STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING -- B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

(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 DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/18/25 Facility Number: 000200 Provider Number: 155303 AIM Number: 100367980 At this Emergency Preparedness survey, Serenity Springs Senior Living At Jasonville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds, with a current census of 37. Quality Review completed on 02/21/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include:	E 0004	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it	02/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah E Davis	LHFA	03/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155303	A. BUILDING -- B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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	Based on review of the Emergency Management plan on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review was 01/26/23. Based on interview at the time of review, the Maintenance Director confirmed the Emergency Management plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. E0004 Corrective Action: The facility will comply with Federal, State, and local emergency preparedness requirements. The emergency management plan was reviewed and updated on 2/24/2025 and continued to be reviewed/updated through 2/27/2025 Potential to others to be affected: The emergency plan was still in effect and being utilized without having any negative effect on others. Systemic Changes: The emergency management plan will be scheduled for review and updated every 12 months or with any Policy or Procedure changes. The annual review/updating will be entered into the TELS system, the task and a calendar reminder for this yearly review will be set for each January. The Maintenance Director and Administrator will meet and make updates as necessary. Monitoring of Systemic changes: The Administrator or designee will	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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			conduct audits of the emergency management plan for any policy or procedure changes/reviews and will report changes at the weekly risk meeting times, 3 months. In addition, the Maintenace Director or designee will report to the QAPI committee during Quality Assurance meetings, until compliance is deemed met.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Management plan on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 01/26/23. Based on interview at the time of review, the Maintenance Director confirmed the policies and procedures within the Emergency Management plan have not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit	E 0013	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. E 013 Development of EP Policies and Procedures Corrective Action: The facility	02/28/2025

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	155303	A. BUILDING -- B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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	conference.		will comply with all applicable Federal, State, and local emergency preparedness requirements. The emergency management plan and its policies and procedures were reviewed and updated on 2/24/25 and continued to be reviewed/updated through 2/27/25. The staff were educated on 3-4 and 3-5-25 as to the updated Emergency Management Plan. Potential having to be affected: The emergency plan's policies and procedures were in effect and being utilized without having any negative outcomes to others. Systemic Changes: The emergency management plan will be scheduled for review and updating every 12 months or with any Policy or Procedure changes. The annual review/updating will be entered into our TELS system, the task and a calendar reminder for this yearly review will be set for each January. The Maintenance Director and Administrator met and updates were put in place on 2/24/25 through 2/27/25. Monitoring of Systemic Changes: The Administrator or designee will conduct audits of the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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			emergency management plan for any policy or procedure changes/reviews and will report changes at the weekly risk meeting times 3 months. In addition, the Maintenance Director or designee will report the outcomes of the audits to the QAPI committee during monthly Quality Assurance meetings, until compliance is deemed met. Completion date 2/28/25	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Management plan on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the facility's emergency preparedness plan did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 01/26/23. Based on interview at the time of review, the Maintenance Director confirmed the Communication Plan within the Emergency	E 0029	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. E 029 Development of Communication Plan	02/28/2025

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	Management plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Corrective Action: The facility will comply with all applicable Federal, State, and local emergency preparedness requirements. The communication plan within the emergency management plan was reviewed and updated on 2/24/25 and continued to be reviewed/updated through 2/27/25, and staff education was performed on 3.4 through 3.5.25 Potential having to be affected: The facility's communication plan was in effect and being utilized without having any negative outcomes to others. Systemic Changes: The communication plan within the emergency management plan will be reviewed and updated timely with any changes that occur and within 12 months. The communication plan will be a daily task, that is discussed during the morning leadership meeting, the yearly review will be set for each January. The Maintenance Director and Administrator met and updates were put in place, on 2/24/25 through 2/25/25. Monitoring of Systemic Changes: The Administrator or designee will conduct audits of the facility's	

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			emergency management communication plan for any changes/reviews and will report changes at the weekly risk meeting times 3 months. In addition, the Maintenance Director or designee will report the outcomes of the audits to the QAPI committee during monthly Quality Assurance meetings, until compliance is deemed met. Completion Date: 2/28/25	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Management plan on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 01/26/23. Based on interview at the time of review, the Maintenance Director confirmed the training and testing policy and procedure within the Emergency Management plan has not been reviewed and updated within the past twelve	E 0036	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. E 036	03/06/2025

