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	04/16/2024

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

(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: 04/16/24 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 49 at the time of this visit. Quality Review completed on 04/23/24	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: 04/16/24 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 5/7/24 to the state findings of the Life Safety	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Sluder	Administrator	05/06/2024

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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 49 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 04/23/24		Survey. We are requesting paper compliance.	
K 0100 SS=F Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, interview, and observation; the facility failed to ensure 31 of 31 resident room smoke alarms were tested for sensitivity in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 edition.	K 0100	It is the practice of this facility to ensure resident rooms were tested for sensitivity. All resident room smoke alarms are to be tested for sensitivity yearly upon new	05/06/2024

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	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, Section 14.4.5.3 requires in other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7, Section 14.4.5.3.1 requires sensitivity shall be checked within 1 year after installation and Section 14.4.5.3.2 requires sensitivity shall be checked every alternate year thereafter. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, there was no documentation available to show 31 resident room single station smoke alarms were tested for sensitivity. Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of documentation for the testing of sensitivity of the single station resident room smoke alarms. Based on observations between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, it was confirmed all resident rooms are provided with single station battery operated smoke alarms that are addressable to the fire alarm panel. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to ensure		installation and then every alternate year. It is the practice of this facility to ensure battery operated smoke alarms are tested monthly and battery changed yearly. 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 vendor (Safe Care) completed the sensitivity testing and has replaced the failed alarms identified. Documentation received of completed work. (Attachment #1) c The Maintenance Director and/or Designee replaced all batteries for the year and documented on worksheet. (Attachment #2) 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	

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	documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was available. 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 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 record review on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, the facility was unable to provide a preventative maintenance report that resident room battery powered smoke alarms were tested on a monthly basis. Furthermore, there was no documentation to show the batteries in all resident room smoke alarms were changed during the past 12 month period or any time prior. Based on observation of a resident room battery powered smoke alarm at the time of record review, the back of the smoke alarm stated, "Replace Batteries Every Year". Based on interview at the time of record review, the Maintenance Supervisor acknowledged that there was no documentation to show that the resident room battery powered smoke alarms had been tested on a monthly basis or batteries changed at least annually. Based on observation during a tour of the facility with the Maintenance Supervisor between 1:20 p.m. and 3:30 p.m., all resident sleeping rooms were		place the smoke alarms on a preventative maintenance schedule for monthly inspection and yearly battery change. b. The Maintenance Director will place the sensitivity testing dates on the calendar to ensure compliance. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director will provide a copy to the Administrator for review of the maintenance schedule for the replacement of the monthly inspection with yearly battery change and the sensitivity testing of those alarms. 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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	equipped with battery powered smoke alarms which were addressable to the fire alarm system. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of over 10 exit signs was continuously illuminated. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the exit sign above the Hall 2 exit door was not fully illuminated. Only the "X" was illuminated. Based on interview at the time of observation, the Maintenance Supervisor agreed the exit sign over the Hall 2 exit door was not fully illuminated and said he would fix it as soon as possible. This finding was reviewed with the Director of	K 0293	It is the practice of this facility to ensure exit signs are continuously illuminated. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. b. The Maintenance Director replaced the bulb in the exit sign at the end of hall 2. (Attachment #3) 2. How other residents having the potential to be affected by the	05/03/2024

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	Nursing and Maintenance Supervisor during the exit conference. 3.1.19(b)		same deficient practicies will be identified and what corrective action will be taken: a. 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 exit signs on a preventative maintenance schedule for monthly inspection. Identified issues will be immediately addressed. b. All staff were educated on the importance of reporting if a bulb is burnt out in any exit sign so they can be replaced. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director will provide a copy to the Administrator for review of the maintenance schedule for monthly inspection of exit signs. 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 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all	K 0324	It is the practice of this facility to ensure staff are instructed in the proper use of the UL 300 hood fire suppression system. 1. What corrective actions will be accomplished for those residents found to be affecteed by the deficient practice: a. Dietary Staff and any resident in the adjacent dining room have the potential to be affected by the alleged deficient practice. b. Dietary Staff were in-serviced on the use of the UL 300 hood	04/18/2024

