STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155341	A. BUILDING -- B. WING	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTGATE MANOR NURSING AND REHABILITATION	2119 E NATIONAL HWY WASHINGTON, IN 47501

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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: 05/19/25 Facility Number: 000301 Provider Number: 155341 AIM Number: 100289090 At this Emergency Preparedness survey, Eastgate Manor Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 62 certified beds. At the time of the survey, the census was 54. Quality Review completed on 05/22/25	E 0000		
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: 05/19/25 Facility Number: 000301 Provider Number: 155341 AIM Number: 100289090 At this Life Safety Code survey, Eastgate Manor	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Hubbell	Executive Director	05/30/2025

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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	Nursing and Rehabilitation was found in substantial 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. This one story facility 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 and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 62 and had a census of 54 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached wood framed garage used for maintenance and facility storage. Quality Review completed on 05/22/25			
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, 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, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements	K 0300	This plan of correction constitutes the facility's written allegation of annual survey for the efficiencies cited. The submission of the plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Department's inspection report. The provider respectfully requests that this plan of correction be considered the letter of credible	05/30/2025

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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 all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director on 05/19/25 at 12:25 p.m., preventative maintenance documentation of resident room battery operated smoke alarms for the week of 02/23/25 was not available for review. Based on interview at 12:28 p.m., the Maintenance Director stated he was off work that week and confirmed the battery operated smoke alarms were not tested. During the tour of the facility, battery operated smoke detectors were observed in the resident sleeping rooms. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		allegation of compliance and requests a desk review. If more information is needed to support this request, please contact the Executive Director, Stacey Hubbell at 812-254-3301. What corrective action(s) will be accomplished for those residents found have been affected by the deficient practice. Battery operated smoke alarms were tested and documented in TELS. In the event that the maintenance Director is out of the facility during routine preventative tasks these will be completed by the Executive Director or designee for the time period of absence. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents having battery operated smoke detectors could be affected. All resident rooms have battery operated smoke detectors. All battery operated smoke detectors were tested and documented in TELS by Brandon Underhill, Maintenance. The Executive Director or designee will ensure completion of preventative maintenance in the Directors absence. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Results of TELS task verification	

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			will be presented in the QAPI committee. If 95% is not achieved an action plan will be completed. Communication between the ED and Maintenance Director prior to absence to plan required checks to ensure no tasks are missed. What Quality Assurance program will be put into place. TELS tasks are verified completed weekly. QAPI to verify completion thru monthly audits. If 95% is not achieved an action plan will be completed. By what date the systemic changes for each deficiency will be completed. May 30, 2025	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview; the facility failed to document sprinkler system inspections fully in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 1 of the past 52 weeks for the sprinkler system's pressure gauges. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and	K 0353	What corrective action(s) will be accomplished for those residents found have been affected by the deficient practice. The dry sprinkler gauges have been inspected and documented in TELS. In the event that the maintenance Director is out of the facility during routine preventative tasks these will be completed by the Executive Director or designee for the time period of absence.	05/30/2025

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	fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 05/19/25 at 1:55 p.m. with the Maintenance Director, the facility's dry sprinkler system gauges were not documented as being inspected for the week of 02/23/25. Based on interview at 2:00 p.m., the Maintenance Director stated he was off work that week and confirmed the sprinkler gauges were not inspected that week. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The dry sprinkler gauges have been inspected and documented in TELS by the Maintenance Director. The facility uses a dry sprinkler system this would include all residents and staff being affected. The Executive Director or designee will ensure completion of preventative maintenance in the Directors absence. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. ED to ensure dry sprinkler gauges are inspected and documented in TELS weekly by reviewing documentation in TELS. Communication between the ED and Maintenance Director prior to absence to plan required checks to ensure no tasks are missed. What Quality Assurance program will be put into place. TELS tasks are verified completed weekly. Results of TELS tasks verification will be presented to the QAPI committee. If 95% is not achieved an action plan will be completed. By what date the systemic changes for each deficiency will be completed. May 30, 2025	

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K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 1 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 05/19/25 at 11:35 a.m., documentation for weekly generator testing for the week of 02/23/25 was not available for review. Based on an interview at 11:40 a.m., the Maintenance Director stated he was off work that week and confirmed that weekly generator testing for the week of 02/23/25 had not been documented. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0918	What corrective action(s) will be accomplished for those residents found have been affected by the deficient practice. The generator has been tested and documented in TELS. In the event that the maintenance Director is out of the facility during routine preventative tasks these will be completed by the Executive Director or designee for the time period of absence. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential of being affected in emergency generator use. The Executive Director or designee will ensure completion of preventative maintenance in the Directors absence. The generator has been tested and documented in TELS. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. ED will ensure the generator is tested weekly and documented by reviewing documentation in TELS. Communication between the ED and Maintenance Director prior to	05/30/2025

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			absence to plan required checks to ensure no tasks are missed. Verifying tasks in TELS. What Quality Assurance program will be put into place. TELS tasks are verified completed weekly. Results of TELS tasks verification will be presented to the QAPI committee. If 95% is not achieved an action plan will be completed. By what date the systemic changes for each deficiency will be completed. May 30, 2025	