ENTERS FOI	R MEDICARE & MEDIC				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING <u></u>	COMPL	LETED	
		155519	B. WING		04/16	/2024	
	PROVIDER OR SUPPLIEF		12	TREET ADDRESS, CITY, STATE, ZII 202 S 16TH ST INCENNES, IN 47591	PCOD		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	<u> </u>		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PRE	PROVIDER'S PLAN OF C	CORRECTION N SHOULD BE	COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION		AG CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	DATE	
E 0000	REGULATORT OF	CESC IDENTIF TING INFORMATION	17	10		DATE	
L 0000							
Bldg	conducted by the Irraccordance with 42  Survey Date: 04/16  Facility Number: 0  Provider Number: 100  At this Emergency Care Strategies was Emergency Prepare	5/24  00357 155519 291370  Preparedness Survey, Gentle found in compliance with edness Requirements for	E 0000				
K 0000	and Suppliers, 42 C  The facility has a ca had a census of 49 a	caid Participating Providers FR 483.73  apacity of 60 certified beds and at the time of this visit.  appleted on 04/23/24					
Bldg. 01	Licensure Survey w Department of Head 483.90(a).  Survey Date: 04/16  Facility Number: 0 Provider Number: 100  At this Life Safety	000357 155519	K 0000	By submitting the fol material we are not a truth or accuracy of a findings or allegation reserve the right to a findings or allegation any proceedings and responses pursuant regulatory obligation requests the plan of considered our alleg compliance effective state findings of the	admitting the any specific as. We contest the as as part of a submit these to our s. The facility correction be ation of 5/7/24 to the		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Susan Sluder Administrator 05/06/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155519		A. BUILDIN B. WING	NG <u>01</u>	COMPLI 04/16/2	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION DATE	
	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation of the National Fire Protect Life Safety Code (L Health Care Occupation of the National Fire System with hard with corridors, spaces op battery powered smallering rooms, which the fire alarm system facility has a capacity at the time of this All areas where residence were sprinklered and	the 2012 edition of the ention Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2.  Type V (000) construction and d. The facility has a fire alarm entered smoke detectors in the ent to the corridors, plus to be detectors in all resident ench were also addressable to envia a wireless system. The ty of 60 and had a census of so survey.  Type V (000) construction and d. The facility has a fire alarm entered smoke detectors in the ent to the corridors, plus to the corridors, plus obtained to the via a wireless system. The ty of 60 and had a census of so survey.  The type V (000) construction and d. The facility accessed all areas providing facility elered, except two detached reacility storage.		Survey. We are requesting p compliance.	aper		
K 0100 SS=F Bldg. 01	Section 18.1 and of that are not address K-tags, but are desalong with the app NFPA standard cit on Form CMS-2561. Based on record observation; the factoresident room smok sensitivity in according	ents - Other LKS section any LSC 19.1 General Requirements seed by the provided ficient. This information, licable Life Safety Code or ation, should be included	K 0100	It is the practice of this facility ensure resident rooms were t for sensitivity. All resident roo smoke alarms are to be tested sensitivity yearly upon new	ested om	05/06/2024	

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Event ID:

 $U7H321 \qquad {\tt Facility \, ID:} \quad 000357$ 

If continuation sheet Page 2 of 28

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	01	COMPL	ETED
		155519	B. W	NG		04/16/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD  16TH ST		
CENTLE	CARE STRATEGIE	=0			NNES, IN 47591		
GENTLE	CARE STRATEGI	=5		VINCEI	NINES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		2.3 states existing life safety			installation and then every		
		the public, if not required by			alternate year. It is the praction	ce of	
	the Code, shall be n	naintained. NFPA 72, Section			this facility to ensure battery		
	14.4.5.3 requires in	other than one- and two-family			operated smoke alarms are te	ested	
	dwellings, sensitivi	ty of smoke detectors and			monthly and battery changed		
	-	e-station smoke alarms shall be			yearly.		
		e with 14.4.5.3.1 through			What corrective actions	will	
		14.4.5.3.1 requires sensitivity			be accomplished for those		
	shall be checked wi	thin 1 year after installation			residents found to be affected	by	
		3.2 requires sensitivity shall be			the deficient practice:		
	1	nate year thereafter. This			a. All residents, staff		
	deficient practice could affect all residents, as well				members, and visitors have the	ne	
	as staff and visitors				potential to be affected by the		
					alleged deficient practice.		
	Findings include:				b. The vendor (Safe Care)		
					completed the sensitivity testi	ng	
		view on 04/16/24 between 8:45			and has replaced the failed al	arms	
	_	with the Maintenance			identified. Documentation		
		there was no documentation			received of completed work.		
		1 resident room single station			(Attachment #1)		
		tested for sensitivity. Based			c The Maintenance Directo	or	
		time of record review, the			and/or Designee replaced all		
	^	visor confirmed the lack of			batteries for the year and		
		the testing of sensitivity of the			documented on worksheet.		
		ent room smoke alarms. Based			(Attachment #2)		
		ween 1:20 p.m. and 3:30 p.m.			How other residents have	_	
	_	facility with the Maintenance			the potential to be affected by		
	_	confirmed all resident rooms are			same deficient practices will b	e	
	-	e station battery operated			identified and what corrective		
		are addressable to the fire alarm			action will be taken:		
	panel.				a. All residents, staff member		
					and visitors have the potential		
	_	viewed with the Director of			be affected by the alleged def	icient	
	_	enance Supervisor during the			practice.		
	exit conference.						
