| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155519 | A. BUILDING **01**<br>B. WING _____ | R<br>**06/09/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GENTLE CARE STRATEGIES** | **1202 S 16TH ST**<br>**VINCENNES, IN 47591** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/15/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 06/09/25<br><br>Facility Number: 000357<br>Provider Number: 155519<br>AIM Number: 100291370<br><br>At this PSR survey, Gentle Care Strategies was found in compliance with 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.<br><br>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 54 at the time of this survey.<br><br>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. | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {K 000} | Continued From page 1<br>Quality Review completed on 06/12/25 | {K 000} | | |