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	month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		EP Training and Testing Corrective Action: The facility will comply with all applicable Federal, State, and local emergency preparedness requirements. The emergency management plan was reviewed and updated on 2/24/25 and continued to be reviewed/updated through 2/27/25. The training and testing information was reviewed and updated. Current staff training and testing has been posted for 3-4 and 3-5-25 at 4 different time intervals to accommodate each shift. Potential having to be affected: Others had the potential to be affected, however no negative outcomes occurred to others. Systemic Changes: The Maintenance Director or designee will manage staff education on changes of the emergency plan's policy and procedures. New employee class orientation will include the emergency plan and its content, testing will occur and be reviewed with the employee to ensure understanding. Annual training and testing will also occur timely	

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			Monitoring of Systemic Changes: The Administrator or designee will conduct audits of the facility's emergency management training-testing plan, any employee with a questionable understanding of the policies and procedures will receive additional training. The compliance of training and testing sessions will be reported at the weekly risk meeting times 3 months. In addition, the Maintenance Director or designee will report the outcomes of the training sessions to the QAPI committee during monthly Quality Assurance meetings, until compliance is deemed met. Completion Date : 3/6/25	
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: 02/18/25 Facility Number: 000200 Provider Number: 155303 AIM Number: 100367980	K 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the	

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	At this Life Safety Code survey, Serenity Springs Senior Living At Jasonville was found not 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. 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 detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 60 and had a census of 37 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 garages used for facility storage and maintenance. Quality Review completed on 02/21/25		purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, was provided with a properly working self closing device. This deficient practice could at least 10 residents and staff. Findings include: Based on observations on 02/18/25 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the left side Nursing Storage Room corridor door was provided with a	K 0321	K0000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of	02/21/2025

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	self closing device, however, when tested, the door did not self close completely and latch. The room was over 50 square feet in size and stored several cardboard boxes, and a variety of other combustible items. Based on interview at the time of observation, the Maintenance Director acknowledged the Nursing Storage Room was not provided with a properly working self closing device. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 321 Hazardous Areas - Enclosure Corrective actions: On 2/20/25 the facility had a new self-closing device and door latch added to the door frame to the Nurse Storge Room on the left side, no other areas were identified during the survey and during subsequent preventative maintenance rounds. Other residents having the potential to be affected: Residents in the facility have the potential to be Affected Systemic changes implemented: The facility will ensure that per Preventative maintenance rounds, hazardous areas are protected by an automatic fire extinguishing	

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			system and doors shall have a properly working self-closing device and door latch in place. Any need of repairs or installation of self-closure door devices or door latches should be communicated to the Maintenance department and copied to the Administrator. Re-education of the facility staff has been accomplished. Monitoring of the corrective action: The Maintenance Director and/or his designee will monitor and assist in monitoring hazardous areas and immediately report of any need for or issues with self-closing door devices or door latches, audits will occur 5 times weekly during random rounding times for 3 weeks, then weekly for 4 weeks. Audit findings will be discussed during clinical care meetings until QAPI committee review has audits and 100 % compliance have been met and it has been determined that substantial compliance has been obtained. Completion date : 02/21/2025	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure complete documentation was available for the sensitivity testing of all hard wired smoke detectors, and to show what testing instrument was used to test all smoke detectors for sensitivity. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.	K 0345	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 345: Fire Alarm System: Testing and Maintenance Corrective actions: On 3.6.25, Western States Fire & Protection company was re-educated on the conducting and proper documentation when completing the sensitivity range for each smoke detector, The Maintenance	03/06/2025

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SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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	(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was documentation available to show a smoke detector sensitivity test of all hard wired smoke detectors was performed on 02/28/24 by the facility's fire alarm system inspection vendor, however, the report did not include the sensitivity range for each smoke detector or the name of the manufacturer's calibrated sensitivity test instrument. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		staff is aware of their responsibility to ensure the completeness of their documentation Other residents having the potential to be affected: Residents, staff and visitors have the potential to be affected The Maintenance Director will continue to audit aspects of the fire alarm system to assure corrections are maintained. Systemic changes implemented: The facility will assure its fire alarm system is tested and maintained in accordance with an approved program that complies with requirements stated in NFPA 70 NFPA 72 and that documentation is all encompassed within the requirement and readily available for review. The Administrator and/or designee will educate Maintenance staff on importance of receiving and reviewing for proper documentation from the facility's' fire alarm/sprinkler vendor, of the required annual visual and functional status of all devices to include sensitivity range for each smoke detector or the name of the	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			manufacturers calibrated sensitivity test instrument. Updating of the TELS preventative maintenance program will be done as deemed necessary. Monitoring of the corrective action: The Administrator or designee will conduct review audits, along with the Maintenance Director, of fire alarm visual and functional quarterly and/or annual testing results to include sensitivity ranges, the monthly audits for 3 months until QAPI committee review and deem that substantial compliance has been obtained. Completion date: 3/6/2025	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 6 smoke compartments and 2 of 3 porch overhangs covered with corrosion or paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive	K 0353	K0000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the	03/06/2025