					What measures will be put		
	3.1-19(b)				place and what systemic char	nges	
					will be made to ensure that		
		review, observation, and			deficient practice does not rec		
	interview; the facili	ty failed to ensure	1		a. The Maintenance Director	will	

	MEDICARE & MEDIC				UNIB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155519	B. WING		04/16/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t		16TH ST		
GENITI E	CARE STRATEGIE	=8		NNES, IN 47591		
GLIVILE	OANL OTNATEGI		VIINCE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	documentation for t	he preventative maintenance		place the smoke alarms on a		
	of all battery operat	ed smoke alarms in resident		preventative maintenance		
	rooms was available	e. NFPA 101 in 4.6.12.3 states		schedule for monthly inspection	on	
	existing life safety	features obvious to the public,		and yearly battery change.		
		ne Code, shall be maintained.		b. The Maintenance Director	will	
		Fire Alarm and Signaling Code,		place the sensitivity testing da	ntes	
		Maintenance and Tests states		on the calendar to ensure		
		nent shall be maintained and		compliance.		
		e with the manufacturer's				
		ons and per the requirements		4. How the corrective actions	will	
	1 -	PA 72, 14.2.1.1.1 Inspection,		be monitored to ensure the	WIII	
	_	nance programs shall satisfy		deficient practices will not occ	aur.	
	_	this Code and conform to the		a. The Maintenance Director		
		eturer's published instructions.			WIII	
		-		provide a copy to the		
	_	ice could affect all residents,		Administrator for review of the		
	staff, and visitors.			maintenance schedule for the		
	F: 1: : 1 1			replacement of the monthly		
	Findings include:			inspection with yearly battery		
				change and the sensitivity tes	ting	
		view on 04/16/24 between 8:45		of those alarms.		
	_	with the Maintenance		b. This is an ongoing progran	n,	
		the facility was unable to		should non-compliance be		
		ive maintenance report that		observed, corrective action sh	nall	
		ry powered smoke alarms were		be taken, the observations an		
	· ·	basis. Furthermore, there was		any corrective actions taken w	vill	
		o show the batteries in all		be reviewed during Quality		
		te alarms were changed during		Assurance Meeting and the pl	lan	
	the past 12 month p	eriod or any time prior. Based		of action adjusted accordingly	if	
	on observation of a	resident room battery		warranted.		
	powered smoke alas	rm at the time of record review,				
	the back of the smo	ke alarm stated, "Replace				
	Batteries Every Yea	ar". Based on interview at the				
	1	ew, the Maintenance Supervisor				
		there was no documentation				
	_	ident room battery powered				
		peen tested on a monthly basis				
		l at least annually. Based on				
		a tour of the facility with the				
		visor between 1:20 p.m. and				
	_	ent sleeping rooms were				
	J.50 p.m., an reside	an accepting rooms were	1			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/16/2024
	PROVIDER OR SUPPLIER CARE STRATEGIE		1202 S	ADDRESS, CITY, STATE, ZIP COD 5 16TH ST NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0293 SS=E Bldg. 01	which were address.  This finding was re Nursing and Mainte exit conference.  3.1-19(b)  NFPA 101  Exit Signage  Exit Signage  Exit Signage  2012 EXISTING  Exit and directiona accordance with 7 illumination also s lighting system.  19.2.10.1  (Indicate N/A in or occupancies with where the line of 6 Based on observation failed to ensure 1 or continuously illuminations.)  Findings include:  Based on observation failed to ensure 1 or continuously illuminations.  Findings include:  Based on observation failed to ensure 1 or continuously illuminations.  Findings include:  Based on observation failed in the Maintenance Supervisor agreed to door was not fully in fix it as soon as positive in the soon	less than 30 occupants exit travel is obvious.) on and interview, the facility fover 10 exit signs was nated. This deficient practice 10 residents, as well as staff ons on 04/16/24 between 1:20 during a tour of the facility with apervisor, the exit sign above was not fully illuminated. Only nated. Based on interview at tion, the Maintenance he exit sign over the Hall 2 exit lluminated and said he would	K 0293	It is the practice of this facility to ensure exit signs are continuous illuminated.  1. What corrective actions will accomplished for those resident found to be affected by the deficient practice: a. Residents, staff members, a 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 potential to be affected by the	be nts and e nt

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U7H321

Facility ID: 000357

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			LETED	
		155519	B. WING 04/16/2024			/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	₹			16TH ST		
GENTLE	CARE STRATEGI	ES			NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	_	enance Supervisor during the			same deficient practicies will b	е	
	exit conference.				identified and what corrective		
	2.1.10(1-)				action will be taken:		
	3.1.19(b)				a. Residents, staff members,		
					visitors have the potential to b		
					affected by the alleged deficie practice.	IIL	
					practice.		
					3. What measures will be put	in	
					place and what systemic chan		
					will be made to ensure that	3	
					deficient practice does not rec	ur:	
					a. The Maintenance Director		
					place exit signs on a preventa	tive	
					maintenance schedule for mo	nthly	
					inspection. Identified issues w	vill	
					be immediately addressed.		
					b. All staff were educated on		
					importance of reporting if a bu		
					burnt out in any exit sign so th	ey	
					can be replaced.		
					4. How the corrective actions	will	
					be monitored to ensure the		
					deficient practices will not occ		
					a. The Maintenance Director	will	
					provide a copy to the		
					Administrator for review of the		
					maintenance schedule for mo	nthly	
					inspection of exit signs.		