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	residents while in the adjacent dining room. Findings include: Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the kitchen was provided with a UL 300 hood system. Based on interview with two kitchen dishwashing staff, when asked what they would do if there was a fire underneath the range hood. Kitchen dishwashing staff #1 said she didn't know. Kitchen dishwashing staff #2 said (and pointed to) he would use the K-class fire extinguisher. Neither kitchen dishwashing staff said they would pull the range hood fire suppression system pull station. This was acknowledged by the Maintenance Supervisor at the time of observation and interview with the two kitchen dishwashing staff. The Maintenance Supervisor said more training for kitchen staff would be a priority. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)		system. (Attachment #4) 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. Dietary Staff and any resident in teh adjacent dining room 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. Dietary Staff were in-serviced on the use of UL 300 hood system. (Attachment #4) b. New employee hired for the Dietary Department will be instructed during orientation of the operation of the steps of a fire in the kitchen. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. 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 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure alcohol-based hand sanitizer dispensers were not installed over an ignition source in 1 of 5 smoke compartments. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a	K 0325	It is the practice of this facility to ensure alcohol-based hand sanitizer dispensers were not installed over an ignition source. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. All residents, staff members,	04/17/2024

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	1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect up to 17 residents, staff, and visitors in Hall 1. Findings include: Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, there were four alcohol-based hand sanitizer dispensers installed on the Hall 1 corridor walls directly above electrical receptacles and a light switch. Based on interview at the time of each observation, the Maintenance Supervisor confirmed the alcohol-based hand sanitizer dispensers were installed on the Hall 1 corridor walls directly above electrical receptacles and a light switch. The finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)		and visitors have the potential to be affected by the alleged deficient practice. b. Alcohol-based hand sanitizer dispensers located above an electrical outlet were relocated. (Attachment #5) 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. Alcohol-based hand sanitizer dispensers located above an electrical outlet were relocated. (Attachment #5) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. 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 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. 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 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection/test dated 09/22/23 by the facility's fire	K 0345	It is the practice of this facility to ensure the fire alarm system is tested and maintained visually inspected semi-annually. And the completed sensistivity method. 1. What corrective actions will be accomplished for thosse 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 vendor (Tri-State Fire) docoumentation received of completed inspections for the annual and semi-annual for the fire alarm system. (Attachments #13, #14, #15) c. The vendor (SafeCare) completed inpsection which includes the sensitivity testing. (Attachment #1) 2. How other residents having the potential to be affected by the	05/06/2024

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	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 after the annual fire alarm system inspection/test. Based on interview at the time of record review, the Maintenance Supervisor 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. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. 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:		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 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 fire alarm inspection and sensitivity testing dates on the calendar to ensure compliance. 4. How the corrective actions will be monitored to esnure the deficient practices will not occur: a. The Maintenance Director will provide a copy to the Administrator for review of the fire alarm inspection and the sensitivity reports 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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	(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. (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 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, there was documentation available to show a smoke detector sensitivity test of all hard wired smoke detectors was performed on 09/22/23 by the facility's fire alarm system inspection vendor, however, the report did not include the name of the manufacturer's calibrated sensitivity test instrument. This was confirmed by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)			

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K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete and accurate written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include the following information: a. Notifying the Authority having jurisdiction; Indiana Department of Health (IDOH) and others when the fire alarm system is out of service for more than 4 hours in a 24-hour period. b. Contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. c. Indicating the person conducting the fire watch has been properly trained. Based on an interview at the time of record review,	K 0346	It is the practice of this facility to ensure a complete and accurate written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system must be placed out of service for four hours or more in a twenty-four period. 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 fire watch policy has been updated to include the required documentation. (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,	04/17/2024