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 resident, as well as staff and visitors. Findings include: Based on observations on 02/18/25 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was one sidewall sprinkler head under the southwest corridor exit porch overhang covered with corrosion. b. There was one sidewall sprinkler head in the 400 hall shower room partially covered with paint. c. There were four sidewall sprinkler heads under the southeast corridor exit porch overhang covered with corrosion. Based on interview at the time of each observation, the Maintenance Director acknowledged the previously mentioned sprinkler heads were covered with corrosion or paint. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 353 Sprinkler System Maintenance and Testing Corrective actions: On 3/6/25 the sprinkler heads with corrosion were inspected and ordered, the affected ones will be replaced upon delivery a 1 sidewall sprinkler head under the southwest corridor exit porch overhang with corrosion b 1 side wall sprinkler head in the 400 hall shower room with paint present c 4 side wall sprinkler heads under the southeast corridor exit porch overhang with corrosion Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented:	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			During Maintenance Directors' or designees' weekly preventative maintenance rounds, sprinkler heads will be inspected thoroughly if any substance or corrosion is noted, they will be replaced. The Administrator will be informed immediately to ensure timely correction is done Monitoring of the corrective action: The Administrator or designee will conduct, along with the Maintenance Director, monthly audits of the sprinkler head inspections, which will be verified by random follow-up rounding results performed by the Administrator. The results will be reviewed monthly for 4 months until QAPI committee review has deemed that substantial compliance has been obtained Completion date : 3/6/25	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter	K 0511	K0000 Preparation and execution of this	03/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where		response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. K 511 Utilities – Gas and Electric Corrective actions: On 2-19-2025, proper GFCI protection was installed to the identified receptacle in the East Nurses Station sink. A No other issues were noted by the survey Other residents having the potential to be affected: Residents, staff and visitors have the potential to be affected	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one or two staff. Findings include: Based on observations on 02/18/25 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there was one electric receptacle within three feet of the sink in the east Nurse's Station room not provided with GFCI protection. When tested with a GFCI testing device the receptacles did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the receptacle in the east Nurse's Station was not properly GFCI protected. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Systemic changes implemented: The facility will ensure proper GFCI protection against electric shock is maintained in accordance with requirements stated in NFPA 70, NEC 2011, and that the facility provides GFCI protection within the requirements. The Maintenance Director and/or designee will conduct and record inspections of areas within the facility to ensure GFCI compliance is being maintained, 5 times weekly, times 3 weeks, then record monthly in Tels system. Monitoring of the corrective action: The Administrator or designee will conduct random follow-up audits, along with the Maintenance Director, for 3 months and report to the QAPI committee to review until the committee deems that substantial compliance has been obtained. Completion date: 3/6/2025	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(b)		Completion date: 3/6/2025 .	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide an accurate written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 0711	K 711 Evacuation and Relocation Plan Corrective actions: On 2-19-2025, the facility's Fire Plan was updated with the current name and contact information for the Sprinkler and Fire Alarm system inspection company. Current staff training and testing have been posted for 3-4 and 3-5-25 at 4 different time intervals to accommodate each shift, this will be a part of staff review as to where this information can be located.	03/07/2025

