STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155519	A. BUILDING -- B. WING	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GENTLE CARE STRATEGIES	1202 S 16TH ST VINCENNES, IN 47591

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/15/25 Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370 At this Emergency Preparedness Survey, Gentle Care Strategies was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 60 certified beds and had a census of 56 at the time of this visit. Quality Review completed on 05/20/25	E 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 05/30/2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey. We are requesting paper compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/15/25 Facility Number: 000357 Provider Number: 155519 AIM Number: 100291370 At this Life Safety Code survey, Gentle Care Strategies was found not in compliance with	K 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 05/30/2025 to the state findings of the Life Safety	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Sluder	Administrator	05/28/2025

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.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery powered smoke detectors in all resident sleeping rooms, which were also addressable to the fire alarm system via a wireless system. The facility has a capacity of 60 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds used for facility storage. Quality Review completed on 05/20/25		Code Recertification and Emergency Preparedness Survey. We are requesting paper compliance.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements	K 0100	It is the practice of this facility to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms are complete. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. All residents, staff members, and visitors have the potential to	05/27/2025

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	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect 20 residents, staff, and visitors. Findings include: Based on record review on 05/15/15 at 12:30 p.m. with the Director of Nursing present, the monthly preventative maintenance documentation for resident room battery powered smoke alarms were incomplete. Rooms 24-34 were not documented as being tested for the months of November and December 2024. Based on interview at 12:33 p.m., the Director of Nursing confirmed the provided documentation showed that the battery powered smoke alarms for resident room 24-34 had not been tested on a monthly basis for the months of November and December 2024. This finding was reviewed with the Director of Nursing at the exit conference. 3.1-19(b)		be affected by the alleged deficient practice. b. The Maintenance Director and/or Designee has completed the preventative maintenance inspection inculding documentation. (Attachment #1) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The Maintenance Director will place the smoke alarms on a preventative maintenance schedule for monthly inspection. A copy of the monitoring tool will 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 occur: a. The Maintenance Director will place the smoke alarms on a preventative maintenance schedule for monthly inspection. A copy of the monitoring tool will be provided monthly for the	

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			Administrator to review for completeness. b. This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly if warranted.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 20 residents, staff and visitors in the dining room. Findings include: Based on observation with the Director of Nursing at 2:25 p.m. on 05/15/25, the battery operated emergency light in the dining room failed to function when its respective test button was pushed four times. Based on interview at 2:27 p.m., the Director of Nursing confirmed the battery	K 0291	It is the practice of this facility to ensure all battery powered emergency lights are maintained and properly charged condition. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. All residentsm, staff memebers, and visitors have the potential to be affected by the alleged deficient practice. b. The identified battery-operated emergency light found not functioning during survey has been replaced by vendor on 5/22/2025. The light was tested and found to be in working order. (Attachment #4) 2. How other residents having the potential to be affected by the same deficient practices will be identifed and what corrective	05/27/2025

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	operated light failed to function when its respective test button was pushed. This finding was reviewed with the Director of Nursing at the exit conference. 3.1-19(b)		action will be taken: a. All residents, staff members, and visitors ahve the potential to be affected by the alleged deficient practice. b. The battery-operated emergency lights are to be tested monthly and documented on preventative maintenance worksheet. (Attachment #5) 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The Maintenance Director will complete the monthly preventative maintenance worksheet. A copy of this worksheet will be given to the Administrator for reviedw monthly. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director will complete the monthly preventative maintenance worksheet for the battery-operated emergency lights. A copy of the monitoring tool will be provided monthly for the Administrator to review for completenesws. b. This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan	

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			of action adjusted accordingly if warranted.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 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 accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: 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 04/16/25 by the facility's fire alarm inspection vendor, however, the facility could not provide information of a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors, pull stations, and heat detectors within six months from the annual fire alarm system inspections/tests. Based on interview at 11:43	K 0345	It is the practice of this facility to ensure the fire alarm system is tested and maintained visually inspected semi-annually. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. b. The contracted vendor completed inspections in the dates referenced during survey. The facility was able to retrieve from vendor the inspection report on 11/8/24. (Attachment #7) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that	05/30/2025