					b. This is an ongoing program	١,	
					should non-compliance be	-11	
					observed, corrective action sh		
					be taken, the observations and		
					any corrective actions taken w	/111	
					be reviewed during Quality	on	
					Assurance Meeting and the pl		
					of action adjusted accordingly warranted.	11	
					wananteu.		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155519	B. W	ING		04/16/	2024
	PROVIDER OR SUPPLIER		•	1202 S	ADDRESS, CITY, STATE, ZIP COD 16TH ST NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer poor conditions under 10 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure staff use of the UL 300 h 1 of 1 kitchen. NFF Control and Fire Pro Cooking Operations	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2,  open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not reidor.  18.3.2.5.4, 19.3.2.5.1  19.9.2.3, TIA 12-2  19.10 and interview, the facility of were instructed in the proper mood fire suppression system in PA 96, Standard for Ventilation of Commercial standard in 10.5.7 states	K 0	324	It is the practice of this facility ensure staff are instructed in the proper use of the UL 300 hood suppression system.  1. What corrective actions will	he I fire	04/18/2024
	regarding the proper extinguishers and the fire-extinguishing estinguishing for man extinguishing systems conspicuously in the reviewed with employed	provided to employees r use of portable fire ne manual activation of quipment. Section 11.1.4 states nually operating the fire m shall be posted e kitchen and shall be toyees by management. This build affect kitchen staff plus all			accomplished for those reside found to be affecteed by the deficient practice:  a. Dietary Staff and any reside in the adjacent dining room hat the potential to be affected by alleged deficient practice.  b. Dietary Staff were in-service on the use of the UL 300 hoods.	ent ve the	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/16/2024	
	155519	B. WI	_		04/16/.	2024
NAME OF PROVIDER OR GENTLE CARE STE			STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591			
(X4) ID SI	IMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
l '	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	ATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
residents v	hile in the adjacent dining room.			system. (Attachment #4)		
Findings i  Based on op.m. and 3 the Mainterprovided vinterview when asked underneath staff #1 sadishwashi would use kitchen distrange hoof. This was a Supervisor interview. The Maintefor kitchen. This finding	observations on 04/16/24 between 1:20 ct 30 p.m. during a tour of the facility with nance Supervisor, the kitchen was with a UL 300 hood system. Based on with two kitchen dishwashing staff, d what they would do if there was a fire at the range hood. Kitchen dishwashing d she didn't know. Kitchen ag staff #2 said (and pointed to) he the K-class fire extinguisher. Neither hwashing staff said they would pull the after suppression system pull station. Ecknowledged by the Maintenance at the time of observation and with the two kitchen dishwashing staff. Enance Supervisor said more training staff would be a priority.			2. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken:  a. Dietary Staff and any reside in teh adjacent dining room hat the potential to be affected by alleged deficient practice.  3. What measures will be put place and what systemic chan will be made to ensure that deficient practice does not rec a. Dietary Staff were in-service on the use of UL 300 hood system. (Attachment #4) b. New employee hired for the Dietary Department will be instructed during orientation of operation of the steps of a fire the kitchen.  4. How the corrective actions be monitored to ensure the deficient practices will not occia. This is an ongoing program should non-compliance be observed, corrective actions taken where the deficient actions taken where the detail and the place of action adjusted accordingly warranted.	e ent ve the in ges ur: ed ef the in will ur: all de ill an	
staff #1 sa dishwashi would use kitchen dis range hood This was a Supervisor interview The Maint for kitchen This findin Nursing an exit confer	d she didn't know. Kitchen ng staff #2 said (and pointed to) he the K-class fire extinguisher. Neither hwashing staff said they would pull the I fire suppression system pull station. cknowledged by the Maintenance at the time of observation and with the two kitchen dishwashing staff. enance Supervisor said more training staff would be a priority.  g was reviewed with the Director of d Maintenance Supervisor during the			3. What measures will be put place and what systemic chan will be made to ensure that deficient practice does not rec a. Dietary Staff were in-service on the use of UL 300 hood system. (Attachment #4) b. New employee hired for the Dietary Department will be instructed during orientation of operation of the steps of a fire the kitchen.  4. How the corrective actions be monitored to ensure the deficient practices will not occi a. This is an ongoing program should non-compliance be observed, corrective action she taken, the observations and any corrective actions taken with the deficient of the corrective action in the taken, the observations and any corrective actions taken with the corrective action of the steps of a fire the kitchen.	ges ur: ed  f the in will ur: n, all d	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETED 04/16/2024		
	PROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP COD 3 16TH ST NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0325 SS=E Bldg. 01	Alcohol Based Ha ABHRs are protect 8.7.3.1, unless all * Corridor is at lea * Maximum individ 0.32 gallons (0.53 and 18 ounces of * Dispensers shall horizontal spacing * Not more than a fluid or 135 ounce single smoke com cabinet, excluding per room * Storage in a sing greater than 5 gall 30 * Dispensers are r an ignition source * Dispensers over sprinklered smoke * ABHR does not * Operation of the with Section 18.3. * ABHR is protecte access 18.3.2.6, 19.3.2.6, 460, 482, 483, and	dual dispenser capacity is gallons in suites) of fluid Level 1 aerosols have a minimum of 4-foot in aggregate of 10 gallons of is aerosol are used in a partment outside a storage one individual dispenser gle smoke compartment ons complies with NFPA not installed within 1 inch of it carpeted floors are in a compartments exceed 95 percent alcohol dispenser shall comply 2.6(11) or 19.3.2.6(11) and against inappropriate			
	Based on observation failed to ensure along dispensers were not source in 1 of 5 smc Section 19.3.2.6(8) installed in the folion (a) Above an ignition horizontal distance source	on and interview, the facility shol-based hand sanitizer installed over an ignition ske compartments. NFPA 101, states dispensers shall not be	K 0325	It is the practice of this facility ensure alcohol-based hand sanitizer dispensers were not installed over an ignition sour  1. What corrective actions wi accomplished for those reside found to be affected by the deficient practice:  a. All residents, staff member	ce. Il be ents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155519	B. W	NG	04/16/2024		
NAME OF B	DOVIDED OD CLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	C.	1202 S 16TH ST				
GENTLE	CARE STRATEGIE	≣S		VINCE	NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		stance from the ignition source			and visitors have the potential		
		tion source within a 1-inch			be affected by the alleged defi	cient	
		om the ignition source ice could affect up to 17			practice.		
	residents, staff, and	-			b. Alcohol-based hand sanitiz	er	
	residents, starr, and	VISITOIS III FIAII 1.			dispensers located above an electrical outlet were relocated	ı	
	Findings include:				(Attachment #5)	١.	
	rindings include.				(Attachment #5)		
	Based on observation	Based on observations on 04/16/24 between 1:20			2. How other residents having	the	
	p.m. and 3:30 p.m. during a tour of the facility with				potential to be affected by the	•	
	the Maintenance Su	pervisor, there were four			same deficient practices will be	Э	
	alcohol-based hand	sanitizer dispensers installed			identified and what corrective		
	on the Hall 1 corridor walls directly above				action will be taken:		
	electrical receptacle	es and a light switch. Based on			a. All residents, staff members	s,	
		e of each observation, the			and visitors have the potential	to	
	Maintenance Super				be affected by the alleged deficient		
		sanitizer dispensers were			practice.		
		l 1 corridor walls directly					
	above electrical rec	eptacles and a light switch.			3. What measures will be put		
					place and what systemic chan	ges	
	_	viewed with the Director of			will be made to ensure that		
	_	enance Supervisor during the			deficient practice does not rec		
	exit conference.				a. Alcohol-based hand sanitiz	er	
					dispensers located above an		
	3.1-19(b)				electrical outlet were relocated	l.	