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Plan on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, the current plan still included the name and contact information for the facility's former sprinkler system inspection company and fire alarm system inspection company. Based on interview at the time of record review, the Maintenance Director acknowledged the contact information in the Fire Plan needed to be updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Other residents having the potential to be affected: Residents, staff, and visitors have the potential to be affected Systemic changes implemented: The Maintenance Director or designee will manage staff education regarding the facility's Fire Plan and any changes that occur. New employee class orientation will include the Fire Plan and its Inspection Company information, testing will occur and be reviewed with the employee to ensure understanding. Annual training and testing will also occur Monitoring of Systemic Changes: The Administrator or designee will conduct audits of the facility's emergency management plan to include the facility's Fire Plan, and the information within it. The compliance of current information listed in the Fire Plan will be reported at the weekly risk meeting, times 2 months.	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			In addition, the Maintenance Director or designee will report the outcomes to the QAPI committee during monthly Quality Assurance meetings, until compliance is deemed met. Completion date: 3/6/2025 .	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure all 17 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 02/28/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, all 17 fire drill reports did not include the time the transmission the alarm was received by the monitoring company, and at least 8 fire drill reports did not	K 0712	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations	03/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	include the name or operator number of the person at the monitoring company receiving the transmission of the alarm. Based on interview at the time of record review, the Maintenance Director confirmed all 17 fire drills reports during the past 12 month period were not provided with a time of transmission the monitoring company received the alarm, plus the name or operator number was not included on at least half of the fire drill reports. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b) 3.1-51(c)		Manual. K 712 Fire Drills Corrective actions: On 2/28/25 the Maintenance Director received written re-education concerning the proper documentation that is required within Fire Drills in accordance of NFPA 101. Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility's Maintenance Director will ensure that the Fire Drills performed, have the proper information included within the Fire Drill report. Complete documentation of the transmission of the Fire Drill must include the time of transmission, that the alarm was received, the name of the operator or the number of the operator receiving the transmission of the alarm. The Fire Drill report will be reviewed by the Administrator and if the Drill report does not encompass the information required, the drill report will be updated	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Monitoring of the corrective action: The Administrator will review Fire Drills that are performed monthly for 4 months to ensure all information required is present, if compliance is not met upon review of the Fire Drills, disciplinary action will be taken. Audit findings will be discussed during QUAPI meetings until QAPI committee review has deemed that 100 % compliance has been met. Completion date : 3/4/2025	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the	K 0921	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation	04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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	manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 02/18/25 between 9:30 a.m. and 1:00 p.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items and was not aware of the requirement. Based on observation between 1:00 p.m. to 3:00 p.m. during a tour of the facility with the Maintenance Director , it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		of compliance in accordance with 7305 of the State Operations Manual. Addendum as requested for K-921 K 921 Electrical Equipment Testing and Maintenance Corrective actions: On 2/20/25 the Maintenance Director contacted Crown Electric to provide electrical testing and documentation of the facility's Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 2012, 10.3 and 10.5. Crown Electric was on site on March 11th and March 18th, collecting data on the electrical equipment used in patient care to perform the repairs found during the IR scan. Crown Electric has the information needed to start the required NFPA 99 testing of patient care equipment and will return on 3-24-25 to continue to perform the required testing in its entirety, using the Electrical Safety inspection PCREE from, NFPA 99 2012 edition, please see attached.	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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			Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility's maintenance director will accompany Crown Electric during the Electrical testing of patient care equipment and for training purposes. The Maintenance Director will ensure that PCREE electrical testing is done before any PCREE is put into service, after any repair or modification., or will contact an electrician if any issue noted is beyond his scope of practice. Any PCREE in use will have maintenance manuals and operating instructions readily available. PCREE such as electric beds, oxygen concentrators, nebulizers, air pumps for air mattresses will be inspected and have safety labels and condensed operating instructions on the appliance are legible. PCREE records will be maintained at the facility. Monitoring of the corrective action: The Administrator will review the	

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	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

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			documentation that is necessary to meet the PCREE requirement, any changes or modifications that are performed will be brought monthly to the QA meeting for 4 months, to ensure all information required is present until the QA committee has reviewed and deemed compliance has been met Completion date : 4/10/2025	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transfilling takes place, was provided with properly wired mechanical ventilation that would operate continuously. This deficient practice could affect at least 10 residents in the east wing of the facility. Findings include: Based on observations on 02/18/25 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the oxygen storage/transfilling room was equipped with a mechanically vented exhaust fan, however, the exhaust fan was controlled by a switch on the wall within the oxygen storage/transfilling room that	K 0927	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation	02/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 01 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	could potentially be turned off at any time. Based on interview at the time of observation, the Maintenance Director acknowledged the mechanically vented exhaust fan was controlled by a switch on the wall within the room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		of compliance in accordance with 7305 of the State Operations Manual. K 927 Gas Equipment Transfilling Cylinders Corrective actions: On 2/20/25 the Maintenance Director provided the Oxygen room with properly wired mechanical ventilation that operates continually. Other residents having the potential to be affected: Residents in the facility have the potential to be affected. Systemic changes implemented: The facility's Maintenance Director ensured that the Oxygen room was equipped with a mechanically vented exhaust fan that ran continuously without the chance of being turned off. Monitoring of the corrective action: The Maintenance Director will ensure no other circumstance of this kind will occur, if any issues arise it will be brought forth to the Administrator. This will be	

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			discussed in the weekly risk assessment meeting times 3 then it will be brought monthly to the QA meeting for 4 months to ensure all information required is present, until the QA committee has reviewed and deemed compliance has been met Completion date : 2/22/25	