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	the Maintenance Supervisor confirmed the fire watch documentation that was provided lacked the previously mentioned information. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)		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 fire watch policy has been updated to include the required documentation. (Attachment #6) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. 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 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, in the Maintenance shop/office there were were at least three areas where wires and conduits were tethered to sprinkler pipes with zip ties. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the wires and conduits tethered to the sprinkler pipes with zip ties and said he would address the situation as soon as possible. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0353	It is the practice of this facility to ensure the sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. 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 Maintenance Director removed lines that were tethered to the sprinkler pipes.(Attachment #7) 2. How other residents having the potential to be affected by the same deficient practicies 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:	04/19/2024

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			a. The Maintenance Director removed lines that were tethered to the sprinkler pipes. b. A walk through of the facility was completed to ensure no lines were attached to sprinkler pipes. No further issues identified. 4. How the corrective actions will be monitored to ensure the deficient practices will no occur: a. During weekly rounds, the Maintenance Director will observe if anything is tethered to the sprinkler pipes. If issues identified, immediate correction will be taken. 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 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more			

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	than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, the facility did provide fire watch documentation, however, it was incomplete. The plan failed to include the following information: a. Notifying the Authority having jurisdiction;	K 0354	It is the practice of this facility to ensure a complete written policy containing procedures to be followed for the protection of all occupants in the event of the automatic sprinkler systems has be to be placed out-of-service for 10 hours or more in a 24-hour period. 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 sprinkler fire patrol watch policy has been updated to include the required documentation. (Attachment #6) 2. How other residenets 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	04/17/2024

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	Indiana Department of Health (IDOH) and others when the sprinkler system is out of service for more than 10 hours in a 24-hour period. b. Contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH Gateway. c. Indicating the person conducting the fire watch has been properly trained. Based on an interview at the time of record review, the Maintenance Supervisor confirmed the fire watch documentation that was provided lacked the previously mentioned information. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that deficient practice does not recur: a. The sprinkler fire patrol watch policy has been updated to include the required documentation. (Attachment #6) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. 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 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 2 of 8 portable fire extinguishers observed were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect up to 30 residents, staff, and	K 0355	It is the practice of this facility to ensure fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. The portable fire extinguishers are inspected monthly. 1. What corrective actions will be	04/17/2024

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	visitors. Findings include: Based on observation on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The portable fire extinguisher mounted on the wall next to the Hall 1 exit door was measured at 5 feet 6 inches at the top of the extinguisher. b. The portable fire extinguisher mounted on the wall next to the Hall 2 exit door was measured at 5 feet 3 inches at the top of the extinguisher. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of each observation. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 2 of 8 portable fire extinguishers each month during the past 12 month period. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for		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 Maintenance Director lowered the fire extinguishers below 5 feet which places them in required placement. (Attachment #8) c. The Maintenance Director completed the monthly required inspection on the fire extinguishers dientified during survey. (Attachment #9) 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 lowered the fire extinguishers below 5 feet which places them in required placement. b. The Maintenance Director checked all fire extinguisheres to ensure that they were mounted per regulations. No further issues	

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	self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The ABC portable fire extinguisher in the kitchen was not inspected monthly in October through December of 2023, and January through current of 2024. The annual inspection of this fire extinguisher by the facility's vendor was performed in August of 2023. a. The ABC portable fire extinguisher in the laundry room was not inspected monthly in October through December of 2023, and January		identified. c. The Maintenance Director completed the monthly required inspection on the fire extinguishers identified during survey. d. The Maintenance Director has added the missed fire extinguishers to the monthly check list. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director has added the location to the monthly checklist for the portable fire extinguishers. 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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	through March of 2024. The annual inspection of this fire extinguisher by the facility's vendor was performed in August of 2023. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned portable fire extinguishers had not been inspected monthly. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure intake combustion air from the outside was provided in 1 of 1 rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for mostly staff in the laundry room and other adjacent rooms in the basement. Findings include:	K 0522	It is the practice of this facility to ensure intake combustion air fromteh outside in a room containing fuel fired equipment. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Staff members have the potential to be affected by the	05/07/2024