					(Attachment #5)		
					4. How the corrective actions	will	
					be monitored to ensure the	vviii	
					deficient practices will not occu	ur:	
					a. This is an ongoing program		
					should non-compliance be	• ,	
					observed, corrective action sha	all	
					be taken, the observations and		
					any corrective actions taken w		
					be reviewed during Quality		
					Assurance Meeting and the pla	an	
					of action adjusted accordingly		
					warranted.		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(x3) date survey completed 04/16/2024
	PROVIDER OR SUPPLIER		1202 \$	ADDRESS, CITY, STATE, ZIP COD S 16TH ST ENNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarn Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on record facility failed to ma accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual inspectance of the if requiringuisdiction. Table must be visually instance and the control unit troubles. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification applie. Magnetic hold-op This deficient praction the facility.  Findings include:  Based on record revalum, and 1:20 p.m. Supervisor present, provided regarding	m is tested and maintained in an approved program is requirements of NFPA 70, Code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available.  FPA 70, NFPA 72  review and interview, the intain 1 of 1 fire alarm system in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section alless otherwise permitted by ections shall be performed in a schedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals attors  (e.g. duct detectors, manual cart detectors, smoke detectors, siances	K 0345	It is the practice of this facility to ensure the fire alarm system is tested and maintained visually inspected semi-annually. And completed sensistivity method  1. What corrective actions will accomplished for thosse reside found to be affected by the deficient practice:  a. All residents, staff members and visitors have the potential be affected by the alleged defipractice.  b. The vendor (Tri-State Fire) docoumentation received of completed inspections for the annual and semi-annual for the alarm system. (Attachments ##14, #15)  c. The vendor (SafeCare) completed inpsection which includes the sensitivity testing. (Attachment #1)  2. How other residents having potential to be affected by the	the be ents s, to cient e fire £13,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
		155519	B. W	B. WING 04/16/2024			
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER	L .			16TH ST		
GENTL F	CARE STRATEGIE	ES .	VINCENNES, IN 47591				
	Г		-		,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	-	TAG		DATE	
		ndor, however, the facility			same deficient practices will b	e	
	_	nformation of a semi-annual			identified and what corrective		
	_	the facility's fire alarm			action will be taken:		
		oke detectors, pull stations,			a. All residents, staff member		
		vithin six months after the			and visitors have the potential	l l	
	· ·	stem inspection/test. Based			be affected by the affected by	tne	
		time of record review, the			alleged deficient practice.		
	_	visor confirmed there was no			0 10/15-24 11	:	
		inspection of the facility's fire			3. What measures will be put	l l	
	· ·	es, such as smoke detectors,			place and what systemic chan	ges	
	pull stations, and he	eat detectors.			will be made to ensure that		
	Tr1 ' C' 1'	: 1 :4 4 D: 4 C			deficient practice does not rec		
	1	viewed with the Director of			a. The Maintenance Director		
	_	enance Supervisor during the			place the fire alarm inspection		
	exit conference.				sensitivity testing dates on the		
	2.1.10(1.)				calendar to ensure compliance	e.	
	3.1-19(b)				4 Hayyatha as was atiyya a ati a wa	ill	
	2 D11				4. How the corrective actions	WIII	
		review and interview, the			be monitored to esnure the		
	1	sure complete documentation			deficient practices will not occ		
		e sensitivity testing of all hard			a. The Maintenance Director	WIII	
		ors, and to show what testing d to test all smoke detectors			provide a copy to the	fina	
		PA 72, National Fire Alarm			Administrator for review of the	iire	
					alarm inspection and the		
		, Section 14.4.5.3.1 states			sensitivity reports to ensure		
		shall be checked within 1 year every alternate year thereafter.			compliance.		
		quired calibration test, if			b. This is an ongoing program	1,	
		cate that the detector has			should non-compliance be		
	1	listed and marked sensitivity			observed, corrective action sh		
		time between calibration tests			be taken, the observations and		
		be extended to a maximum of			any corrective actions taken w	'III	
					be reviewed during Quality	on	
	-	nency is extended, records of			Assurance Meeting and the pl		
		sance alarms and subsequent ns shall be maintained. In			of action adjusted accordingly warranted.	"	
		re nuisance alarms show an			warranteu.		