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	a.m., the Director of Nursing confirmed there was no semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors, pull stations, and heat detectors was available for review at the time of the survey. This finding was reviewed with the Director of Nursing during the exit conference. 3.1-19(b)		deficient practice does not recur: a. The Maintenance Director will add the semi-annually visual inspection report to the preventative maintenance program. The inspection will be completed and documented on a semi-annual basis. Upon completion of this inspection, a copy will be provided to the Administrator for review to ensure compliance. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director will add the semi-annually visual and/or inspection report to the preventative maintenance program. The inspection will be completed and documented on a semi-annual basis. Upon completion of this inspection, a copy will be provided to the Adminsitrator for review to ensure compliance. b. This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly if warranted.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the dry pipe sprinkler system had an three year air leak test. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 13.4.4.2.9 requires dry pipe systems shall be tested once every 3 years for air leakage. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of sprinkler system inspection records on 05/15/25 at 12:43 p.m. with the Director of Nursing present, the inspection dated 03/26/25 had 'N/A' marked as the answer for 'Date of the last three year air leak test.' The most recent dry pipe 3 year air leak test was not available for review at the time of the survey. There was documentation of a three year trip test on the dry pipe system on 6/15/23. During an interview at 12:46 p.m., the Director of Nursing confirmed there was no written documentation available to show	K 0353	It is the practice of this facility to ensure that the dry pipe sprinkler system had a three year leak test. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. There were no residents affected by the alleged deficient practice. b. Contracted vendor completed the required air leak test on 5/23/2025. (Attachment #6) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents, staff members, and visitors have the potential to be affectded by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The Administrator and/or Designee will monitor for inspection due dates and confirm with Maintenance Director that inspections have been scheduled. 4. How the corrective actions will be monitored to ensure the	05/23/2025

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	the most recent air leak test for the dry pipe sprinkler system at the time of the survey. This finding was reviewed with the Director of Nursing at the exit conference. 3.1-19(b)		deficient practices will not occur: a. The Maintenance Director and/or Designee will monitor for upcoming inspections and notify the Administrator and/or Designee when inspections are scheduled. Vendor reports of completed work and maintenance records will be reviewed by Administrator and/or Designee to ensure deadlines have been met. The monitoring wll 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.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 05/15/25 at 11:47 a.m. with the Director of Nursing, there was no fire drill documentation available for third shift of the third quarter (July, August, and September) of 2024. The completed fire drills provided were 07/29/24 at 7:30 a.m., 8/21/24 at 3:40 p.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 be accomplished for those residents found to be affected by the deficient practice: a. All residents have the potential to be affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the	05/27/2025

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	on interview at 11:50 a.m., the Director of Nursing confirmed there were no fire drill reports available to review at the time of the survey for the third shift of the third quarter of 2024. This finding was reviewed with the Director of Nursing during the exit conference. 3.1-19(b) 3.1-51(c)		same deficient practicies will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. A schedule for the year has been developed that has fire drills occurring on each shit, each quarter at varying times and days of month. (Attachment #2) b. The Maintenance Director has been instructed on fire drills being conducted on each shift, each quarter at varying times and days of month. (Attachment #3) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director will provide a copy of the fire drill documentation to the Adminsitrator for review. b. This is an ongoing program, should non-compliance be observed, correctived action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly if warranted.	

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K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 4. Findings include: Based on observations with the Director of Nursing during a tour of the facility at 2:20 p.m. on	K 0920	It is the practice of this facility to ensure extension cords including power strips ae not used as a substitute for fixed wiring. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. All residents have the potential to be affected by the alleged deficient practice. b. Room 4 identified during the survey was immediately corrected by plugging the medical equipment directly into a hard-wired electrical receptacle. (Attachment #8) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficient practice. b. Facility rounds were completed on all devices that require an electrical connection. No further issues were identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. Staff were educated that all	05/30/2025

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	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 must be plugged into a hard-wired electrical receptacle. (Attachment #9) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. Quality Assurance tool has been developed and implemented to monitor the use of electrical receptacles and to ensure that only hospital grade power cords are used for specific designated items. This tool will be completed by the Housekeeping/Laundry Supervisor and/or designee for 4 residents rooms weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Should non-compliance be observed, corrective action shall be taken. This will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly if warranted. (Attachment #10)	