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	Based on observations on 04/16/24 between 1:20 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the the dryer room within the laundry room had two fuel fired dryers that had no currently working fresh air vent for intake combustion air from the outside provided for this enclosed room. There was a wall vent fan plugged into a receptacle that opened into the building crawl space, however, the vent fan was caked with lint/dust/dirt and was not running at the time of observation. Based on interview at the time of observation, the Maintenance Supervisor confirmed the vent fan was not currently working and agreed there was no fresh air vent for intake combustion air from the outside in the dryer room. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)		alleged deficient practice. b. Maintenance Director assessed the fresh air intake and the crawl space has several air intake vents. An intake fan was installed behind the dryer. (attachment #10) 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. Staff members 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. Maintenance Director installed an intake fan behind the drye. b. Maintenance Director and Housekeeping Supervisor will complete a worksheet and document findings to ensure fans are cleaned and maintained. (Attachment # 11) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. 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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GENTLE CARE STRATEGIES	1202 S 16TH ST VINCENNES, IN 47591

(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
			of action adjusted accordingly if warranted.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate facility specific 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	It is the practice of this facility to ensure a complete and accurate facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems. 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. Administrator reviewed and updated emergency preparedness plan (EPP) to include the appropriate steps for kitchen fire.	04/18/2024

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	155519	A. BUILDING 01 B. WING	04/16/2024

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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 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, the plan did address the use of the K-class fire extinguisher in the kitchen, however, it was addressed prior to the manual use of the range hood suppression system. The Fire plan stated: "Steps to take in case of a kitchen fire" "a. Employee pull the fire alarm b. Turn off the stove and anything else running electrical as well as all exhaust fans. c. Access the appropriate fire extinguisher in kitchen to attempt to put out the fire if can. (A) SILVER Fire Extinguisher is to be used for GREASE FIRES (B) RED Fire Extinguisher is for all other fires but can also be used for grease fires." "d. If employee unable to extinguish the fire safely in the kitchen, leave the kitchen. As you exit the kitchen pull the manual release for the range Ansul system located to the right of the kitchen exit door." Based on interview at the time of record review,		(Attachement #4) 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 Administrator reviewed and updated the emergency preparedness plan (EPP) to include the appropriate steps for kitchen fire. b. All Staff were in-service on the updated emergency preparedness plan on 04/18/2024. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The facility will provide a yearly in-service for all staff on the emergency preparedness plan. 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 accoringly if warranted.	

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	the Maintenance Supervisor acknowledged and agreed that the use of the K-Class fire extinguisher in the Fire plan was not written in the correct order in the event of a fire under the range hood. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to ensure 5 of 12 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:	K 0712	It is the practice of this facility to ensure fire drill reports include documentation of the transmission of a fire alarm signal to the monitoring company. 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.	05/07/2024

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	Based on review of the facility's fire drill reports on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, 5 of 12 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. These drill dates and times include: 06/29/23 at 10:00 p.m., 09/29/23 at 5:45 a.m., 12/27/23 at 6:15 a.m., 01/31/24 at 9:30 a.m., and 03/26/24 at 3:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no information on 5 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3-1.19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 04/16/24 between 8:45 a.m. and 1:20 p.m. with the Maintenance Supervisor present, 4 of 4 second shift (evening) fire drills were performed between 2:08 p.m. and 3:10 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.		b. Administrator updated the fire drill report to show documentation of the signal being received by monitoring station. 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 havee 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 utilize the updated fire drill report which includes signal received by monitoring station. (Attachment #12) b. The Maintenance Director will place the sensitivity testing dates on the calendar to ensure compliance. c. A schedule for the year has been developed that has fire drills occurring on each shift, each quarter at varying times and days of month. d. The Maintenance Director has been instructed on fire drills being conducted on each shift, each quarter at varying times and days of month. 4. How the corrective actions will be monitored to ensure the	

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	This finding was reviewed with the Director of Nursing and Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)		deficient practices will not occur: a. The Maintenance Director will provide a copy to the Administrator for review of the maintenance schedule for the monthly inspection smoke detectors with yearly battery change and the completed report of the sensitivity of testing of those alarms when those occur. b. The Maintenance Director will provide a copy of the fire drill documentation to the Administrator for review. c. This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions will be reviewed during Quality Assurance Meeeting and the plan of action adjusted accordingly if warranted.	