	_	evious year, calibration tests					
		To ensure that each smoke					
		s listed and marked sensitivity					
	range, it shall be tes	sted using any of the methods:				ĺ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155519		 UILDING	nstruction  01	(X3) DATE COMPL 04/16/	ETED	
	PROVIDER OR SUPPLIEI		1202 S	DDRESS, CITY, STATE, ZIP COD 16TH ST INES, IN 47591		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(1) Calibrated test in (2) Manufacturer's instrument. (3) Listed control expurpose. (4) Smoke detector arrangement where at the control unit with the cont	nethod. calibrated sensitivity test quipment arranged for the /fire alarm control unit by the detector causes a signal where its sensitivity is outside range. I sensitivity method acceptable ring jurisdiction. have sensitivity outside the ensitivity range shall be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		l í	JILDING	onstruction 01	(X3) DATE COMPL 04/16	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0346 SS=F Bldg. 01	services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to \$9.6.1.6  Based on record revialled to provide a contract of the service of the servic	f Service re alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall e building shall be approved fire watch shall be rties left unprotected by the e fire alarm system has service.  riew and interview, the facility complete and accurate written	K 0	346	It is the practice of this facility ensure a complete and accura	ate	04/17/2024
	indicating procedur the fire alarm system service for four hour hour period in acco	estion of all occupants es to be followed in the event m has to be placed out of ars or more in a twenty four rdance with LSC, Section ent practice affects all cility.			written policy for the protection all occupants indicating procedures to be followed in the event the fire alarm system must be placed out of service for followers or more in a twenty-four period.  1. What corrective actions will account the discrete for the extra street of the str	ne ust ur ·	
	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,				accomplished for those reside found to be affected by the deficient practice:  a. All residents, staff member and visitors have the potential be affected by the alleged defipractice.  b. The fire watch policy has bupdated to include the require documentation. (Attachment and the components of the same deficient practices will be identified and what corrective action will be taken:  a. All residents, staff member	s, to icient een d #6) g the	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPI A. BUILDIN B. WING	ee construction G <u>01</u>	COMF	E SURVEY PLETED 5/2024
	PROVIDER OR SUPPLIER		120	EET ADDRESS, CITY, STATE, ZIP 12 S 16TH ST ICENNES, IN 47591	? COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO TH	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
		pervisor confirmed the fire on that was provided lacked information.		and visitors have the be affected by the all practice.	•	
	_	viewed with the Director of chance Supervisor during the		3. What measures we place and what system will be made to ensure deficient practice does a. The fire watch pole updated to include the documentation. (Attained the documentation of the monitored to ensure deficient practices with a. This is an ongoing should non-complian observed, corrective be taken, the observed any corrective actions be reviewed during the control of action adjusted activation adjusted activation and warranted.	emic changes re that es not recur: licy has been ne required achment #6)  e actions will ure the ill not occur: g program, nce be action shall ations and st taken will Quality and the plan	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with Nappection, Testing Water-based Fire Records of system inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, Iting are maintained in a Ind readily available. It system last checked				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155519 B. WING 04/16/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1202 S 16TH ST **GENTLE CARE STRATEGIES** VINCENNES, IN 47591 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0353 04/19/2024 It is the practice of this facility to failed to maintain 1 of 1 sprinkler systems in ensure the sprinkler piping shall accordance with NFPA 25. NFPA 25, Standard for not be subjected to external loads the Inspection, Testing, and Maintenance of by materials either resting on the Water-Based Fire Protection Systems, 2011 pipe or hung from the pipe. edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials 1. What corrective actions will be either resting on the pipe or hung from the pipe. accomplished for those residents This deficient practice could affect all residents, found to be affected by the staff, and visitors. deficient practice: a. All residents, staff members, Findings include: and visitors have the potential to be affected by the alleged deficient Based on observations on 04/16/24 between 1:20 practice. p.m. and 3:30 p.m. during a tour of the facility with b. The Maintenance Director the Maintenance Supervisor, in the Maintenance removed lines that were tethered shop/office there were were at least three areas to the sprinkler pipes.(Attachment where wires and conduits were tethered to sprinkler pipes with zip ties. Based on interview at the time of the observation, the Maintenance 2. How other residents having the Supervisor acknowledged the wires and conduits potential to be affected by the tethered to the sprinkler pipes with zip ties and same deficient practicies will be said he would address the situation as soon as identified and what corrective possible. action will be taken: a. All residents, staff members, This finding was reviewed with the Director of and visitors have the potential to Nursing and Maintenance Supervisor during the be affected by the alleged deficient exit conference. practice. 3.1-19(b) 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 6/2024
	ROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP C 5 16TH ST NNES, IN 47591	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				a. The Maintenance D removed lines that wer to the sprinkler pipes. b. A walk through of the was completed to ensure were attached to sprinkly the further issues idented.  4. How the corrective be monitored to ensure deficient practices will a. During weekly roun Maintenance Director wife anything is tethered to sprinkler pipes. If issue identified, immediate of will be taken. b. This is an ongoing probable taken. b. This is an ongoing probable taken, the observed be taken, the observed any corrective actions be reviewed during Quental Assurance Meeting an of action adjusted accomparated.	ne facility ure no lines kler pipes. ified.  actions will e the no occur: ds, the will observe to the es orrection  program, e be ction shall ions and taken will hality d the plan	
K 0354 SS=F Bldg. 01	extent and duration been determined, are inspected and recommendations management or durand the fire depart having jurisdiction	- Out of Service er system is impaired, the en of the impairment has areas or buildings involved risks are determined,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED	
		155519	B. W	ING		04/16/	/2024	
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
OFNITIF	OADE OTDATEOU	-0			16TH ST			
GENTLE	CARE STRATEGIE	=5		VINCE	NNES, IN 47591			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	than 10 hours in a	24-hour period, the						
		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)							
		view and interview, the facility	$ _{K0}$	354	It is the practice of this facility	to	04/17/2024	
		complete written policy	K U	JJ <del>T</del>	ensure a complete written poli		04/1//2024	
	_	res to be followed for the			containing procedures to be	Oy .		
		cupants in the event the			followed for the protection of a	ш		
					occupants in the event of the	111		
	automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour				automatic sprinkler systems ha	36		
	period in accordance with LSC, Section 9.7.5. LSC				be to be placed out-of-service for			
				10 hours or more in a 24-h				
	9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard							
		Testing and Maintenance of			period.			
