations. We		
	Survey Date: 05/15	/25			reserve the right to contest th		
	Facility Number: (000357			findings or allegations as part any proceedings and submit		
	Provider Number:				responses pursuant to our	uicse	
	AIM Number: 100				regulatory obligations. The fa	acility	
					requests the plan of correction	•	
		Preparedness Survey, Gentle			considered our allegation of		
		s found in compliance with			compliance effective 05/30/20		
		edness Requirements for			the state findings of the Life S	3afety	
		icaid Participating Providers			Code Recertification and		
	and Suppliers, 42 C	FR 483./3			Emergency Preparedness Survey. We are requesting p	apor	
	The facility has a c	apacity of 60 certified beds and			compliance.	apei	
	•	at the time of this visit.			compilaries.		
	Quality Review con	mpleted on 05/20/25					
K 0000							
Bldg. 01							
2.49.01	A Life Safety Code	Recertification and State	K 0	000	By submitting the following		
		vas conducted by the Indiana	100	000	material, we are not admitting	the	
	_	lth in accordance with 42 CFR			truth or accuracy of any spec	-	
	483.90(a).				findings or allegations. We		
					reserve the right to contest th		
	Survey Date: 05/15	7/25			findings or allegations as part		
	Facility Number: 0	000357			any proceedings and submit	these	
	Provider Number: 0				responses pursuant to our regulatory obligations. The fa	acility	
	AIM Number: 100				requests the plan of correction	-	
	- 1111111111111111111111111111111111111	=- == / V			considered our allegation of	50	
	At this Life Safety	Code survey, Gentle Care			compliance effective 05/30/20	025 to	
		d not in compliance with			the state findings of the Life S		
			I				1

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

(X6) DATE

TITLE

Susan Sluder Administrator 05/28/2025

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: PU9E21 Facility ID: 000357 If continuation sheet Page 1 of 12

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155519		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/15/2025	
	ROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP COD 16TH ST NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This one story facili	articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, and ancies and 410 IAC 16.2. Ity with a basement was Type V (000) construction and		Code Recertification and Emergency Preparedness Survey. We are requesting pacompliance.	aper
	was fully sprinklere system with hard w corridors, spaces op battery powered sm sleeping rooms, wh the fire alarm system	d. The facility has a fire alarm ired smoke detectors in the en to the corridors, plus oke detectors in all resident ich were also addressable to m via a wireless system. The ty of 60 and had a census of			
	were sprinklered an services were sprink wood sheds used fo	dents have customary access d all areas providing facility stered, except two detached r facility storage.			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirem				
	interview; the facili documentation for t of all battery operat rooms was complete existing life safety f if not required by th NFPA 72, National 2010 Edition, 29.10 fire-warning equipm tested in accordance.	riew, observation, and ty failed to ensure he preventative maintenance ed smoke alarms in resident e. NFPA 101 in 4.6.12.3 states reatures obvious to the public, the Code, shall be maintained. Fire Alarm and Signaling Code, Maintenance and Tests states ment shall be maintained and e with the manufacturer's ms and per the requirements	K 0100	It is the practice of this facility ensure documentation for the preventative maintenance of a battery operated smoke alarm resident rooms are complete. What corrective actions will be accomplished for those reside found to be affected by the deficient practice: a. All residents, staff member and visitors have the potential	ell es in es ents

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

Event ID:

PU9E21

Facility ID: 000357

If continuation sheet

Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			ETED	
		155519	B. WING 05/15/2025			2025	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			16TH ST		
GENTI E	CARE STRATEGI	FS			NNES, IN 47591		
OLIVIEL	-			VIIVOLI	141420, 114 47001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	•	PA 72, 14.2.1.1.1 Inspection,			be affected by the alleged def	icient	
	_	nance programs shall satisfy			practice.		
	_	this Code and conform to the			b. The Maintenance Director		
		cturer's published instructions.			and/or Designee has complete		
	_	tice could affect 20 residents,			the preventative maintenance		
	staff, and visitors.				inspection inculding		
					documentation. (Attachment	#1)	
	Findings include:				2. How other regidents having	r the	
	Bosed on record rev	view on 05/15/15 at 12:30 p.m.			2. How other residents having potential to be affected by the		
		f Nursing present, the monthly			same deficient practices will b		
		enance documentation for			identified and what corrective		
	_	ry powered smoke alarms were			action will be taken:		
		24-34 were not documented as			a. All residents, staff member		
	_	months of November and	and visitors have the potential to				
		ased on interview at 12:33 p.m.,	be affected by the alleged deficient				
		sing confirmed the provided			practice.	loiont	
		wed that the battery powered			practice.		
		esident room 24-34 had not			3. What measures will be put	in	
		onthly basis for the months of			place and what systemic char		
	November and Dec	-			will be made to ensure that	iges	
	1 10 10 110 110 110 110 110 110 110 110				deficient practice does not rec	ur.	
	This finding was re	viewed with the Director of			a. The Maintenance Director		
	Nursing at the exit				place the smoke alarms on a		
					preventative maintenance		
	3.1-19(b)				schedule for monthly inspection	on.	
					A copy of the monitoring tool v		
					be provided monthly for the		
					Administrator to review for		
					completeness.		
					· '		
					4. How the corrective actions	will	
					be monitored to esnure the		
					deficient practices will not occ	ur:	
					a. The Maintenance Director		
					place the smoke alarms on a		
					preventative maintenance		
					schedule for monthly inspection	on.	
					A copy of the monitoring tool		
					be provided monthly for the		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 05/15/2025			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
GENTLE	CARE STRATEGIE	ES		NNES, IN 47591	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		LSC IDENTIFYING INFORMATION	TAU	Administrator to review for completeness. b. This is an ongoing program should non-compliance be observed, corrective action should be taken, the observations and any corrective actions taken where the take	n, nall d vill
K 0291 SS=E Bldg. 01	failed to ensure all blights were maintain LSC 7.9.2.6 states blights shall use only batteries provided was maintaining them in Batteries used in suapproved for their in with NFPA 70 Nationstates the emergence either continuously capable of repeated manual intervention affect 20 residents, room. Findings include: Based on observation Nursing at 2:25 p.m. operated emergency to function when its pushed four times. I	on and interview, the facility pattery powered emergency and in accordance with LSC 7.9. Pattery operated emergency reliable types of rechargeable with suitable facilities for a properly charged condition. In the lights or units shall be antended use and shall comply conal Electric Code. LSC 7.9.2.7 by lighting system shall be in operation or shall be automatic operation without and the different practice could staff and visitors in the dining on with the Director of an on 05/15/25, the battery of light in the dining room failed respective test button was Based on interview at 2:27 from Nursing confirmed the battery	K 0291	It is the practice of this facility ensure all battery powered emergency lights are maintain and properly charged condition. 1. What corrective actions with accomplished for those reside found to be affected by the deficient practice: a. All residentsm, staff memebers, and visitors have potential to be affected by the alleged deficient practice. b. The identified battery-oper emergency light found not functioning during survey has replaced by vendor on 5/22/2. The light was tested and foun be in working order. (Attachr #4) 2. How other residents having potential to be affected by the same deficient practices will be identifed and what corrective	ned on. Il be ents the ated been 025. d to ment

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

Event ID:

PU9E21 Facility ID: 000357

If continuation sheet

Page 4 of 12

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

PRINTED: 06/04/2025 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. B	JILDING	01	COMPL	ETED
		155519	B. WING 05/15/2025			2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				16TH ST			
GENTLE CARE STRATEGIES				NNES, IN 47591			
	T		-		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
operated light failed to function when its				action will be taken:			
respective test button was pushed.				a. All residents, staff member			
	This finding was re	viewed with the Director of			and visitors ahve the potential		
	Nursing at the exit				be affected by the alleged def	Clefft	
	ivursing at the exit	conference.			practice. b. The battery-operated		
	3.1-19(b)				T -	stad	
	3.1-17(0)				emergency lights are to be test monthly and documented on	,ı. c u	
					preventative maintenance		
					worksheet. (Attachment #5)		
					Worksheet. (Attachment #5)		
					3. What measures will be put	in	
					place and what systemic char		
					will be made to ensure that	goo	
					deficient practice does not rec	ur.	
					a. The Maintenance Director		
					complete the monthly prevent		
					maintenance worksheet. A co		
					of this worksheet will be given		
					the Administrator for reviedw	.0	
					monthly.		
					4. How the corrective actions	will	
					be monitored to ensure the	ļ	
					deficient practices will not occ	ur:	
					a. The Maintenance Director		
					complete the monthly prevent		
					maintenance worksheet for th		
					battery-operated emergency	ļ	
					lights. A copy of the monitorir	ıg	
					tool will be provided monthly f	or	
					the Administrator to review for		
					completenesws.		
					b. This is an ongoing progran	١,	
					should non-compliance be	ļ	
					observed, corrective action sh		
					be taken, the observations an	d	
					any corrective actions taken w	/ill	
					be reviewed during Quality	ļ	
					Assurance Meeting and the pl	an	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE CO A. BUILDING B. WING	01	DATE SURVEY COMPLETED 05/15/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
				of action adjusted accordingly if warranted.			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm Systen Maintenance Based on record rev	-	K 0345	It is the practice of this facility to	05/30/2025		
Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in		K 0343	ensure the fire alarm system is tested and maintained visually inspected semi-annually.				
	accordance with the more often if requir jurisdiction. Table	e schedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following spected semi-annually:		 What corrective actions will be accomplished for those residents found to be affected by the deficient practice: All residents, staff members, 			
	a. Control unit troul b. Remote annuncia c. Initiating devices	ole signals		and visitors have the potential to be affected by the alleged deficier practice. b. The contracted vendor	nt		
	etc.) d. Notification appl e. Magnetic hold-op This deficient pract			completed inspections in the dates referenced during survey. The facility was able to retrieve from vendor the inspection report			
	in the facility. Findings include:			on 11/8/24. (Attachment #7) 2. How other residents having the potential to be affected by the	•		
	Based on record review on 05/15/25 at 11:40 a.m. with the Director of Nursing present, there was documentation provided regarding an annual fire alarm system inspections/tests dated 04/17/24 and			same deficient practices will be identified and what corrective action will be taken:			
	04/16/25 by the fac vendor, however, the information of a ser	ility's fire alarm inspection he facility could not provide ni-annual visual inspection of		 a. All residents, staff members, and visitors have the potential to be affected by the alleged deficier practice. 	nt		
	detectors, pull static	rm devices, such as smoke ons, and heat detectors within annual fire alarm system ased on interview at 11:43		What measures will be put in place and what systemic changes will be made to ensure that			

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

Event ID:

PU9E21 Facility ID: 000357

If continuation sheet

Page 6 of 12

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

			A. BUILDING 01		
AND PLAN	OF COKKECHON	IDENTIFICATION NUMBER 155519	A. BUILDING B. WING	<u>01</u>	COMPLETED 05/15/2025
		100018	D. WING		03/13/2023
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
				S 16TH ST	
GENTLE	CARE STRATEGII	<u>-</u> S	VINCE	NNES, IN 47591	
(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 APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	a.m., the Director o	f Nursing confirmed there was		deficient practice does not re	cur:
		al inspection of the facility's		a. The Maintenance Director	· will
		evices, such as smoke		add the semi-annually visual	
		ons, and heat detectors was		inspection report to the	
	available for review	at the time of the survey.		preventative maintenance	
				program. The inspection will	
		viewed with the Director of		completed and documented	on a
	Nursing during the	exit conference.		semi-annual basis. Upon	
	2.4.40.43			completion of this inspection,	а
	3.1-19(b)			copy will be provided to the	
				Administrator for review to er	nsure
				compliance.	
				4. How the corrective actions	النبد
				be monitored to ensure the	5 WIII
				deficient practices will not occ	cur.
				a. The Maintenance Director	
				add the semi-annually visual	WIII
				and/or inspection report to the	e
				preventative maintenance	
				program. The inspection will	be
				completed and documented of	
				semi-annual basis. Upon	
				completion of this inspection,	a
				copy will be provided to the	
				Adminsitrator for review to er	nsure
				compliance.	
				b. This is an ongoing prograi	m,
				should non-compliance be	
				observed, corrective action s	hall
				be taken, the observations ar	
				any corrective actions taken	will
				be reviewed during Quality	
				Assurance Meeting and the p	olan
				of action adjusted accordingly	y if
				warranted.	
					[

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

Event ID:

PU9E21

Facility ID: 000357

If continuation sheet

Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 05/15/2025	
	ROVIDER OR SUPPLIER CARE STRATEGIE		STREE 1202 VINC		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg, 01	NFPA 101 Sprinkler System -	Maintenance and Testing			
Bldg. 01	Based on record revisited to provide we evidence the dry pip three year air leak to device, equipment of compliance with this accordance with app Sprinkler systems of accordance with NF Inspection, Testing, Water-Based Fire P 4.3.1 requires recordinspections, tests, an components and shas authority having jur requires that records performed (e.g., instead the organization that results, and the date dry pipe systems shayears for air leakage affect all residents, and facility. Findings include: Based on review of records on 05/15/25 of Nursing present, had 'N/A' marked as last three year air lepipe 3 year air leak review at the time of documentation of a significant residence of the significant residenc	iew and interview, the facility itten documentation or other be sprinkler system had an est. LSC 4.6.12.1 requires any or system required for a Code be maintained in olicable NFPA requirements. In the properly maintained in the PA 25, Standard for the and Maintenance of the system and maintenance of the system and maintenance of the system of the indicate the procedure prection, test, or maintenance), the performed the work, the shall be tested once every 3 to the indicate the procedure prection, test, or maintenance), the performed the work, the shall be tested once every 3 to the inspection at 12:43 p.m. with the Director the inspection dated 03/26/25 to the answer for 'Date of the lak test.' The most recent dry test was not available for for the survey. There was three year trip test on the dry	K 0353	It is the practice of this facility ensure that the dry pipe sprint system had a three year leak 1. What corrective actions with accomplished for those reside found to be affected by the deficient practice: a. There were no residents affected by the alleged deficient practice. b. Contracted vendor complet the required air leak test on 5/23/2025. (Attachment #6) 2. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents, staff member and visitors have the potential be affected by the alleged deficient practice. 3. What measures will be put place and what systemic charm will be made to ensure that deficient practice does not recall. The Administrator and/or Designee will monitor for inspection due dates and conwith Maintenance Director that inspections have been schedicent.	kkler test. Il be ents ent ted g the es se, I to in nges cur: firm at
	12:46 p.m., the Dire	/23. During an interview at octor of Nursing confirmed there umentation available to show		How the corrective actions be monitored to ensure the	will

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

Event ID:

PU9E21 I

Facility ID: 000357

If continuation sheet

Page 8 of 12

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		A. BUILDING B. WING	01	COMPLETED 05/15/2025	
	ROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP COD 16TH ST NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	sprinkler system at t	eak test for the dry pipe the time of the survey. viewed with the Director of conference.		deficient practices will not occura. The Maintenance Director and/or Designee will monitor for upcoming inspections and notion the Administrator and/or Designee when inspections are scheduled. Vendor reports of completed wand maintenance records will be reviewed by Administrator and Designee to ensure deadlines have been met. The monitoring be an ongoing process and if non-compliance is observed, corrective action will be taken immediately. b. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.	or fy inee ed. vork be vor or ng wll
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills				
	failed to provide qua for 1 of 3 shifts duri deficient practice co as staff and visitors Findings include: Based on review of on 05/15/25 at 11:47 Nursing, there was r available for third sl August, and Septem fire drills provided v	iew and interview, the facility arterly fire drill documentation ing 1 of 4 quarters. This ould affect all residents, as well in the facility. the facility's fire drill reports 7 a.m. with the Director of income fire drill documentation inft of the third quarter (July, ber) of 2024. The completed were 07/29/24 at 7:30 a.m., and 9/11/24 at 2:20 p.m. Based	K 0712	It is the practice of this facility to ensure fire drills are completed including documented for each shift quarterly. 1. What corrective actions will accomplished for those resider found to be affected by the deficient practice: a. All residents have the poter to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the	be nts

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

Event ID:

PU9E21 Facility ID: 000357

If continuation sheet Page 9 of 12

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/15/2025
	PROVIDER OR SUPPLIER		1202 5	ADDRESS, CITY, STATE, ZIP COD S 16TH ST :NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF on interview at 11:5 confirmed there we to review at the tim shift of the third qu	viewed with the Director of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROLED TO THE A	DATE COMPLETION DATE III be ve otential d out in nanges recur:
				been developed that has fir occurring on each shit, eac quarter at varying times and of month. (Attachment #2) b. The Maintenance Direct been instructed on fire drills conducted on each shift, eac quarter at varying times and of month. (Attachment #3) 4. How the corrective action	re drills h d days or has s being ach d days
				be monitored to ensure the deficient practices will not of a. The Maintenance Direct provide a copy of the fire didocumentation to the Adminsitrator for review. b. This is an ongoing program should non-compliance be observed, correctived action be taken, the observations any corrective actions taken be reviewed during Quality Assurance Meeting and the of action adjusted according warranted.	occur: for will fill ram, n shall and n will

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

Event ID:

PU9E21 Facility ID: 000357

If continuation sheet

Page 10 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/15/2025	
	PROVIDER OR SUPPLIEF		1202 \$	ADDRESS, CITY, STATE, ZIP COD S 16TH ST ENNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION DATE
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment Extens Based on observation failed to ensure 1 or power strips were in fixed wiring. LSC comply with Section electrical wiring an NFPA 70, National NFPA 70, Article 4 specifically permitted shall not be used as a structure. LSC Seservice equipment of safety shall be designed as a structure with NFPA 99, Standard edition, defines patter of a health care facilinated to be exampled to be exampled for the exampled for the exampled for the bed, device that support examination and treextends vertically to floor. NFPA 99, Se or office appliances grounding conducted be permitted provide the patient care vicinity is defined as a structure.	ent - Power Cords and on and interview, the facility f 1 extension cords including ot used as a substitute for 19.5.1 requires utilities to n 9.1. LSC 9.1.2 requires d equipment to comply with Electrical Code, 2011 Edition. 00.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ection 4.5.7 states any building or safeguard provided for life gned, installed and approved all applicable NFPA standards. for Health Care Facilities, 2012 tent care areas as any portion lity wherein patients are nined or treated. Patient care as a space, within a location unination and treatment of 6 ft (1.8 m) beyond the normal chair, table, treadmill, or other	K 0920	It is the practice of this facili ensure extension cords inclipower strips ae not used as substitute for fixed wiring. 1. What corrective actions accomplished for those resifound to be affected by the deficient practice: a. All residents have the post to be affected by the alleged deficient practice. b. Room 4 identified during survey was immediately corby plugging the medical equipment directly into a hard-wired electrical recepta (Attachment #8) 2. How other residents have potential to be affected by the same deficient practices will identified and what correctivaction will be taken: a. All residents have the post to be affected by the alleged deficient practice. b. Facility rounds were comon all devices that require a electrical connection. No furissues were identified.	ty to uding a will be dents tential d the rected acle. ing the ne I be //e stential d npleted n
	resident sleeping R Findings include: Based on observation			3. What measures will be p place and what systemic ch will be made to ensure that deficient practice does not r a. Staff were educated that	anges ecur:

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

Event ID:

PU9E21 Facility ID: 000357

If continuation sheet

Page 11 of 12

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
155519		B. WING		05/15/2025	
	PROVIDER OR SUPPLIER CARE STRATEGIES SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	1202 S	ADDRESS, CITY, STATE, ZIP COD 16TH ST NNES, IN 47591 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	05/15/25, a CPAP machine, a fan and cell phone charging cable were plugged into a power strip placed on a bedside table at the head of the bed within one foot of the resident bed nearest the door in resident sleeping Room 4. The UL listing of the power strip was 1363A. Based on interview at 2:23 p.m., the Director of Nursing agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was also being used as a substitute for fixed wiring in the aforementioned resident sleeping room. This finding was reviewed with the Director of Nursing during the exit conference. 3.1-19(b)		resident medical equipment medical equipment medical equipment medical electrical receptacle. (Attachmed) 4. How the corrective actions be monitored to ensure the deficient practices will not occur. Quality Assurance tool has been developed and impleme to monitor the use of electrical receptacles and to ensure the only hospital grade power contare used for specific designate items. This tool will be completely the Housekeeping/Laundry Supervisor and/or designee for residents rooms weekly for forweeks, then monthly for three months, and then quarterly for three quarters. Should non-compliance be observed, corrective action shall be take This will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly if warranted. (Attachment #10)	ust nent will ur: nted t ds ed eted or 4 ur .	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PU9E21 Facility ID: 000357 If continuation sheet Page 12 of 12