	_	Protection Systems. NFPA 25,			What corrective actions will	l ha		
	_	e procedures that the nator shall follow. A.15.5.2 (4)			accomplished for those reside	ทเร		
	_				found to be affected by the			
		ch should consist of trained			deficient practice:	_		
	_	inuously patrol the affected			a. All residents, staff member			
		to fire extinguishers and the			and visitors have the potential			
		notify the fire department are			be affected by the alleged defi	cient		
	_	consider. During the patrol of			practice.			
		should not only be looking			b. The sprinkler fire patrol was	icn		
		sure that the other fire			policy has been updated to			
	•	of the building such as egress			include the required	<b>''</b> (0)		
		stems are available and			documentation. (Attachment #	<del>/</del> 6)		
		y. This deficient practice						
	could affect all occu	upants in the facility.			How other residenets havir	•		
					the potential to be affected by			
	Findings include:				same deficient practices will be	е		
					identified and what corrective			
		view on 04/16/24 between 8:45			action will be taken:			
	_	with the Maintenance			a. All residents, staff member			
		the facility did provide fire			and visitors have the potential			
		on, however, it was incomplete.			be affected by the alleged defi	cient		
	_	nclude the following			practice.			
	information:							
	a. Notifying the Au	thority having jurisdiction;			3. What measures will be put	in		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/16/2024	
	PROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP COD 5 16TH ST NNES, IN 47591	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	when the sprinkler s more than 10 hours b. Contacting the II contacting the Incid on the IDOH Gatew c. Indicating the pe has been properly to Based on an intervi- the Maintenance Su watch documentation the previously ment	DOH with the web link for ent Reporting System located vay.  rson conducting the fire watch ained.  ew at the time of record review, pervisor confirmed the fire on that was provided lacked		place and what systemic char will be made to ensure that deficient practice does not reca. The sprinkler fire patrol was policy has been updated to include the required documentation. (Attachment:  4. How the corrective actions be monitored to ensure the deficient practices will not occa. This is an ongoing program should non-compliance be observed, corrective actions he taken, the observations an any corrective actions taken where the taken was accordingly warranted.	eur: ttch  #6)  will  ur: n, nall d
K 0355 SS=F Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5.  1. Based on observ facility failed to ensextinguishers observaccordance with NF Portable Fire Exting 6.1.3.8.1 states fire weight not exceeding that the top of the fithan five feet above	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.	K 0355	It is the practice of this facility ensure fire extinguishers having gross weight not exceeding 40 shall be installed so that the to the fire extinguisher is not mo than five feet above the floor. portable fire extinguishers are inspected monthly.  1. What corrective actions will	ng a O lb. op of re The

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  04/16/2024	
	PROVIDER OR SUPPLIER		1202 5	ADDRESS, CITY, STATE, ZIP COD S 16TH ST ENNES, IN 47591	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	visitors. Findings include:			accomplished for those reside found to be affected by the deficient practice: a. All residents, staff membe	
	Based on observation on 04/16/24 between 1:20			and visitors have the potentia	
		during a tour of the facility with		be affected by the alleged de	ficient
	noted:	pervisor, the following was		practice. b. The Maintenance Director	
		extinguisher mounted on the		lowered the fire extinguishers	
		1 1 exit door was measured at 5		below 5 feet which places the	
		top of the extinguisher.		required placement. (Attachr	
	b. The portable fire extinguisher mounted on the			#8)	
	wall next to the Hall 2 exit door was measured at 5			c. The Maintenance Director	
	feet 3 inches at the top of the extinguisher.			completed the monthly requir	ed
		, this was acknowledged by		inspection on the fire	
		pervisor at the time of each		extinguishers dientified during	9
	observation.			survey. (Attachment #9)	
		viewed with the Director of		2. How other residents havin	_
		enance Supervisor during the		potential to be affected by the	
	exit conference.			same deficient practices will be	
	2.1.10/1)			identified and what corrective	
	3.1-19(b)			action will be taken:	
	2 Događan shaam	ention and interviews the		a. All residents, staff membe	
		ation and interview, the pect 2 of 8 portable fire		and visitors have the potential be affected by the alleged de	
		month during the past 12		practice.	licient
	_	PA 10, Standard for Portable		practice.	
	_	Section 7.2.1.2 states fire		3. What measures will be pu	t in
		be inspected either manually or		place and what systemic char	
	_	etronic device/system at a		will be made to ensure that	
	1 -	intervals. Section 7.2.2 states		deficient practice does not rec	cur:
	1	or electronic monitoring of fire		a. The Maintenance Director	
		include a check of at least the		lowered the fire extinguishers	;
	following items:			below 5 feet which places the	em in
	(1) Location in desi			required placement.	
		to access or visibility		b. The Maintenance Director	
	` /	reading or indicator in the		checked all fire extinguishere	s to
	operable range or p			ensure that they were mounted	ed
	(4) Fullness determ	ined by weighing or hefting for		per regulations. No further is	sues

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/16/2024	
	PROVIDER OR SUPPLIER		1202 S	ADDRESS, CITY, STATE, ZIP COD 5 16TH ST NNES, IN 47591	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	self-expelling-type cartridge-operated of (5) Condition of tire nozzle for wheeled (6) Indicator for nor using push to-test p Section 7.2.4.1 state inspections shall ke extinguishers inspections shall ke extinguishers inspections shall ke extinguishers inspection of the conducted, the date performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a tax extinguisher, on an maintained on file, Section 7.2.4.5 requal demonstrate that at inspections have be practice could affect visitors in the facility. Findings include:  Based on observation p.m. and 3:30 p.m. the Maintenance Sunoted:  a. The ABC portable kitchen was not instructed in Augusta. The ABC portable laundry room was resulted.	extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers are chargeable extinguishers ressure indicators. Es personnel making manual ep records of all fire cted, including those found to ction. Section 7.2.4.3 requires the manual inspections are the manual inspection was nitials of the person ection shall be recorded. Eitres where manual inspections rds for manual inspection that the last 12 monthly en performed. This deficient that all residents, staff and ty.  Ons on 04/16/24 between 1:20 during a tour of the facility with a time performed. The following was the fire extinguisher in the pected monthly in October of 2023, and January through the annual inspection of this fire facility's vendor was	TAG	identified. c. The Maintenance Director completed the monthly requir inspection on the fire extinguishers identified during survey. d. The Maintenance Director added the missed fire extinguishers to the monthly check list.  4. How the corrective actions be monitored to ensure the deficient practices will not occa. The Maintenance Director added the location to the mor checklist for the portable fire extinguishers. b. This is an ongoing program should non-compliance be observed, corrective actions are any corrective actions taken to be reviewed during Quality Assurance Meeting and the pof action adjusted accordingly warranted.	ed  g has s will cur: has hthly m, hall hd will

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155519	B. WIN	NG		04/16/	2024
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
GENTLE	CARE STRATEGIE	ES		1202 S 16TH ST VINCENNES, IN 47591			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION
TAG	through March of 20 this fire extinguished performed in August Based on interview Maintenance Supernaforementioned por been inspected mon	at the time of observation, the visor acknowledged the table fire extinguishers had not		TAG			DATE
K 0522 SS=E Bldg. 01	heating plant, is do combustible mater device, and has a and shut down equexcessive temperature fuel fired, the devitation and shut down excessive temperature fuel fired, the devitation are takes air for commoccupied are 19.5.2.2  Based on observation failed to ensure intained to ensure intained to ensure intained fuel fired equipment create an atmospheric which could cause provides the strength of the strength	ng Device e, other than a central esigned and installed so rials cannot be ignited by safety feature to stop fuel uipment if there is ature or ignition failure. If ce also: nt connected. bustion from outside. mbustion system separate a atmosphere.  on and interview, the facility ke combustion air from the ed in 1 of 1 rooms containing t. This deficient practice could be rich with carbon monoxide ohysical problems for mostly room and other adjacent	K 05	322	It is the practice of this facility ensure intake combustion air fromteh outside in a room containing fuel fired equipmen  1. What corrective actions will accomplished for those reside found to be affected by the deficient practice:  a. Staff members have the potential to be affected by the	t. be	05/07/2024

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 $U7H321 \qquad {\tt Facility \, ID:} \quad 000357$ 

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1	JILDING	01	COMPL	
		155519	B. WI			04/16/	ZUZ4 
	PROVIDER OR SUPPLIE			1202 S	ADDRESS, CITY, STATE, ZIP COD 16TH ST NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	Based on observati	ions on 04/16/24 between 1:20		1710	alleged deficient practice.		DITTE
		during a tour of the facility with			b. Maintenance Director		
		upervisor, the the dryer room			assessed the fresh air intake		
		room had two fuel fired dryers			the crawl space has several a		
		ly working fresh air vent for			intake vents. An intake fan w	as	
		air from the outside provided			installed behind the dryer.		
		oom. There was a wall vent fan			(attachment #10)		
		eptacle that opened into the ce, however, the vent fan was			How other residents having	g the	
		st/dirt and was not running at			potential to be affected by the	•	
	the time of observa	ation. Based on interview at the			same deficient practices will b		
	time of observation	n, the Maintenance Supervisor			identified and what corrective		
	confirmed the vent	fan was not currently working			action will be taken:		
	and agreed there w	as no fresh air vent for intake			a. Staff members have the		
	combustion air from	m the outside in the dryer room.			potential to be affected by the		
					alleged deficient practice.		
		eviewed with the Director of					
	_	enance Supervisor during the			3. What measures will be put	in	
	exit conference.				place and what systemic char	nges	
					will be made to ensure that		
	3.1-19(b)				deficient practice does not red	cur:	
					a. Maintenance Director insta		
					an intake fan behind the drye.		
					b. Maintenance Director and		
					Housekeeping Supervisor will		
					complete a worksheet and		
					document findings to ensure f	ans	
					are cleaned and maintained.		
					(Attachment # 11)		
					4. How the corrective actions	will	
					be monitored to ensure the		
					deficient practices will not occ	ur:	
					a. This is an ongoing program	n,	
					should non-compliance be		
					observed, corrective action sh		
					be taken, the observations an		
					any corrective actions taken v	/ill	
					be reviewed during Quality		
					Assurance Meeting and the p	lan	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155519			JILDING	onstruction 01	(X3) DATE COMPL <b>04/16</b> /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
					of action adjusted accordingly warranted.	if	
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. The of the fire safety per 18/19.2.2.  18.7.1.1 through 18.7.2.3.19.7.2.12, 19.7.2.12, 19.7.2.12, 19.7.2.19.8.2.3.19.7.2.1.2, 19.7.2.1.2.19.7.2.19.7.2.19.7.2.19.7.2.19.7.2.19.7.2.19.7.2.19.7.2.19.7.2.2.2.19.7.2.2.2.19.7.2.2.2.19.7.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.	elocation Plan plan for the protection of all eir evacuation in the event  priodically instructed and their duties under the plan, plan is readily available erator or with security. The e basic response required 7.2.1.2 and provides for all lan components per  8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 2, 19.7.2.3 Priew and interview, the facility complete and accurate facility safety plan for the protection courately address all life safety em addressing all items 101, 2012 edition, Section 1.2.2 requires a written health care try plan that shall provide for  Calarm to fire department the call to fire department mediate area moke compartment cloors and building for	K 0	711	It is the practice of this facility ensure a complete and accura facility specific written fire safe plan for the protection of all residents to accurately addres life safety systems.  1. What corrective actions will accomplished for those reside found to be affected by the deficient practice:  a. All residents, staff members and visitors have the potential be affected by the alleged defi practice.  b. Administrator reviewed and updated emergency preparedr plan (EPP) to include the appropriate steps for kitchen fi	tte tty s all l be nts s, to cient l ness	04/18/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155519	B. WI	NG		04/16/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					16TH ST		
GENTLE	CARE STRATEGIE	ES		VINCE	NNES, IN 47591		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	Section 19.2.3.4(4) states any required aisle or				(Attachement #4)		
	` '	e less than 48 inches in clear			, ,		
	width where serving as means of egress from				2. How other residents having	the	
	patient sleeping rooms. Projections into the				potential to be affected by the	,	
	required width shall be permitted for wheeled				same deficient practices will b	e	
	equipment provided the relocation of wheeled				identified and what corrective	_	
	equipment during a fire or similar emergency is				action will be taken:		
	addressed in the written fire safety plan and				a. All residents, staff member	s	
	training program for the facility. The wheeled				and visitors have the potential		
	equipment is limited to:				be affected by the alleged defi		
	i. Equipment in use and carts in use				practice.		
	ii. Medical emergency equipment not in use				praduos.		
	iii. Patient lift and transport equipment				3. What measures will be put	in	
	This deficient practice could affect all occupants				place and what systemic chan		
	in the event of an emergency.				will be made to ensure that	900	
					deficient practice does not rec	ur.	
	Findings include:				a. The Administrator reviewed		
					updated the emergency	auna	
	Based on a review of	of the facility's Fire plan on			preparedness plan (EPP) to		
		:45 a.m. and 1:20 p.m. with the			include the appropriate steps	or	
		visor present, the plan did			kitchen fire.	01	
	_	he K-class fire extinguisher in			b. All Staff were in-service on	the	
		er, it was addressed prior to the					
		ange hood suppression		updated emergency preparedness plan on 04/18/2024.			
	system. The Fire pl				Piair 617 6 17 16/262 1.		
	"Steps to take in case				4. How the corrective actions	will	
	"a. Employee pull				be monitored to ensure the		
		e and anything else running			deficient practices will not occ	ıır.	
	electrical as well as				a. The facility will provide a ye		
		opriate fire extinguisher in			in-service for all staff on the		
		o put out the fire if can.			emergency preparedness plar	1.	
	_	extinguisher is to be used for			b. This is an ongoing program		
		B) RED Fire Extinguisher is for all			should non-compliance be	-,	
	,	also be used for grease fires."			observed, corrective action sh	all	
		able to extinguish the fire			be taken, the observations and		
		_			any corrective actions taken w		
	safely in the kitchen, leave the kitchen. As you exit the kitchen pull the manual release for the				be reviewed during Quality		
	_	located to the right of the			Assurance Meeting and the pl	an	
	kitchen exit door."	riceased to the right of the			of action adjusted accoringly if		
		at the time of record review,			warranted.		
	Dasca on micrylew	at the time of record leview,	1		ı wallalıcu.		1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MUL <sup>2</sup> A. BUIL <sup>1</sup> B. WINC	<u>v .</u>		(X3) DATE SURVEY COMPLETED 04/16/2024		
NAME OF PROVIDER OR SUPPLIER  GENTLE CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 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		PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE	
K 0712 SS=F Bldg. 01	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		K 071		It is the practice of this facility to ensure fire drill reports include documentation of the transmiss of a fire alarm signal to the monitoring company.  1. What corrective actions will accomplished for those resider found to be affected by the deficient practice:  a. All residents have the poter	sion be nts	05/07/2024	
	Findings include:				to be affected by the alleged deficient practice.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155519	B. WING			04/16/2024	
			<u> </u>	CTDEET	ADDRESS CITY STATE ZIR COD	l	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD  16TH ST		
GENTLE CARE STRATEGIES					NNES, IN 47591		
GENTLE	CARE STRATEGI			VINCE	NINES, IIN 47591		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
		the facility's fire drill reports			b. Administrator updated the fire		
	on 04/16/24 between 8:45 a.m. and 1:20 p.m. with			drill report to show documentation			
	the Maintenance Supervisor present, 5 of 12 fire				of the signal being received by		
	drill reports performed during the past 12 month				monitoring station.		
	period were not provided with documentation for						
		the alarm to the monitoring		2. How other residents ha		the the	
		rill dates and times include:	pot		potential to be affected by the	-	
	06/29/23 at 10:00 p.m., 09/29/23 at 5:45 a.m.,			same deficient practices will be			
		m., 01/31/24 at 9:30 a.m., and			identified and what corrective		
		m. Based on interview at the			action will be taken:		
		ew, the Maintenance Supervisor			a. All residents havee the		
		e was no information on 5 of 12			potential to be affected by the		
	•	verify that transmission of the			alleged deficient practice.		
	alarm was received	by the monitoring company.					
					3. What measures will be put		
	_	viewed with the Director of			place and what systemic chan	ges	
	Nursing and Maintenance Supervisor during the				will be made to ensure that		
	exit conference.				deficient practice does not recur:		
					a. The Maintenance Director will		
	3-1.19(b)				utilize the updated fire drill rep		
	3.1-51(c)				which includes signal received	-	
					monitoring station. (Attachmer	nt	
		ord review and interview, the			#12)		
	_	sure fire drills were held at			b. The Maintenance Director		
		of 3 employee shifts during 3 of			place the sensitivity testing da	tes	
	_	ficient practice could affect all			on the calendar to ensure		
	residents in the facility.				compliance.		
	Findings include:				c. A schedule for the year has		
	Findings include:				been developed that has fire o	ITIIIS	
	Based on review of the facility's fire drill reports				occurring on each shift, each	01/0	
		-			quarter at varying times and d of month.	ays	
		en 8:45 a.m. and 1:20 p.m. with				haa	
	the Maintenance Supervisor present, 4 of 4 second shift (evening) fire drills were performed			d. The Maintenance Director has			
	between 2:08 p.m. and 3:10 p.m. Based on			been instructed on fire drills being			
	_	-			conducted on each shift, each		
	interview at the time of record review, the				quarter at varying times and days		
	Maintenance Supervisor acknowledged the times				of month.		
	the second shift fire drills were performed and agreed the times were not varied enough.				4. How the corrective actions	vazill	
	agreed the times we	ere not varied enough.				WIII	
					be monitored to ensure the		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155519	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/16/2024	
NAME OF PROVIDER OR SUPPLIER GENTLE CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 1202 S 16TH ST VINCENNES, IN 47591				
(X4) ID PREFIX TAG	ENTLE CARE STRATEGIES  4) ID SUMMARY STATEMENT OF DEFICIENCIE LEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  deficient practices will not occ a. The Maintenance Director 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 rep of the sensitivity of testing of the alarms when those occur.  b. The Maintenance Director 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 she he taken, the observations will be	(X5) COMPLETION DATE	
					reviewed during Quality Assur Meeeting and the plan of actic adjusted accordingly if warran	n	

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